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HIV-negative Men-who-Have-Sex-with-Men who Bareback are Concerned about HIV Infection: Implications for HIV Risk Reduction Interventions

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Abstract

The emergence of barebacking (intentional unprotected anal intercourse in situations where there is risk of HIV infection) among men who have sex with men (MSM) has been partially attributed to a decrease in HIV-related concerns due to improved anti-retroviral treatment. It is important to understand the level of concern these men have regarding HIV infection because it can affect their interest in risk reduction behaviors as well as their possible engagement in risk reduction interventions. As part of a study on MSM who use the Internet to seek sexual partners, 89 ethnic and racially diverse men who reported never having an HIV-positive test result completed an in-depth qualitative interview and a computer-based quantitative assessment. Of the 82 men who were asked about concerns of HIV infection during the qualitative interviews, 30 expressed "significant concern" about acquiring HIV, while 42 expressed "moderate concern," and 10 expressed "minimal concern. Themes that emerged across the different levels of concern were their perceptions of the severity of HIV infection, having friends who are HIV positive, and their own vulnerability to HIV infection. However, these themes differed depending on the level of concern. Among the most frequently mentioned approaches to decrease risk of HIV infection, participants mentioned avoiding HIV-positive sex partners, limiting the number of partners with whom they barebacked, and not allowing partners to ejaculate inside their rectum. Findings suggest that many MSM who bareback would be amenable to HIV prevention efforts that do not depend solely on condom use.

Keywords

gay men; HIV prevention; HIV concerns; HIV optimism; raw sex

INTRODUCTION

The emergence of barebacking among men who have sex with men (MSM) over the past decade has caused concern, as it marked a shift from momentary lapses in using condoms to intentionally choosing not to use them for some or all sexual encounters (Berg, 2009; Wolitski, 2005). A consensus on the definition of barebacking remains elusive. Most study participants from gay community samples have used the term to describe any condomless

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anal intercourse, while some researchers have used it to refer to intentional condomless anal intercourse and other researchers to intentional condomless anal intercourse when there is risk of HIV infection-thus excluding HIV-negative MSM in monogamous relationships from the definition (Carballo-Dieguez, et al., 2009; Huebner, Proescholdbell, & Nemeroff, 2006). Studies have found that the majority of MSM do not engage in barebacking (Berg, 2008; Elford, Bolding, Davis, Sherr, & Hart, 2007; Halkitis, Wilton, & Galatowitsch, 2005; Mansergh, et al., 2002), that MSM who bareback are more likely to be HIV positive (Halkitis, Parsons, & Wilton, 2003; Halkitis, et al., 2005; Mansergh, et al., 2002; Wilton, Halkitis, English, & Roberson, 2005), and that men who bareback tend to seek out partners of their same serostatus (Halkitis, et al, 2003; Halkitis, et al., 2005; Halkitis & Parsons, 2003; Mansergh, et al., 2002; Wilton, et al., 2005). However, the proportion of HIV-negative study participants who have reported engaging in bareback sex has been as high as 41.8% (Halkitis, et al., 2003), and about one-fourth of HIV-negative MSM who bareback have reported doing so with partners who were HIV positive or whose serostatus was unknown (Berg, 2008; Mansergh, et al., 2002; Wilton, et al., 2005). As such, barebacking has been implicated in the rise of HIV infections among MSM in the United States over the past 8–10 years (Berg, 2009; Halkitis, 2007) and it has not been limited to the U.S. (Adam, Husbands, Murray, & Maxwell, 2005; Elford, et al., 2007; Ridge, 2004).

Men who bareback report that in doing so, they seek greater intimacy, connectedness, and physical pleasure in their sexual interactions and are thus willing to tolerate greater risk of HIV infection (Carballo-Dieguez, el al., 2011; Mansergh, et al., 2002). However, researchers have proposed that a number of factors coalesced to facilitate the emergence of barebacking as a cultural phenomenon in the gay community, including: drug use, especially “club drugs” such as ecstasy, GHB, and methamphetamines (Halkitis, Parsons, & Stirrat, 2001; Wilton, et al., 2005); the Internet, which facilitated finding other partners into barebacking (Carballo-Diéguez, et al., 2006; Davis, Hart, Bolding, Sherr, & Elford, 2006; Grov, 2006; Halkitis, et. al., 2003; Wolitski, 2005) and the formation of social norms around barebacking (Berg, 2008); and growing fatigue and disinterest in AIDS prevention campaigns and the availability of effective anti-retrovirals, which helped to diminish concerns about HIV infection (Halkitis, et. al., 2003; Wolitski, 2005; Wolitski & Branson, 2002).

Although an extensive literature has emerged over the past 10 years on demographics of MSM who bareback, meanings and experiences of bareback sex, and possible reasons for engaging in barebacking, much less emphasis has been placed on interventions to reduce HIV risk among this population. A recent review of the barebacking literature (Berg, 2009) shows that although there are articles on possible HIV-risk reduction approaches, such as psychodynamic psychotherapy (Blechner, 2002; Cheuvrant, 2002) or Motivational Interviewing (Parsons, 2005; Shernoff, 2006), and researchers have recommended public health and harm reduction interventions for this population (Adam, et al., 2005; Grov, 2006; Parsons & Bimbi, 2006; Suarez & Miller, 2001), to date there are no studies aimed at developing or testing interventions whose aim is to reduce HIV risk behavior among this very high-risk population.

Prior to developing such interventions, however, it is important to understand the level of concern that MSM who practice bareback sex have about HIV infection. Many theories of health behavior change, such as the Health Belief Model, the AIDS Risk Reduction Model, the Transtheoretical Model of Behavior Change, Social Cognitive Theory, and the Information-Motivation-Behavioral Skills model, consider concerns or perceived vulnerabilities about a health risk behavior as a critical component of health behavior change (Fisher & Fisher, 2000). For example, the first two stages of the Transtheoretical Model (TTM) of behavior change (Prochaska, et al., 1994) differentiate between people who, due to lack of information or lack of concern about a risk behavior, are not contemplating

behavior change (Pre-Contemplation), and those who are distressed by their risk behavior and are contemplating changing their behavior (Contemplation). As such, concern about a particular risk behavior would be necessary for the person to move from a pre-contemplation stage to contemplation. However, there is little data about the concerns that MSM who engage in barebacking have about HIV infection.

In the initial descriptions of barebacking there was often little differentiation between barebacking and bugchasing (ie., purposely seeking to become HIV infected), with the assumption made that MSM who barebacked, at best, did not care if they became HIV infected and, at worst, sought HIV infection as part of a death wish (Gauthier & Forsyth, 1999; Tomso, 2004). Although recent literature differentiates more clearly between barebacking and bugchasing, questions remain as to how concerned MSM who bareback are about HIV infection and how motivated they are to reduce their HIV risk behavior (Parsons & Bimbi, 2006). Decreased HIV concerns have been associated with increased HIV risk behavior among HIV-positive and negative men (Vanable, et. al., 2000). Yet, in assessing the impact of HIV treatment advances on concerns of HIV infection, Berg (2007) found that MSM who engaged in barebacking considered HIV to be more serious than those who did not bareback. And Halkitis, et al., (2005) found no difference among MSM who bareback and those who do not, in terms of decreased worries about HIV infection. Although these quantitative findings tell us whether or not MSM who bareback are concerned about HIV infection, they do not allow a deeper understanding of how HIV negative MSM who bareback experience their own concerns about HIV infection, including how concerned they are about HIV infection, how important it is to them to remain HIV negative, and how they believe their lives would be impacted if they acquired HIV. Understanding these subjective experiences and meanings is necessary in order to develop effective HIV prevention interventions (Crossley, 2004).

Given the high risk behavior in which these men have decided to engage, the aim of this paper is to explore concerns about HIV infection among HIV-negative men who bareback and to identify some of the risk reduction activities in which they currently engage. This can provide valuable insights into how to best engage these men in reducing their risk of HIV infection and the types of risk reduction interventions to which they may be most amenable.

METHOD

Participants

Participants for this study, titled “(title omitted to preserve anonymity)” were recruited from April 2005 to March 2006 exclusively through websites previously identified by other MSM as sites where one could find men “into barebacking” (reference omitted to preserve anonymity). Men were approached through emails or instant messages directing them to the study website and, if interested, were asked to call for an eligibility screening. To participate, men had to be at least 18 years of age, reside in the New York City metropolitan area, report using the Internet at least twice per month during the past few months to seek sexual partners, repot having intentional condomless anal intercourse with a man met over the Internet, use one of the six Internet sites identified in the first phase of the study as most popular for meeting men into barebacking, and report being “barebackers” or “into barebacking.” Recruitment targeted similar proportions European-American, African-American, Latino, and Asian/Pacific Islander men and oversampled HIV-negative men so they would constitute two-thirds of the final sample. This paper focuses solely on these HIV-negative participants. The study was approved by the Institutional Review Board of the New York State Psychiatric Institute.

Interview

After signing informed consent, participants underwent an in-depth interview with one of three doctoral-level clinical psychologists who have extensive experience in sexual interviewing. The interview inquired about participants' definition of bareback sex, feelings toward and experiences of barebacking, concerns about HIV infection, substance use, and ethnic and racial identity. Following the interview, participants completed a structured, quantitative assessment using Computer Assisted Self-Interview (CASI), which included a section on HIV testing practices and HIV status. Participation in the study lasted about two hours and participants received $50 as compensation for their time.

Data Analysis

In-depth interviews were audiotaped, transcribed by a transcription service, and verified for accuracy. A preliminary codebook, constructed from the structure of the interview guide, was developed by a six-person team of researchers involved with the study. The codebook specified the first level code headings, which were based on the different sections of the interviews (i.e. Bareback Definition; HIV/STI; Condom Use; Disease Prevention Strategies), the definition, and inclusion and exclusion criteria for each code. Four transcripts were coded independently to assess concurrence in coding using these first level codes. Subsequently, the codebook was further specified and a team of four coders, who had reached 80% intercoder convergence (Hruschka, et. al., 2004; Marques & McCall, 2005; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Thompson, McCaughan, Cullum, Sheldon, & Raynor, 2004) using NVivo qualitative analysis software, proceeded to code all the transcripts.

In this manuscript, we focus on the codes "HIV/STI" and "Disease Prevention Strategies." From the "HIV/STI" code report, we extracted the sections focused on concerns about contracting HIV or STIs. And we excluded from the NVivo report any participants who responded "Yes" to the question "Have you ever tested HIV positive?" which was asked during the CASI. Once the initial review of participants' comments about HIV infection revealed a spectrum of HIV concern, two researchers independently categorized each participant as "significant," "moderate," or "low" concern. The concordance for this initial review was 61.8%. Subsequently, the two researchers discussed discrepancies in the categorization of specific participants until consensus was reached as to which category to place each participant. Once divided into the categories of concerns, thematic analysis was used to identify issues that emerged during the interviews. For the Disease Prevention Strategies code, once the strategies used by participants were identified from the text of the interviews, they were tallied based on the number of participants who reported using each practice.

RESULTS

Demographics

As seen in Table 1, the 89 ethnically diverse participants had a mean age of 32, a median income of $25,500 and had completed a mean of 14 years of schooling, with 90% of the sample having completed a high school education. The great majority of participants were gay-identified and had undergone prior HIV testing (93%), with 39 (43%) of the participants reporting 10 or more HIV tests during their lifetime.

Concerns about HIV Infection

Of the 82 men who were asked about concerns of HIV infection during the qualitative interviews, 30 expressed "significant concern" about acquiring HIV, while 42 expressed "moderate concern," and 10 expressed "minimal concern. As seen in Table 2, African-

American participants were over-represented in the "minimal concern" group. Three central themes were present in participants' narratives in each of the concern levels: perception of HIV as a treatable illness, contact with others who are HIV-infected, and a sense of vulnerability to HIV infection. A fourth theme, the impact of their HIV infection on family members, was mentioned by participants in the significant and moderate concerns, but not in the minimal concern group. Below, we expand upon the themes identified, presenting them by level of concern.

Significant concerns—When asked about how big of a concern HIV infection was, these participants strongly stated that they did not want to become infected with HIV. In general, these men considered HIV/AIDS to be a serious medical condition which, although currently treatable, is not curable, and would bring significant consequences. Although these participants recognized the discrepancy between their concerns and their sexual behavior, most elaborated spontaneously on the concerns they expressed.

> They're a huge concern. That's funny because there are so many diseases out there. But I always think of like AIDS and HIV as like one of the biggest. I've always thought that, diseases like cancer and arthritis or Alzheimer, you can't prevent those. Those just happen. But something like AIDS or HIV, you could prevent. So, to me, that's very scary. And, you know, if I get a disease I can't do anything about, that's fine, but the idea of having HIV or AIDS, something that I could have prevented, that scares me. (#102; Latino, Age 25)

> HIV is a big concern. Um, I will not jump on the bandwagon of 'It's a manageable disease,' not in the sense that I'm disagreeing, and it is a manageable disease now. But people are going, oh, it's like having diabetes. Um, it's -- yeah, my mother has diabetes. It's not fine. Just like the fact that it's manageable, you know, here's a woman who loves Haagen-Dazs ice cream for, like, 40 years of her life, and now she has to think about when she wants to have it. And I kind of think a lot of people don't really think about taking the medications every day. A lot of people don't think about the side effects. I'm really freaked out by taking medication anyway, like when I get a headache, I just lay down and ride it out. I never even take aspirin unless it's really, really bad or prescribed by a doctor. But, HIV -- I don't think we know enough to feel this comfortable. So, I'm not going to let myself feel that comfortable. (#160; Other, Age 28)

For some, the concerns about HIV came after engaging in bareback sex as they recollected the sexual event and, in retrospect, focused on the risk of HIV infection. These participants spoke of HIV testing as a highly stressful event, as they assessed their level of HIV risk behavior over the past months.

> A lot [of HIV concerns], but only in retrospect. While the event is happening, you know, not too much. You know, I mean, it's great, yeah. But you -- you don't really think about it. It's not until the -- you know -- the schedule of the HIV test, when you really start freaking out. And you're like, oh my god, oh my god, I fucked that guy, and that was probably not a good idea. (#011; Latino, Age 23)

> I go in there, they draw the blood, take a test for any other, you know, STDs. And I go there about a week later, get the results. And that's, like, a scary week. (laughter) That's a very scary week. Especially what I do. Um, like, you be biting your nails to where you're bleeding. (laughter) And it's just from anxiety. (#123; African-American, Age 18)

For these participants, their experiences with friends or acquaintances who are HIV positive reinforced their desire to avoid HIV infection by highlighting the challenges faced by these individuals in terms of treatments, side effect, and stigmatization.

> Well, I've seen people living HIV life and…and I think like they are -- like it's so painful and so, it's so bad that I don't want to be one of those, you know (#072, Other, Age 24)

> [HIV] is just the big hassle. You get all the issues internally and, you know, outside yourself. You get all sorts of issues. And then, economic-wise, you've got to do this, you've got to do that. You've got to buy this. And then there's the stigma and -- It's just like, if you have it, it's -- It's not the end of it, but it's like you cannot reverse it. (#098, Asian/Pacific Islander, Age 31)

> I don't want to get infected. Well, of course, according to some people, I'm doing everything I can to get infected. I don't want to get infected. I know too many people, um, who have died from HIV infection, of AIDS. Don't want to do that. (#111, African-American, Age 47)

For others, the increased vulnerability stemmed from prior experiences with sexually transmitted infections or situations in which they thought they had been infected with HIV.

> I just worry that I'll contract -- I've had gonorrhea and I've had Chlamydia, and I've had this thing where my balls swelled up. I don't want any of those again ever. They were all awful experiences and really made me frightened, particularly the one -- where my testicles became very sensitive and swollen […] I was a little confused as to how that happened but then later I was researching it and it does say that it's an STD. So it was very strange for me. I have been tested since all of those things so I know that none of those things led to any type of -- to HIV, which is my primary concern ----that and you know, syphilis, I think there's a resurgence in that in New York so I'm concerned about that but not as much as HIV…and there's no reason why I wouldn't be as concerned about syphilis. The only reason is that syphilis is not in the news as much as HIV and HIV has been a constant, on my mind since '83. (#155; African-American, Age 39)

Three participants also spoke of wanting to remain HIV negative for their families, who would be distraught if they seroconverted and felt a responsibility to not bring distress onto their family by becoming infected with HIV.

Moderate concerns—Responses from these participants often reflected a decreased concern about HIV and a greater perception of HIV as a manageable disease to which one would have to adapt, but, given treatment advances, would no longer be a death sentence. Compared to the men who expressed significant concern about HIV infection, the majority of these men did not specifically state that they did not want to be infected with HIV and often qualified their expressions of concerns with statements such as those that follow.

> They [HIV and STIs] concern me to a certain degree, you know. They don't overwhelm me. I kind of go through that kind of short scan of my brain before I go there, and then I really just assess the risk, and then you do them or you don't do them, and then I don't really beat myself up about it later. You know, it's kind of like, to get on a plane, if you want to spend the next three hours worrying if the pilot can land it, you know-- you need to give that up when you get on a plane. Because it's not -- there's nothing you can do about it now, you know. And if this is bad behavior, and you think it's going to freak you out, then don't do it. But, you know, there's no point of having an hour of fun, and then three weeks of worry. You know, like, why go there? (#020; European-American, Age 37)

> I mean, it's definitely a concern. You know, if I were to become HIV-positive, I don't think it'd be the end of the world. People can continue with their regular lives with the anti-retrovirals, and you wouldn't even know it. But, I mean, I think some people glamorize that and think that it doesn't matter anymore, without knowing that, OK, some of these people you may not see are vomiting and really just don't feel well because they're taking these medications. So I'd rather avoid all that if I can. But it's definitely different than before these treatments out, where it was almost like, you're going to die, pretty much. So I don't think there's really that fear any more. (#151; Asian/Pacific Islander, Age 36)

While participants categorized as having "moderate concern" about HIV also spoke about knowing others who are HIV positive, contrary to the group with "significant concerns," these participants tended to de-emphasize the challenges HIV-positive people face and emphasize how these friends were still healthy due to new medications.

> Um, I have friends that have had it for over 15 years and they're still healthy. The HIV part doesn't bother me as much as the full blown AIDS. The HIV you can kind of control to some extent, but the AIDS thing, that I definitely don't want to get to. (#061; European-American, Age 51)

> Even one of my best friends from college…I can remember him telling me, like in 1988, that he was HIV positive. And what a huge drama that was. Well, you know, he's healthy as a horse today -- 17 years later. So, there's so many of those stories now, that, they've reshaped what HIV is and means. (#076; European-American, Age 46)

For some participants, not having been infected with HIV in spite of their sexual risk behavior has contributed to a sense of diminished vulnerability to HIV infection.

> I was doing AIDS education and… I really began wondering…how are you debilitating your immune system through heavy drug use? And how does that matter about whether or not you get HIV […] because I'm really kind of very vigilant about what I eat and my whole health diet, keeping healthy. But I wondered if I might have been exposed but didn't get infected and whether or not, is that a reality or is that a theory?
>
> I: Or do you have a little bit of protective, some immunity kind of thing.
>
> R: Right. Right. (#055; European-American, Age 44)

> I've tried [having sex with someone who is HIV positive] and it's really nerve-wracking. Yeah. I can't -- I never knowingly had unprotected sex with someone who I knew was HIV-positive. You know, I'm sure I have without knowing it. Actually, my very first bareback experience -- And you would think that this would have turned me off to barebacking completely. But I think it kind of like enforced it. But my very first bareback experience was in college. And I had fucked him. And this was right when I was like really just -- I think he was like my third person I was ever with…and I fucked him, and he let me come inside him. And it was raw. And that was the first time I was actually able to come while fucking someone. Before, I was always a bottom. And I thought that was really hot. And then subsequently, he then proceeded to fuck me. And I asked him, you know, "Please don't come inside me." So he didn't. Then I went to school overseas. And I get a phone call from my best friend at the time. And he's like, "Guess who just tested positive?" It was that guy. And so, you know, I was just absolutely frightened. Here I was like stuck overseas in a country that not everybody spoke my language. And you know how long it takes for you to get a positive result-- you know, an absolute result, six months at least. And so for six months I was just agonizing. It's like,

> "Oh, my God. What do I have?" But I was fine. And so I don't know if that's like kind of like, well, I didn't get it from him, so I won't (laughs) get it from anybody! I don't know. Maybe that's like stuck in the back of my mind. I'm thinking -- It's kind of a sick, perverse way of looking at it. But I think that there is that kind of like level of believing that you're, kind of, invulnerable, at that point. Or it's like, you know, I've really had that brush with the devil and didn't get the pitchfork stuck in me that time. But so, yeah, so I don't. I just really can't do it. (#117; European-American, Age 29)

> I would say that I'm more concerned about an STI than HIV. I haven't seroconverted yet after all these years, and I've been involved in a lot of risky behavior, so. (#152; African-American, Age 43)

And two participants expressed concern about HIV, but placed a greater emphasis on pleasure.

> I don't know… I don't like being uncomfortable, or sick or in pain. But again, I tend to be very shortsighted, for the most part. And I'm trying to, you know, make life tolerable, if not pleasurable, right now, by enjoying as much as I can. And --so, I don't know. I guess I'm kind of shortsighted about that. (#137; European-American, Age 23)

> Um, worry about it, but it's not something that's on the forefront of my mind. I mean, I just want to be able to enjoy sex without thinking that sex is going to be a death sentence. (#152; African-American, Age 43)

Minimal concerns—When questioned about concerns of HIV infection, participants who were rated as having minimal concerns embodied a sense of acceptance of their risk behavior and the possibility of current or future HIV infection as a result of their behavior. Responses from the African-American participants who were categorized as having minimal concerns, who constituted 60% of those in this group, revealed a sense of nonchalance towards HIV, with one participant arguing against the conceptualization of HIV and the accuracy of HIV testing.

> I think that's pretty much an accepted -- I think most of the people pretty much accept that, if you bareback, you'll get it. Sooner or later, you will get it. So you just already have a mindset, just live with that, just live with that, you know.

> I: How concerned are you about that?

> Not very. (#039; African-American, Age 29)

> I -- I just don't think about it. I'm not that serious about that, thinking how to prevent it. Uh, I won't like, if there's some bareback group of positive barebackers having an orgy and they're like, "Join us." And I know that they are positive and they're all wanting to fuck me and to come inside me, and I am going to get positive after that I won't do that. Or I won't start sharing needles with people, that kind of stuff. But there is, like -- there is a hookup situation that, you know, you're, like, not sure and you just, like, take the risk -- that, I think I'll -- I don't know if I'll stop doing that. (#143; Asian/Pacific Islander, Age 27)

Only three of the ten participants who were categorized as having minimal concerns mentioned improved HIV treatments as part of their discussion on this topic. For one participant, the lack of concern about HIV infection was based on his belief that he was already infected but hadn't identified as HIV positive for the study because they had not gone to get tested and had not been diagnosed.

> Like I said, you know, I haven't been tested, so. I just let things happen. Which it's just my carefree attitude. And, you know, my roommate's HIV-positive, and he gets on me all the time because he wants me to go get tested and go see a doctor and get meds and stuff. And it's like, you know, I'm just going to -- if anything happens, it happens. You know. If I get sick, I get sick, and all that good stuff. So. And I'm sure I've been with someone positive, you know? Probably 100% sure that I have it. In my head, if you're barebacking you are… because I couldn't fathom someone not being, and barebacking. (#094; Other, Age 35)

> I'm just concerned that, that every, every time [I worry] less. When I start testing for HIV years ago, every test was, like, "Oh, my God, oh, my God," then, it's like (inaudible).. all right. You know? Whatever comes. Now, like, I feel I'm due. I'm like, I'm -- just give me the news. (#144; Latino, Age 45)

For others, their barebacking, coupled with numerous HIV-negative test results, reinforced a belief that they were immune to infection, thereby decreasing their perceived vulnerability to infection and concerns thereof.

> HIV is a concern. But when I go and I get tested, you know, I'm negative, so it's not that big of a concern. I've been through it so many times…I mean, being sexually active, for, like, 20, 21 years. And each time it's, like, less and less anxiety. Because it seems like I know the results -- what it's going to be, anyway. You know? So, it's like, it's no big hassle for me now. If it did come back positive, then I'm right where I'm supposed to be anyway…because I've had 20 great years of fucking. So, finally, join the club. But, on the other hand, if you've been doing this for 20 years, and you haven't tested -- you know, positive -- then the odds say that likely that you're not going to get it. All the sex partners I've had, all the cum that's been exchanged, all -- you know, come on now. (#153; African-American, Age 41)

HIV Risk Reduction Practices

As depicted in Table 3, HIV-negative men who bareback practice a number of strategies to reduce their risk of HIV infection, with most using multiple strategies. Among the 74 participants who reported on their own risk reduction practices, the most frequently reported practice was serosorting (n=50); however, only 18 participants reported asking sexual partners directly about their HIV status. While for some participants this discussion consisted of a quick question during an Internet chat to arrange a meeting for sex, others reported asking again when they spoke with the potential partner on the phone or when they met in person, since participants believed it would be easier for them to sense any dishonesty through these means than through e-mail or an Internet chat session. The majority of participants (n=32) who engaged in serosorting did not ask the partner directly about HIV status but used a variety of approaches to identify partners whom they perceived to be at greater risk of being HIV positive, including partners who: are older than 40 (for younger participants); use methamphetamines; take the receptive role when they bareback; or openly express their interest in bareback sex in their online profiles or in communications prior to meeting, which for some participants signaled they were indiscriminate barebackers. Many participants (n=18) also used direct questioning and indirect assessments to identify and avoid sex partners who might have other sexually transmitted infections. Other risk reduction approaches mentioned were withdrawal of the penis prior to ejaculation (n=30), using condoms with partners they perceived to be high risk (n=18), and limiting the number of partners with whom they bareback (n=13). Ten participants mentioned specific cleansing acts in which they would engage (ie. drinking water to induce urination; forcing a bowel movement after receptive anal intercourse; douching; gargling with own urine after oral

sex), which they believed reduced their risk of HIV infection if their partner was indeed HIV-positive.

Participants at all levels of concern reported taking steps to reduce their risk of HIV infection, even those within the “minimal” concerns group. All participants except one reported using at least one approach to reduce risk, with approximately half the participants reporting using one or two approaches. There was no pattern of differences in the types of risk reduction approaches taken by participants at different levels of concern.

DISCUSSION

Although the men who participated in this study regularly engage in sexual behavior which places them at very high risk of HIV infection, none sought to be infected with HIV, and the great majority expressed concern about HIV infection and attempted to reduce their risk of infection through various means. Our findings suggest that the stereotype of men who bareback as rejecting prevention efforts and unconcerned about HIV infection applies to a small subset of these men, many of whom have accepted that they are or will be infected with HIV. These findings highlight the potential for engaging MSM who bareback in risk reduction interventions and the need for risk reduction interventions focused specifically on this group (Parsons & Bimbi, 2006). The absence of such interventions for MSM who bareback is disconcerting given the body of literature on barebacking that has emerged over the past decade and the significant concerns over the impact of bareback sex on HIV infection rates.

Clearly, these men are not committed to universal condom use. Nonetheless, our findings demonstrate that MSM who bareback take steps to reduce their risk of HIV infection and these steps are consistent with those often recommended in the literature as potentially useful for this population (Parsons, 2005; Parsons & Bimbi, 2007; Shernoff, 2006; Suarez & Miller, 2001). As such, they may provide a starting point as to the behaviors that may be targeted by interventions for these men. For example, although serosorting has generated a lot of study and controversy as a risk reduction approach (Berry, Raymond, Kellogg, & McFarland, 2008; Cassels, Menza, Goodreau, & Golden, 2009; Eaton, Kalichman, O’Connell, & Karchner, 2009; Marks, et al., 2010; Wilson, et al., 2010; Morin, et al., 2008), it is the most frequently used approach among the participants in this study and is often used among MSM to balance concerns about HIV infection with a desire for intimacy (Frost, Stirratt, & Ouellette, 2008). But, for serosorting to be effective in reducing the risk of HIV infection, accurate knowledge of one’s HIV status and the ability to engage in honest discussions with sex partners about serostatus are essential. And, our findings show how inaccurately the serostatus of a partner is assessed. While some participants felt comfortable directly inquiring, even multiple times, about a partner’s HIV status, most of the men using this approach did not ask directly, instead relying on signs—and research with MSM has shown that they tend to assume that a sex partner is of their same serostatus (Gold & Skinner, 1996; Gold, Skinner, & Hinchy, 1999; Parsons, et. al., 2006; Suarez & Miller, 2001). Thus, an important intervention for this high risk group might focus on developing skills to consistently ask sexual partners about their HIV status and most recent date of HIV testing in order to better assess their risk of HIV infection. If rapid HIV home tests become available, an issue currently being considered by the Food and Drug Administration, they would also offer a way to more accurately assess the HIV status of potential partners prior to engaging in bareback sex, although concerns about recent infection and the window period would persist (Carballo- Diéguez, Frasca, Dolezal & Balán, 2011). And, lastly, websites aimed at seeking sexual partners can also facilitate disclosure of serostatus by creating a cultural norm within the site which values asking about and disclosing HIV status and testing information (Carballo-Diéguez, et al., 2006; Grov, 2006).

At a more basic level, our findings also highlight the need for HIV risk reduction information aimed at MSM who bareback in order to dispel erroneous information or myths regarding the effectiveness of cleansing rituals or immunity to HIV, the limitations of risk reduction approaches such as serosorting, and that provides these men with more objective information on which to base risk behavior choices. This, however, requires that providers become more comfortable with an approach to HIV prevention that focuses more on harm reduction than on universal condom use, and the absence of interventions specifically designed for MSM who bareback suggests that there might attitudes and perceptions towards these men that must be addressed and overcome in order to engage them effectively in risk reduction interventions.

Research is also needed into how these men might use biomedical prevention approaches such as microbicides and pre- and post-exposure prophylaxis. While we know that they are hypothetically amenable to their use (Nodin, Diéguez, Ventureac, Balán, & Remien, 2008), studies have shown that there remain challenges to consistent use of the products (Grant, et al., 2010; Karim, et al., 2010; McGowan, 2011). While these products offer alternatives to purely behaviorally-based interventions, they also require adherence and consistent use, which could be affected by a user's level of concern about HIV infection and their commitment to reducing that risk. Nonetheless, for these men, biomedical approaches can be a useful tool in reducing their risk of HIV infection.

While we have presented some of the possible approaches to reducing the risk of HIV infection among this group of men, the challenge still remains as to how these men could be engaged in using these approaches more consistently and effectively. Parsons (2005) and Shernoff (2006) have proposed the use of Motivational Interviewing (MI), a client-centered counseling approach developed by Miller and Rollnick (2002) that strategically uses a person's intrinsic motivation to change to help them achieve the behavior change they seek. MI is most helpful with those who are ambivalent about a behavior and empowers the client to seek their own solutions to behavior change. Our findings suggest that MI would indeed be a helpful approach to enhancing the motivations of men who bareback to reduce their HIV risk behavior and helping them design a risk reduction plan that might be effective for them. An MI-based intervention might be particularly useful combined with HIV testing, which occurred with relative regularity among the participants and which was often accompanied by reflection about prior sexual risk behavior and heightened concerns about the consequences of those behaviors.

Community Based Participatory Research (CBPR) approaches have also been used to develop HIV prevention interventions and (Morisky, Ang, Colyi, & Tiglao, 2004; Rhodes, et al., 2007) might be particularly effective with these men, especially if other MSM who bareback are trained to provide the intervention. The resulting intervention, for MSM who bareback by MSM who bareback, could be particularly powerful by tapping into sexual networks of MSM who bareback, whether one-on-one or in group settings. Interventions targeting networks of MSM who bareback can have a significant effect in decreasing HIV and other sexually transmitted infections (Wohlfeiler & Potterat, 2005). The networks could be used to disseminate information about the (in)effectiveness of commonly used risk reduction strategies, biomedical prevention approaches, and can potentially be used to alter norms around barebacking from within the group. For example, the intervention can focus on normalizing direct inquiries about HIV status or frequent HIV testing to identify recent HIV infections quickly.

While most of our participants were concern about HIV infection, a small subset of our participants (N=11) was not. This subset of men would clearly be the most difficult to engage in risk reduction interventions. That over half of these men were African-American

was striking, especially given the high HIV prevalence and incidence rates among young African-American MSM. Understanding the causes for the nonchalance attitude towards HIV among these men is beyond the scope of this paper and the data collected for this study, but the findings highlight the need for further exploration in this area, not only in trying to understand the psychology underlying their lack of concern about HIV infection, but also in evaluating the willingness and commitment to reducing HIV risk behavior among this very at-risk group.

While the findings from this study offer new insights into HIV risk concerns among MSM who bareback, they should be interpreted within their limitations. This study specifically targeted MSM who use the Internet to meet other sex partners for bareback sex. As such, it is not a representative sample of MSM who may or may not bareback. Similarly, the findings may not be relevant to men who engage in condomless anal intercourse but who do not consider their behavior to be “barebacking” (ie. men in the context of a monogamous relationship). Lastly, our findings rely on self-report of HIV status based on a question asking if the participant ever received an HIV positive test result. Thus, our findings might include some men who have not received such a test result but may believe that he is HIV positive or indeed be HIV positive.

Nonetheless, these findings show that many MSM who bareback remain concerned about HIV infection and might be amenable to HIV prevention efforts that are not focused solely on condom use. With new evidence for the effectiveness of oral PrEP in preventing HIV transmission among MSM, there are new opportunities for the development and implementation of “combination” prevention interventions that can be designed specifically for this very high risk group of MSM and their networks, which may produce significant reductions in HIV infections.

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Table 1

Demographic characteristics of the study participants (N=89)

Characteristic	Mean (SD)	Range
Age	32.03 (9.83)	18 – 63
Level of Education	14.85 (3.06)	2 – 20
Income (*Mdn*, IQR)	25,500 (34,250)	0 – 100,001
Prior HIV tests (*Mdn*, IQR)	7.0 (12)	0 – 50
Race/Ethnicity		n (%)
Latino		22 (24.7)
African-American		19 (21.3)
Asian/Pacific Islander		16 (18.0)
White/European-American		24 (27.0)
Native American		2 (2.2)
Other		6 (6.7)
Sexual Identity		
Gay/homosexual		75 (85.2)
Bisexual		10 (11.4)
Straight/heterosexual		1 (1.1)
Gay and bisexual		2 (2.0) *
Did not respond		1 (1.1)

* participants could select multiple categories

Table 2

Level of HIV risk concern by race/ethnicity (N=82)

Race/Ethnicity	Level of Concern		
	Significant n (%)	Moderate n (%)	Minimal n (%)
African-American	7 (23)	5 (12)	6 (60)
European-American	4 (13)	18 (43)	0 (0)
Latino	8 (27)	11 (26)	1 (10)
Asian/Pacific Islander	6 (20)	6 (14)	2 (20)
Other	5 (17)	2 (5)	1 (10)
TOTAL	30	42	10

Table 3

HIV risk reduction practices reported by participants (N=76)

Risk Reduction Strategy	n
Serosorting:	50
A. Indirect assessment of HIV status	32
"Well there's people who are top, bottom, hung, horny -- you know all these things are people who go online multiple times, so these are people to be…avoided at all risks."	
B. Direct HIV status inquiry	18
"I ask before -- I ask, like 100 times. You HIV negative?"	
Avoiding internal ejaculation	30
"I don't breed or seed, except on very rare occasions and maybe on my birthday."	
Using condoms	18
"Usually if I'm with somebody for the first time, I'll always, always wear a condom."	
Avoiding partners with STIs:	18
A. Visual inspection	
"If you notice someone has a few markings, like dark spots in certain areas, like lesions or bumps, uh, avoid. Avoid like the -- avoid like the plague."	13
B. Direct inquiry	5
"You know, as long as I see the results and I know that you're negative for, you know, all the STDs, then I'm -- I'm OK."	
Reducing bareback sexual partners	13
"In my case, I would just like abstain from new sexual partners and just stick with the old ones. That group is pretty big, I could find a couple I could recycle."	
Cleansing acts: washing, enemas, gargling, urination	10
"Like when I - and this is another thing that I think may have also saved me regarding HIV - which is that, in general, I will gargle with my own piss in between every cock I suck."	
"*I prefer, you know, hosting, because, you know, right after that I shower. I douche, you know make -- let me make sure everything is out, you know."*	
Strategic positioning	9
"Now I'm strictly a top. And I've been for 20 years. I don't know if I would be strictly a top if I thought there would be no risk involved with being bottom"	
Maintaining personal health/Compromised health	8
"I don't really think of going to meet up with anybody if I have any kind of open sore, you know, cold sore, cut, or anything like that."	
Substitutions: offering conciliatory, low-risk sexual acts	6
"There would be lower-risk behavior, which could be just jerking off or, you know, mutual body contact and things like that. That has happened at times, either on a conscious level to reduce the risk or just because that's the way the sex goes."	