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THE SAFE-SEX-LIMIT MOTILITY MODEL:

HOW GAY MEN MAKE UNSAFE SEX SAFE THROUGH DIFFERENTIAL INTERPRETATION AND USE OF AIDS-AVOIDANCE INFORMATION

DAVID TIMOTHY AVELINE

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THE SAFE-SEX-LIMIT MOTILITY MODEL:

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ABSTRACT

The AIDS epidemic is a decade old. Gay men continue to be hit hardest. Prevention campaigns have done much to change behaviour. Still, many continue unsafe practices. Why? First, it is assumed that knowledge of AIDS leads automatically to appropriate behaviour. This is found premature. Second, it is assumed that those continuing unsafe practices do so because they are unaware of the dangers. Existing evidence clearly does not support this. Third, prevention campaigns are in dialectic tension between traditional morality and practical purpose. As a result, effectiveness is weakened considerably. Fourth, emphasis upon partner-dependent and context-dependent definitions of safe sex have led many to use them in behaviour instead of act-dependent ones. As a result, this strategy has backfired. Unsafe sex can be better explained within the theoretical frameworks of symbolic interaction and ethnomethodology. AIDS knowledge is not seen as right or wrong but as something possessed after interpreting AIDS-avoidance information on the basis of already possessed meanings gained from past experience. This ultimately results in action. The safe-sex-limit motility model offers 12 propositions explaining unsafe sex. Partner-dependent and

context-dependent definitions of safe sex develop in addition to act-dependent ones and are used when they successfully neutralize act-dependent ones. Unsafe sex is "made safe" through social construction. To explore this, 35 gay men were interviewed. When unsafe sex was reported, it was reduceable to act-dependent definition neutralization. Since the method does not allow for generalization, theoretical assumptions are made instead. It is recommended that future prevention campaigns avoid references to partner-dependent and context-dependent definitions of safe sex and concentrate on act-dependent ones instead.

* * * * * * *

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INTRODUCTION

One evening in the summer of 1987, I went to a gay bar. The gay community of Montréal is relatively small and, if one goes out often enough, he will be assured of seeing at least a dozen familiar faces. That particular evening, Mike, a friend, was the first one I met. Since we had not seen each other in a while, we sat and had a beer. We covered a variety of topics - what people we both knew were up to, how successful the bar was, our plans for the year, and so on. As we talked, we casually observed the other men passing by. Mike, who had nothing against casual sex, was looking for prospects to cruise later on. This one "looked" available, that one might be willing since he had recently broken up with his lover, etc. He then noticed a man whom he found particularly attractive and said, "He's really my type. I wish he weren't. Its really too bad."

"What's too bad?"

"He's such a sleaze bag. Really bad news. If I know what's good for me, I'll stay as far away as possible."

"How do you know he's a sleaze bag?" I asked.

"He goes for anyone he can get his hands on. Every time I'm here, he leaves with a different guy."

"Maybe he just has a lot of friends."

"I doubt it! Look at the way he dresses, the way he looks at other guys." I saw a young man maybe nineteen or twenty, swarthy, slim, wearing a black levi shirt open about

four buttons, tight faded jeans, and cowboy boots. He was alone, leaning back against the wall, smoking. He was also doing just what we were doing - looking at all the other men around. With him, however, there seemed to have been more of an urgency - as though he were hunting and constrained by time.

"He also hangs around the ground floor where all the couches are." Mike continued. "That shows he's desperate." This was an area of the bar known for its indiscriminate cruisers. It usually fills up an hour before closing time. "God only knows what he does with those guys and God only knows what he's already picked up from them. I may be horny but I'm not stupid." We eventually turned to other subjects and, once we finished our beers, moved on.

This experience led to a number of questions for me. Although Mike enjoyed casual sex, he was conscientious about it. He made it clear many times that he only has safe sex. He will engage in certain acts, in other words, but none where the exchange of body fluids can occur. He had also read extensively on the subject of AIDS and knew quite a bit about it. Still, as he let me know, he would avoid certain types of sex partners because of their likelihood of carrying the AIDS virus [HIV]. Safe sex to Mike, therefore, not only meant adherence to safe acts only but the selection of safe partners as well. Even though the sex itself would be safe, in other words, choosing the right partner made it somehow safer. I wondered how many others made such interpretations.

What intrigued me even more, however, was Mike's assessment of the young man he saw. The several indicators he pointed out - choice of clothing, manner of looking at others, leaving the bar frequently with other men - were sufficient to regard him as an unsafe potential partner. This, in turn, pointed to unsafe sex. Also, seeing the young man in an area where frequent cruising takes place confirmed his assessment even more. An unsafe context pointed to an unsafe partner who, in turn, pointed to ursafe sex. If these patterns of interpretation are common among gay men, would a safe context - perhaps a bar where "decent people" go - point to a safe partner? Would a safe partner point to safe sex? Finally - and most importantly - do assessments of contexts and partners affect people's decision of which acts to perform? If a person believes that his partner is safe, in other words, will he still follow the recommended guidelines for safe sex? In view of the seriousness of the AIDS epidemic, these questions must be explored. It may indeed be possible that many people have unsafe sex because they sincerely believe that the sex they are having is safe. They have safe sex, in other words, because, through social construction, they **make unsafe sex safe.**

With this in mind, I explore the social construction of safe sex among sexually active gay men. I do this within the framework of an interpretive model synthesized from the perspectives of symbolic interaction and ethnomethodology. I offer it as an alternative explanation to the current rational model of education. Rather than assuming that

unsafe sex occurs out of ignorance of the recommended safe-sex guidelines, I emphasize the decisive influence of the interpretive process of the actor - how he comes by AIDS-avoidance information, how he examines it, how he assigns particular meaning to it on the basis of already possessed meanings gained from past experience and ultimately, how he uses it in his sexual behaviour. In other words, how he actively **makes unsafe sex safe.**

I present the research in three parts. Beginning with PART ONE, the first chapter examines four relevant topics: a.] Biomedical aspects of AIDS. b.] The history of the gay community and its struggle for sexual freedom. c.] The impact of AIDS on the gay community. d.] The strength and direction of recent changes in sexual behaviour. My purpose here is to show how the emergent phenomena of the past three decades have influenced sexual behaviour today.

Chapter two looks at the impact of AIDS-prevention efforts themselves. Here, the main components of what I call the "educational model" are explored. This model assumes that unsafe sex continues since those who engage in it lack the proper AIDS-avoidance knowledge. Although this may often be the case, it does not explain why those well informed continue such behaviour. Furthermore, it ignores the rich interpretive process of the actor as a decisive influence upon his behaviour in general.

The third chapter summarizes the assumptions of symbolic interaction and ethnomethodology, justifies their

compatibility for the synthesis of an ad hoc theoretical body, and shows how their principles are well suited to an explanation of AIDS and sexual behaviour. This leads into a discussion of AIDS-prevention messages themselves - the topic of chapter four. Here, I not only point out some of their ambiguities, but their potential for differential interpretation as well.

PART TWO consists of three chapters. In the first, chapter five, I examine three issues: the position of sexuality in sociology and how it has influenced the study of AIDS; other alternative explanations for why gay men have unsafe sex; and past research leading toward an interpretive explanation of the same. In chapter six, I present my own interpretive explanation which I call the "Safe-Sex-Limit Motility Model." With twelve propositions, I show how the likelihood to engage in unsafe sex is based not necessarily upon knowledge of the recommended guidelines but, rather, upon differential introduction, examination, interpretation, and use of AIDS-avoidance information. These propositions are further based upon several axiomatic properties of sexual activity which I detail beforehand.

Chapter seven introduces the method of research. Data were collected from thirty-five unstructured scheduled interviews as well as observations of various gay settings, both social and sexual. These data are presented in chapters eight to twelve of PART THREE.

Chapter eight, beginning the analysis, presents evidence of the polarization of sex acts and, thus, a

"safe-sex limit." Sex acts exist for people on a continuum from safest to least safe and are thus divided by a "limit" into those they are willing to perform in any sexual situation and those they are not. Chapters nine and ten show the polarization of potential sex partners and sexual contexts, respectively. These are alternative definitions of safe sex having strong potential influences upon people's assessments of sexual situations. Chapter eleven explores the methods people use to determine the risk of each sexual situation and, finally, chapter twelve shows safe-sex-limit motility. In any sexual encounter, the limit on the sex-act continuum will do one of three things: a.] Stay as it is so that people will perform only those acts previously assessed as safe. b.] Move to the left making acts previously defined as safe unsafe. c.] Move to the right **making unsafe sex safe**. I end with a discussion of the research as a whole.

This motility model offers a different explanation of unsafe sex. Although it is a reification, it is a useful tool for the understanding of human sexual behaviour. It does not deny the importance of AIDS-prevention messages or emergent norms but, rather, adds to it by emphasizing the interpretation of them as the ultimate source of action. In doing this, I hope, it will be able to contribute to the overall fight against AIDS.

* * * * * * *

P A R T O N E

CHAPTER ONE

A HISTORY OF THE GAY COMMUNITY, THE IMPACT OF AIDS UPON IT, AND THE STRENGTH AND DIRECTION OF CHANGES IN SEXUAL BEHAVIOUR

Principiis obstra; sero medicina paratur
Cum mala per longas convaluere moras.

Stop it at the start, its late for medicine
to be prepared
When disease has grown strong enough
through long delays.

[OVID, 43 B.C. - A.D. 17]

CHAPTER ONE

With the death toll still rising, North America is now entering its tenth year in the battle against AIDS. Although gay men no longer make up the fastest growing carrier group [Buzby & Ramey, 1989], they still have the highest incidence. In Canada, as of August 7th, 1990, there were 4,425 diagnosed cases of AIDS, 73.3% of which were among this group. [Federal Centre for AIDS, 1990] In the United States, although this proportion is much lower due to the high incidence among intravenous drug users and their sex partners, it is still the largest at 61.0%. [Centers for Disease Control, 1989] In view of these figures, it is imperative that sociology look towards an understanding of the sexual behaviour of gay men as it pertains to the epidemiology of AIDS.

This chapter has four purposes. First, it gives a brief biomedical overview of AIDS - what it is, how affects the body, how it is transmitted. Second is a discussion of gay sexuality in the 1960s and 1970s - the rise of gay liberation, the growth of community, the legitimization of homosexuality as an alternative lifestyle. This leads into a discussion of the changes that took place in the 1980s. Once AIDS gained ground, many gay men lived with anxiety, a great many were touched by sadness, and sexual liberty became severely restrained. Finally, I look at the strength and direction of change. Many men do indeed follow the recommended safe sex guidelines but, as it happens also, many

do not. Although the glass is half full, in other words, it still remains half empty.

1.] AIDS: A BIOMEDICAL PROFILE.

On July 3rd, 1981, the first official report of an outbreak of Kaposi's sarcoma [KS] and pneumocystis carinii pneumonia [PCP] appeared in the Morbidity and Mortality Weekly Report. [Friedman-Kien, Laubenstein et al., 1981] There were twenty-six cases in all, all were gay men aged twenty-six to fifty-one, and all eventually died. Although these diseases were known previously [Hennigar, Vinijchaikul et al., 1961; Williams, Stretton & Leonard, 1960], they only occurred in rare isolated cases. This time, however, there was enough concern to alert all physicians to be wary of these "and other opportunistic infections associated with immunosupression" in gay men. [Friedman-Kien, Laubenstein et al, 1981:307] The first Canadian cases were diagnosed a few months later [Trow, 1982] and, eventually, a new clinical entity was identified - Acquired Immune Deficiency Syndrome.

AIDS is caused by a retrovirus known as the human immunodeficiency virus, or HIV [previously HTLV-III]. It attacks the immune system's T-lymphocytes [helper T-cells] which are vital in fighting off various opportunistic infections. AIDS is not a disease in itself, therefore, but a condition which opens the door for other diseases eventually proving fatal. [Redfield & Burke, 1988] Life can be

prolonged to some extent by drugs such as Zidovudine [AZT] but, at present, there is no cure for AIDS.

Although it is not yet possible to detect HIV proper, serologic tests can determine the presence of its antibodies which appear two to six months after "seroconversion." [Berg, 1989] Those who do have the antibodies also have the virus and are known to be "seropositive." An important distinction to be made is that the term "AIDS" is normally reserved only for the final stages of HIV infection. This is known as "full-blown AIDS." Not everyone seropositive will reach this stage. In fact, some evidence suggests that many never develop any symptoms at all and remain healthy. [Mass, 1987] They can, however, transmit the virus to others. Thus, all who are sexually active must exercise caution. The number of people with AIDS is relatively small, but the number of those seropositive is much higher. Although there are only 203,354 diagnosed cases worldwide [Federal Centre for AIDS, 1990], the World Health Organization estimates that between five and ten million people seroconverted in the 1980s. [Mann, 1989] To make matters worse, the incubation period prior to AIDS onset is believed to be as long as eighteen years. [Greatbatch & Holmes, 1989]

Contrary to common beliefs, HIV can not be transmitted by casual contact such as food preparation, sneezing, etc. [Diclemente, 1989; Duffues, 1989; Marin, 1989; Ornstein, 1989] There are only four ways transmission can happen: a.] Receiving contaminated blood products during transfusions. This is now virtually unknown since all blood is screened.

b.] Sharing needles during intravenous drug use. c.] Prenatally from an infected mother [vertical transmission]. d.] **Some** forms of sexual contact [see **APPENDIX ONE**]. For gay men, unprotected anal intercourse is the primary mode of transmission [Friedman & Klein, 1987; Curran, Jaffe et al., 1988; Mulhall, Carter et al., 1989] and multiple partnering [since "promiscuity" is a value-laden term, I avoid it] highly associated with it. [Doll, Byers et al., 1989; Heyward & Curran, 1988] Although this is not in itself a means of transmission, it is generally associated with high risk since those who do have unsafe sex increase their chances of contagion with every partner they have.

2.] GAY LIBERATION AND GAY SEXUAL FREEDOM: THE 1960S AND THE 1970S.

Although it would appear that the story of gay liberation two decades ago has no direct relevance to AIDS and the sexual behaviour of the 1980s, it is important in several respects. First, it led directly to the gay sexual freedom of the 1970s which came on at such a pace that it pushed its way into the next decade. It has therefore affected attitudes toward multiple partnering and casual sex. Second, it paved the way for present-day AIDS activism. This directly affects attitudes towards AIDS-prevention campaigns, government intervention and, to a greater or lesser extent, sexual behaviour. Third, its struggle was recent. Many gay

men still greatly resent the stigma society once placed upon homosexual behaviour and, thus, see AIDS intervention as an extension of that control. Finally, it has relevance to later discussions of gay sexual contexts. Gay liberation is therefore an emergent phenomenon relevant to AIDS and behaviour. In view of this, it cannot be disembodied from the sexual norms and values of the present.

In true dialectical fashion, gay liberation was born out of the oppression of the McCarthy era and the political reform of the 1960s. On December 15th, 1950, a special task force of the American Executive Committee issued a report warning against the existence of "homosexuals and other sex perverts in government." [United States Government, 1950] This was followed by scores of alarming magazine and newspaper articles [e.g. Object lesson..., 1950] which led to an atmosphere of fear and distrust. Gay men and lesbians became the targets of a modern inquisition. Although they had always faced harassment, it was often avoidable since their thriving community was largely undisclosed. With McCarthyism, however, their existence suddenly came to the forefront and such treatment was intensified in the form of bar raids, beatings and arrests. John D'Emilio, author of Sexual Politics, Sexual Communities [1983], describes this climate particularly well in the following:

> Throughout the 1950s gays suffered from unpredictable, brutal crackdowns. Men faced arrest primarily in bars and transportation depots, while women generally encountered

> the police in and around lesbian bars.... The utmost caution did not guarantee protection from the hands of the law. Many of those lucky enough to escape arrest had friends and acquaintances caught in a raid. Newspaper headlines announced that police were combing the cities for nests of deviates. Editors often printed the names, addresses and places of employment of men and women arrested in bar raids. Police parked their squad cars in front of homosexual taverns to intimidate patrons. Every evening spent in a gay setting, every contact with another homosexual or lesbian, every sexual intimacy carried a reminder of the criminal penalties that could be exacted at any moment. [p. 49]

Although the purpose of such action was to erase homosexuality from visible American life, it gave the gay community a focus for its struggle a decade later. Thus, it made it even more visible than before.

The generation that came of age in the 1960s grew up in an era of unusual prosperity. They were indulged in as children, educated, and encouraged toward self expression. This was also a time of technological advancement. The space race was on, travel was easy, and television brought the world into the home. When they reached college age, therefore, they were curious, intellectual, and idealistic. Some sought answers in philosophy and political science while others did so by travel and independence. As a generation, they had no clear-cut career objectives and, as is reflected in period essays such as Jerry Farber's The Student as Nigger [1969], they were unaccepting of an authority that to them had no logical basis. Many were highly dissatisfied with Johnson's America and sought not just reform but revolution.

These were the sentiments and preconditions that gave rise to Theodore Roszak's [1969] counterculture. Clothing and

hairstyles became unconventional, marijuana and LSD became a way of distinguishing oneself from the "straights," song lyrics changed from themes of marriage and romance to ones of injustice and repression, and the Vietnam war became a symbol for all immorality. Out of this counterculture came the "New Left," an unstructured group opposed to racism, capitalism, and militarism. It focused on Marxist ideology, campaigned for civil rights, and made protest a legitimate method of working toward change. [Woods & Jackson, 1982] This was also an era of sexual revolution. Not only did absolute standards of conduct relax as was reflected by the increased acceptance of premarital sex, coed dormitories, and cohabitation before marriage [Hunt, 1974], but feminism linked heterosexual women with lesbians and, as a result, gay men as well. Sexual expression became yet another area for self-exploration and, thus, another area to demand freedom of expression.

With such an atmosphere, the demand for gay rights was inevitable. Increased oppression, growing dissatisfaction, and the pace of change on similar fronts brought fresh energy and focus. The turning point came on June 27th, 1969. When the police raided the Stonewall Inn, a Greenwich Village gay bar, a full-scale riot, which was to be the symbolic birth of gay liberation, erupted. Events moved swiftly afterward leading to the formation of strong advocacy groups that brought the gay community into the 1970s. The first to form - among its members many from the New Left - was the Gay Liberation Front whose demands, exemplified by Carl Wittman's A Gay Manifesto [1973], called not just for equal footing in

society but the liberation of homosexuality in all. They were eventually replaced by the more realistic Gay Activist's Alliance which, in contrast, was highly organized and directed itself toward reform. [Licata, 1980/81] Eventually, there were chapters all over North America. These and other early groups not only paved the way towards more comfortable lives for gay men, but were intrumental in the development of the community as a whole.

The 1970s saw three critically linked developments in what Dennis Altman aptly calls "the Americanization of the homosexual." [1982] First, the status of homosexuality shifted from that of criminality and sickness to "alternative lifestyle." Second, the gay community strengthened and developed politically. Third, gay commercial enterprise mushroomed. Since all are vital to the development of the decade's free sexual climate, I deal with each separately.

Whether polemically or paradigmatically motivated, the shift from sickness to lifestyle came first from science. In December, 1973, the American Psychiatric Association removed homosexuality from its list of mental illnesses and, thus, gave lesbians and gay men what Time magazine called "an instant cure." [An instant..., 1974] Discussions then shifted from the pages of medical journals to those of social science. Views apologist at best [Hooker, 1957] and condemnatory at worst [Beiber et al., 1962; Bergler, 1957] transformed into ones of deviance [Warren, 1972; Bell & Weinberg, 1978] and political disadvantage. [Weeks, 1977]

This latter perspective had the greatest impact for gay men could now be viewed like blacks and Jews as a minority group. Altman sees this as pivotal. It not only places the onus on the oppressors rather than the oppressed, but suggests legal protection as well. Indeed, this has been the case in Quebec since 1977. [Projet de loi No. 88]

The second development, politicization, brought a number of other changes. After several legal battles [Solomon, 1979/80], universities recognized gay student groups and allowed same-sex dances. The gay communities in virtually every major city had political and social groups, church groups of several denominations, community centres, and bookstores. Many also had radio collectives, theater groups, and sports clubs. Furthermore, the gay press - most notably the Advocate in the United States and The Body Politic in Canada - transformed from a few ephemeral underground newspapers to widely read forums with large budgets. All of this most certainly helped gays to live more openly. The newspapers and radio collectives linked communities, the political groups campaigned for civil rights, and the social and religious groups provided safe havens for the development of a positive identity.

To attribute the new openness entirely to political development however would be naive. Although classic liberal thinking would readily do so, the credit must be given to the third development - commercialization. This can be further divided into two areas: the appearance of gay-owned business and the rapid growth of the gay sex/entertainment industry.

While in the 1950s and 1960s, a business such as a travel agency or a small moving company may have had a gay owner, this was incidental. In contrast, gay-owned businesses in the 1970s were able to both advertise as such and cater largely [if not exclusively] to the gay community. By revealing the gay consumer as a viable and often rich source of potential revenue, the growth of such businesses helped to legitimize the gay lifestyle within capitalist society.

The growth of the gay sex/entertainment industry, however, accomplished this task even more. First, bathhouses transformed from seedy, poorly kept places - strangely metaphoric to the guilt and shame that their habitants felt - to large pleasure palaces with bars, restaurants, and the latest technological equipment. [Altman, 1986] Because of this, anonymous sexual encounters - once carried out with trepidation as if harsh societal judgement was only one step behind - became an acceptable, institutionally sanctioned activity. Secondly, bars - most notably discos - became a vital part of the gay community. Again, Altman sees this as a critical development. The disco movement of the 1970s - perhaps typified by the music of Donna Summers and the Village People and chronicled by gay novels such as Andrew Holleran's Dancer from the Dance [1978] and Larry Kramer's Faggots [1978] - pushed the gay sensibility to its limits. Bars, as Weinberg and Williams tell us, became "the cornerstone of the gay community" [1974:47] and the frenetic energy often typical within them a way of affirming identity, sensuality, and sexuality.

An integral part of this new gay sensibility was the emergence of gay masculinity as it was recognized early on by Humphreys [1972]. Limp-wrists, falsetto voices, and feminine clothing quickly became scorned anachronisms and the gay men of the 1970s wore jeans, construction boots, work shirts, and had mustaches - the "clones" of New York City and the "castroids" [from Castro street] of San Francisco. Since masculinity has traditionally been seen in terms of men's conquest of women and physical and emotional detachment to one another, gay men, as Chesbro and Klenk [1981] point out, have had to circumvent this definition. Instead, masculinity was affirmed by gay camaraderie, often sensuous and erotic. The male sexual encounter was not a conquest as heterosexist attitudes would have it, but a celebration of self on equal terms and, thus, a celebration of gay identity. This is perhaps most apparent in the subculture of "leathersexuality" as depicted in the movie Cruising and paid homage to in Geoff Mains' Urban Aboriginals. [1984] Although many would say [not inaccurately] that leathersexuality was the antithesis of the "drag queen" - and, thus, a form of drag in its own right - it was also a strong statement of sexuality between men. Its very existence served to affirm for many that sex, masculinity, and camaraderie were legitimate, rightful and, above all, possible.

Whether the climate of the 1970s actually did lead to an increase in the absolute number of sexual encounters can not be known. The insurmountable problems of sampling the gay community make this impossible. The Gay Report by Jay and

Young [1977], however, an analysis of over 5,000 lesbians and gay men [Males = 4,329; Mean age = 30.7] gives a good picture of gay lives in this era. As Altman accurately states, it is the best we have. When the respondents were asked how many partners they had over the past week, 74% had at least one. For the month, this proportion rose to 89% and, for the year, 98%. Experiences and attitudes towards immediate sex are even more indicative of the sexual climate of the era. Although only 5% did this always, 23% did this very frequently and another 22% somewhat frequently. Regardless of experience, however, 60% had favourable attitudes towards immediate sex.

Much can also be learned from the era's fiction which, in its own right, chronicled life as it was. While the characters of the 1960s - those of Bitter Wine [1969] and The Why Not [1966] among them - were sad pitiful souls yielding reluctantly to a relentless internal evil, those a decade later celebrated it. As Edmund White, author of States of Desire [1980], remembers in a later essay, the sexual adventure was an integral part of gay life in the 1970s. [1983:31] It was part and parcel of the new assertiveness and, thus, the new identity. For some, it was even seen as an act of defiance as the novels of John Rechy - The Sexual Outlaw [1977] and Rushes [1979] above all - well illustrate. Indeed, sex often became overly routine. As one character put it in Holleran's short story Fast Food Sex [1983], "Getting blown is so easy now, and so meaningless, that its about as significant an event as a sneeze!"

Without necessarily attempting a Marxist explanation, it

could be argued that sexual attitudes of the 1970s were a direct result of the growth in the gay sex/entertainment industry. With many livelihoods at stake - bathhouse, bar and erotic bookstore owners; writers, producers and peddlers of erotica; drug dealers to a large extent; and even many recording artists and their promoters - the anonymous sexual encounter became a vital unit. As Laud Humphreys [1972:66] states:

> Cruising for "one-night stands" is a major feature of the market economy of sex.... This capitalist ideal is realized in the sex exchange of the homosexual underworld perhaps more fully than any other social group, and the cruising scene of the gay world may continue for another hundred years or more.

Although sex was not what was being sold per se, it served to perpertuate the industry. For if attitudes were different, this industry could not exist.

Humphreys wrote this eighteen years ago. When considering the subject of the next section - the onset of AIDS - his words are particularly interesting.

3.] FROM SEXUAL FREEDOM TO SEXUAL ACCOUNTABILITY: THE 1980S.

After a decade of living with AIDS, it is now clear that the sexual freedom of the 1970s is over. While bathhouse adventures and one-night stands were once defiant assertions of self and community, they are now seen as acts of puerility and destructiveness. An arena of exploration and discovery is

now a field of fear and accountability. A spirit once celebrated is now a strange anachronism.

With so much written upon the political and spiritual effects of the AIDS epidemic on gay men, it is difficult to avoid slipping into rhetoric. It is also difficult to do them justice. Since they are emergent characteristics directly affecting sexual behaviour however, I will discuss two relevant areas: a.] The affects of AIDS on the gay community - fear, re-examination of lifestyle, sorrow. b.] The gay community response - anger, self-regulation, activism.

On July 3rd, 1981, an article by Lawrence Altman entitled "Rare cancer seen in 41 homosexuals" appeared in the New York Times. Among other things, it reported that:

> According to Dr. Friedman-Kien, the reporting Doctors said that most cases had involved multiple and frequent sexual encounters with different partners, as many as 10 sexual encounters each night up to four nights a week.

Since the popular press - notably, the New York Times [Rothenberg, 1981] - had not had a history of treating gay issues objectively [D'Emilio, 1983], the first reactions to this were highly defensive. As one reporter from The Body Politic ["Gay" cancer..., 1981] said:

> The most pernicious section of this article... is the manner in which it suggests a link between the sex lives of gay men and KS. Although there has been no systematic, scientific study of the men involved, Altman, provides some highly questionable speculation on the nature of the disease.

And, as Lewis and Coates [1981], also from The Body Politic, added later:

> The moral message was clear; if gay men insist on having lots of sex with a variety of partners, they will have to suffer the revenge of cancer.

Even though it was later confirmed that the means of transmission was indeed sexual, such outrage remained. The article, it was thought, did not imply a link between cancer and sex but, rather, cancer and "promiscuity." As Dennis Altman says [1986:34], this link was clearly made and "seized upon by both medicos and media."

While popular opinion saw the gay lifestyle in and of itself as a means of transmission - hence, phrases such as "fast-lane sex" - the gay press did its best to dispel this. As Lewis said later [1983]:

> Whatever definition you use, promiscuity does not cause AIDS. The baths and backrooms have not created this disease. Without them, it may have taken us longer to recognize this condition and the current high rate of increase may have been lower, but we would still have to face AIDS just as we have had to face other sexually transmitted diseases.

For the next few years, however, popular opinion took the lead and many who had lived in the free spirit of the 1970s were fearful of the consequences. Eventually, a climate of hysteria developed which one reporter from The New Republic dubbed "AFRAIDS" [Acute fear regarding AIDS] [AFRAIDS, 1985] and Fisher [1985] called "a plague mentality." As Newsweek reported as early as April, 1983:

> The disease's drawn out incubation period has thousands of gay men sweating in terror, seeing every bruise as a Kaposi's sarcoma lesion; every cough the onset of Pneumocytis carinii pneumonia.

Even with its strong sensationalistic overtones, this description was not inaccurate. A cohort of 414 gay men in Chicago, for example, was surveyed six times between 1984 and 1988. Each time, the mean level of psychological stress was above that of the general population. [Caumartin, Tal et al., 1989] Furthermore, Gilada, Bhimani et al. [1989]; Tortaglia and Filson [1988]; Valdiserri [1986]; and Morin and Batchelor [1984] - all psychoanalyts - have all reported panic attacks, depression, and other extreme reactions to AIDS in their patients. These feelings have sometimes gone to such a level that a number have attempted suicide. [Parga, 1989]

Harowski [1987] and Hirsch and Enlow [1984] have both mentioned "denial" and "withdrawal" as major reactions to the threat of AIDS. In the first case, gay men, aware of the disease, deny the dangers in a manner not unlike Kubler-Ross' [1970] first stage of dying. They deliberately ignore the guidelines either to prove to themselves that no danger exists or to confirm that past sexual encounters were indeed safe. In the second case, they not only stop having sex entirely, but withdraw from all social contacts. Frustration often mounts up and, if it becomes too great, they may binge and engage in even riskier sexual behaviour than before.

In mid-1983, once AIDS had already claimed hundreds of lives, a serious debate over the closure of bathhouses began.

While those in favour - AIDS journalist Randy Shilts and novelist Larry Kramer [1983] among them - felt that the atmosphere they typically foster perpetuates contagion, those opposed believed that this would only cause those having unsafe sex to go elsewhere. The issue was a sensitive one leading to heated debates in ad hoc comittees [Fain, 1984], shifts of position by health officials [San Francisco..., 1984], and a number of court battles. [Cabrera, 1985]

There are several reasons for this political difficulty. First, the baths had often faced the same fate before on moral grounds. This happened in Toronto [Hannon, 1981a] and Edmonton [Hannon, 1981b], for example, as late as 1981. Barely healed wounds were therefore opened and the fact that these latest threats were matters of health rather than morals did little to quell the outrage. Second, with the political ground gained in the 1970s, bathhouses had become a symbol of gay sexual freedom. Indeed, the loud cheers heard when the Bulldog Baths float arrived at San Francisco's civic centre during the 1980 Gay Freedom Day Parade served as a testimonial to this. [Shilts, 1987:19] As a result, the closure discussions were regarded not only as an infringement upon this freedom, but as a possible precedent for denying it in other areas as well. As placards in one San Fancisco demonstration said, "Today the tubs, tomorrow your bedrooms." [Altman, 1986:152]

A third problem lies in the message that would be sent to the general public. Numerous articles in the popular press [e.g., Morganthau, Coppola et al., 1983] had already painted

lurid pictures of bathhouse activities and, to gay politicos, closure would almost certainly give ammunition to moral opportunists [Jerry Falwell being one of the first to call for bathhouse closures] opposed to homosexuality in general. Shilts [1984] sees this as a particularly unfortunate example of pride impeding common sense. Gay political issues, he believes, are being put before gay lives. What must also be considered, however, is that closures may reinforce the belief that it is location rather than activity that leads to AIDS. I explore this belief in depth later on.

A fourth issue considered - and insightfully discussed by Conway [1988] and Rabin [1986] - was the possible infringement upon individual rights. While some believed that dangers to public health should take precedence regardless, others maintained that while health is more immediate, attention can still be given it without entering the realm of consenting adults in private. They believed that education rather than regulation would be more effective over time.

While bathhouses did indeed close in many cities -- and, along with them, some notorious "fuck bars" such as New York City's Mineshaft [Bisticas-Cocoves, 1985] - many, like those in Montréal and Toronto, continue to be open. Due to the attitudes of the 1970s and, perhaps also, the general discomfort surrounding homosexuality, the bathhouse issue continues to be one of politics and law, and not health. The question still remains, however, as to whether closures would indeed reduce the absolute number of unsafe encounters. Would those having unsafe sex simply do so elsewhere, or would no

bathhouses mean less unsafe sex? Furthermore, can this risky behaviour be reduced more so by on-site education when people are still reachable? It would seem that these are questions not for politicians but social scientists. To date, however, social science has given little attention to this matter.

The AIDS pandemic also has given rise to an entrely new type of activism - that by people stricken with a disease. During past epidemics, those afflicted either accepted their lot as given or placed their trust in medical science. Now, instead, people with AIDS [PWAs] have organized themselves to take an active role in their fate. Groups such as ACT UP [AIDS Coalition to Unleash Power] in the United States, AIDS Action Now! in Toronto, and Réaction SIDA in Montréal, have all adopted the "zapping" techniques made famous by the Gay Activist's Alliance in the early 1970s. They purposely disrupt press conferences, meetings of public health officials, and the like. Probably the most memorable zap took place last year in Montréal at the Fifth International Conference on AIDS. Three hundred protesters stormed past security and, once they reached the main podium, "officially" opened the proceedings. Due to their loud disruptions of plenary speeches, frequent confrontations, and boistrous chanting ["AIDS action now! The whole world is watching!], theirs was a presence felt probably more than any other.

Why do they protest? The immediate answer - and the most obvious one - is due to perceived government inaction. Certainly, as the works of Panem [1988], Shilts [1987], Crimp

[1987], Patton [1986], and numerous others will attest, this perception is justified. Both the Canadian and American governments [and, no doubt, others as well] have not only been slow to respond to the crisis, but perpetuated it with this slowness as well. Issues of education, PWA care and treatment, and the approval of drugs have often been caught up in a web of bureaucracy. The answer would not be complete, however, without grounding AIDS activism in history. For gays, the struggles before and after Stonewall are recent enough to be remembered and, thus, they play an active part. Since the gay community is accustomed to viewing the government as disapproving of their lifestyle, its response to AIDS - a disease affecting mostly gay men - is viewed largely as an extension of this. Indeed, since AIDS issues are often clouded by homophobic attitudes [Altman, 1987; Patton, 1986], the responses to AIDS and to homosexuality in society can not be separated. Gamson [1989] sees this as particularly problematic. As he states:

> AIDS politics and gay politics stand in tension, simultaneously associated and dissociated.... AIDS activists find themselves simultaneously attempting to dispel the notion that AIDS is a gay disease (which it is not) while, through their activity and leadership, treating AIDS as a gay problem (which, among other things, it is). [p. 356].

A second consequence of AIDS activism lies in the creation of scepticism. As W.I. Thomas tells us, if people define situations as real, they are real in their consequences. This rule can be well applied here. If government inaction leads to activism, then activism

undoubtedly leads to a perception of government inaction. The activities of ACT UP and other groups, in other words, may certainly lead to an improvement of the government's response but, in doing so, they also serve to expose it. Gay men, therefore, who would otherwise be unaware of this response will come to know it and, thus, perceive any future ones in the same way. As one man I talked to at a gay meeting place said upon noticing a new government safe-sex pamphlet, "What shit are they handing us now?" Although it is often good to be sceptical, such hermeneutics often go beyond scepticism to outright resistance. In these cases, AIDS-education efforts are thwarted. I discuss this in more detail in the next chapter.

AIDS has had a devastating effect upon the lives of gay men. It has caused untold fear which has not only led many of them to re-examine their lifestyle, but the gay community in general as well. AIDS has also caused much sorrow. In October, 1988, when **The Quilt** was on display in Washington D.C., it consisted of more than eight thousand segments, all with messages of love from friends, lovers, and relatives. As a whole, it made up one of the greatest testimonials to sorrow this century has seen. Now, two years later, there are many more than eight thousand - and there will be many more.

4.] SEXUAL BEHAVIOUR AND THE STRENGTH AND DIRECTION OF CHANGE.

In the last section, I discussed recent political, social and economic changes which took place in the gay community. In this section, I discuss changes in sexual behaviour. By looking at trends shown in cohorts and surveys as well as the rates of other sexually transmitted diseases [STD], I not only look at the actual changes themselves, but also the lack of them. My purpose therefore is twofold: first, to look at evidence of the declining rates of multiple partnering and unsafe sex; second, to show that these behaviours are still common. Although many gay men have switched to safe sex, in other words, many have not.

In the decade prior to AIDS, homosexual activity was increasingly recognized as an important factor in the epidemiology of STD. Ostrow and Altman [1982], Berger [1977], Barrett-Connor [1974], and Dunlop [1973] had all asserted this. Studies of clinical populations found large proportions of gonorrhea [Judson, Penley et al., 1980], syphilis [British Cooperative Clinical Group, 1973], and Hepatitis B [Dietzman, Harnisch et al., 1977; Szmuness, Much et al., 1975] to be contracted homosexually while broad surveys [e.g. Darrow, Barrett et al., 1981] found high rates among gays in general.

After the onset of AIDS, it was found that STD and HIV seropositivity are strongly related to each other both clinically and behaviourally. For syphylis, Sindrup, Weisman

et al. [1986] found its presence almost twice as likely in the sexual history of the seropositive members of their Danish cohort than in those seronegative. Similar associations have been noted by Cannon, Quinn et al. [1989], Anastasia, Kollinikos et al. [1989], DiFerdinando, Arthur et al. [1989], and Poulsen and Ullman [1985]. For Hepatitis B, at least two studies [Antonietta, Viganò et al., 1989; Caradda, d'Arminio et al., 1989] have found significantly strong associations with HIV seropositivity.

When implying a change to safer sex, however, declines in the rates of syphilis and Hepatitis B are not reliable markers. As Judson, Cohn and Douglas [1989] point out, syphilis is often asymptomatic and has a long incubation period while Hepatitis B is not always contracted sexually. Gonorrhea, on the other hand, is readily symptomatic and appears within days of exposure. A strong decline in its rectal incidence, therefore, as reported by Evans, Rutherford et al. [1988], Schultz, Kristal et al. [1984], and Judson [1983], and as shown in **TABLE ONE** [Trow, 1989] and **TABLE TWO** [Rekart, 1989] on the next two pages, is strongly indicative of a substantial change in the rates of unprotected anal sex.

Since cohorts and surveys of gay men are almost always convenience samples [clinical populations, bar and social group solicitations, ad respondents, etc.], they can never be representative. This is also a reason for considerable differences among findings. Nevertheless, those gathered for the study of AIDS certainly show a decline in all risky behaviour and a change therefore - as Hessal, O'Malley et

TABLE ONE

TOTAL CASES OF GONORRHEA (*), FREQUENCY AND PER CENTAGE HOMOSEXUAL: DECLINING RATES, 1982 TO 1987. [AN STD CLINIC, TORONTO, ONTARIO]

YEAR	TOTAL CASES GONORRHEA	RECTAL GONORRHEA	PER CENTAGE RECTAL
1982	1,935	575	29.7
1983	1,581	457	28.9
1984	1,068	280	26.2
1985	1,030	242	23.5
1986	653	92	14.0
1987	378	52	13.6

[Source: Trow, 1989]

(*) Male only.

* * * * * * *

TABLE TWO

TOTAL CASES OF GONORRHEA (*), FREQUENCY AND PER CENTAGE HOMOSEXUAL: DECLINING RATES, 1980 TO 1988. [BRITISH COLUMBIA] (**)

YEAR	TOTAL CASES GONORRHEA	HOMOSEXUAL GONORRHEA	PER CENTAGE RECTAL
1980	10,144	1,246	12.3
1981	9,220	1,244	13.5
1982	8,623	1,099	12.7
1983	6,137	678	11.0
1984	6,359	521	9.5
1985	5,556	280	5.7
1986	3,564	132	3.7
1987	2,942	120	4.1
1988	1,928	67	3.5

[Source; Rekart, 1989]

(*) Both male and female.

(**) In order to rule out under-reporting, these figures were compared with those of a large Vancouver STD clinic. Similar proportions were found.

* * * * * * *

al. [1989], Van Griensven, de Vroome et al. [1989], and Linden, Rutherford et al. [1989] affirm - may be inferred.

Strong behaviour changes were apparent within a few years of AIDS onset as was shown by Pucket, Bart et al. [1985]. Following up a group from August, 1984, eight months later, they found that monogamy, celibacy and no unsafe sex outside a relationship increased from 69% to 81% while having more than one partner in a thirty-day period decreased from 49% to 36%. Later, Martin's cohort [1987], in a follow-up survey from 1985, showed a 70% decline in sexual activity where body fluids are exchanged and an increase in condom use from 1.5% to 20%. Ekstrand, Coates and Stone [1988, 1989] found even more dramatic changes in a San Francisco group [the Gay Men's Health Study] interviewed in 1985 and 1987. The incidence of unprotected receptive anal sex decreased from 44% to 3% while that of unprotected insertive anal sex dropped from 48% to 8%. Among other things, this slight difference in the two could reflect a belief that the former is more dangerous. In a subgroup of fifty-eight bisexual men [Ekstrand, Coates et al., 1989]], sex with men decreased from 91% to 41% and anal sex in general fell from 53.4% to zero incidence. Although sex with women also declined, the drop was not as sharp. The researchers conclude that this suggests a belief that women are safer in general.

Bradford and Johnson [1989] distributed questionnaires in the gay community of Richmond, Virginia in 1985 and 1987 with a 45% and a 68% response, respectively. Not only did the self-reported behaviour changes increase from "only a

minority" to "almost everyone" who responded, but voluntary testing increased from "very few" to 43%. Both of these changes reflect major concerns for AIDS.

In a Canadian cohort [Willoughby, Schecter et al., 1989] of 197 seronegative and 186 seropositive men, 80% and 41% respectively never had receptive anal intercourse with casual partners. Of those who did, 72% always used condoms. Furthermore, the mean number of casual partners per year was three for seropositives and two for seronegatives. Considering the free sexual climate a decade earlier, this suggests a considerable reduction.

Decreases in risky behaviour can also be found in other areas of the world where gay culture and that of the society in general are comparable. In England, first of all, McManus, Davies and Coxon [1989] analyzed 1200 responses to a questionnaire placed in the gay press in 1988. Among other things, they found that 60% had fewer than five sex partners in the last twelve months. In Australia, Tindall, Nicholas and Cooper [1989] studied a group of 1057 homosexual/bisexual men for more than three years. The frequency of all risky behaviours showed marked declines. The numbers of partners in the last six months, for example, dropped from 22 to 4 for seropositive members and from 16 to 2 for seronegative ones. Those who did have unsafe sex usually did so within a monogamous relationship. In The Netherlands, Tielman and Polter [1989] surveyed readers of De GAY Krant, a large gay newspaper, as well as members of activist organizations from 1984 to 1988. Five hundred and thirty-three returned all four

questionnaires. The proportion of those always having safe sex rose from 28% to 49% while that of those never having it fell from 21% to 12%. Again, most unsafe sex took place within a monogamous relationship.

Cohorts also suggest that the seroconversion rate has both dropped and stablized. Cohn, Koleis et al. [1989] followed a group from 1985 to 1988. During the first year, there were 42 seroconversions. During the last year, there were only three. In a group of 477 followed by Sestak, Schecter et al. [1989] since November, 1982, there were 118 seroconversions or 24.7%. The majority of these however were during the first years and, during the last year, the rates were only between 3% and 4%. Haley, Freeman et al. [1989] had comparable findings [3.5%] in their Dallas cohort of 662.

Much of this change, however, is a matter of perspective. Since the proportion of those now presumably having safe sex are high - often 50% to 90% - that of those flouting the guidelines appear small and, thus, insignificant. As Siegal, Bauman et al. [1988] state:

> Previous research on changes in sexual practices by gay men,... has reported the extent to which gay men have reduced activities associated with HIV transmission, including fewer sexual partners, lower rates of participation in specific risky sexual acts, and lower rates of venereal disease. However, many of these studies leave unclear how often gay men are continuing behaviors that might expose them to the AIDS virus. Thus, although these studies have helped to document the extent to which men have reduced their risk, less attention has been given to rates of continued participation in risky behaviors.

This can be said for all studies mentioned. Furthermore, a large change in one behavioural area can obscure a lack of it

in another. Siegel, Bauman and associates well illustrate this in their analysis of a New York City cohort of 162. Eighty-four per cent reported "at least some" modification in their behaviour. This, however, was primarily a reduction in numbers of partners and 48% continued to engage in risky sex.

A third factor clouding the perspective of change is insightfully pointed out by Siegel and Glassman [1989]. As they say, when behaviour is looked upon at the individual level, it appears as though there is a substantial change. When looked upon at the aggregate level, however, a different picture is seen. Several studies illustrate this very well. Golombok, Sketchley and Rust [1989], first of all, surveyed 262 gay men by mail. As they found, 116 engaged in insertive anal sex and, of these, only 32 or 12.2% did not use condoms. When analyzed in terms of the number of encounters with different men during the past year, however, they found that half involved anal sex and half of these were unprotected. The aggregate level, therefore, shows twice the frequency. In another study [Doll, Byers et al., 1989], the responses of 599 men attending STD clinics in three American cities were analyzed. Anyone who had had unprotected anal or oral sex in the preceding four months was considered. In a factor analysis, they found that a small cluster of 54 - those with the highest numbers of partners - had averages of 25.0 episodes of unprotected anal sex and 37.6 episodes of unprotected oral sex during this period. This is in contrast to another larger cluster [N=195] for which these averages were only 7.6 and 4.5, respectively. Richwald, Morisky et al.

[1988], in a third study, interviewed 807 men as they left bathhouses in and around Los Angeles. Only 10% reported having unprotected anal or oral sex. This group, however, was more likely to report having five or more partners in the last month. In all three cases, therefore, the perspective of change at the individual level was substantive. At the aggregate level, however, it can be seen that much unsafe sex still occurs. Also, those who do tend to have unsafe sex also tend to have the highest numbers of partners.

Lastly, it must be stated again that these finding cannot be generalized. Often, they have used clinical populations - those who have voluntarily sought out testing - and this, in itself, is a strong bias. At other times, questionnaires were placed in gay periodicals which presents a bias once again. However, since there is no way of obtaining a representative sample of men who have sex with men, these studies are the best we have. Even if faith cannot be placed in their generalizability, it can at least be placed in their consistency.

In this chapter, I discussed three major topics. First, I have shown both how gay sexual freedom emerged historically and how it was perpetuated by political, economic, and social factors. Second, I discussed the changes taking place after the onset of AIDS. Third, I reviewed the existent empirical evidence of changes in sexual activity - and those that have not. Since a sex act can not be disembodied from its

context - and, thus, its history - all of these factors play a key emergent role in sexual activity today. To study sexual activity - what is done, who it is done with, and the circumstances under which it is done - is to study a host of meanings, all arising from their past, dictated by their present, and implying their future. To fully understand sexual activity, therefore, we must ground it in these dimensions. And, if we are to make a change for the better, we must look at them as well.

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CHAPTER TWO

AIDS PREVENTION EFFORTS, THEIR STRENGTHS AND LIMITATIONS, AND THE ASSUMPTIONS BEHIND THEM

Many men are at least helped to maintain their good resolutions by fear of disease. This is not a motive, experience proves, that holds good for a long time, especially once a man has taken risks and come off lucky. Still, if you really have a horror of bodily filth, and of running the danger of seeing your wretched limbs putrefy while they yet live, you will be helped by fear of venereal disease. I really think one might not do a bad turn to many a young man, by taking him to see - and to smell - rotting venereal patients in a Lock hospital.

[C. C. Martindale, SJ., The Difficult Commandment, 1935]

CHAPTER TWO

Even without being sexually active, AIDS as a topic is hard to miss. Governments agencies, in their efforts to change sexual behaviour, have made extensive use of films, television, billboards, pamphlets and posters; newspapers often have several AIDS-related articles; and AIDS is often the topic of conversation in schools, offices, bars, and streets. Not only does this serve to put "AIDS in the minds of America" as Altman's book title [1986] suggests, but it is the very fabric by which attitudes are shaped and maintained.

This research is concerned with sexually active gay men and their beliefs upon the nature of safe sex. Since these beliefs are gleaned from the larger society in which they live, it is necessary to devote some time to the efforts of that society to shape them. The first part of this chapter, therefore, will look at current efforts towards AIDS prevention. What are these efforts? How effective are they? Do they succeed in their intended task?

In the last chapter, I showed that sexual behaviour has already changed considerably. It is unlikely that formal prevention efforts are fully responsible for this change, however, because of their limitations. Although prevention is [or should be] a matter of health, it has been compromised by its political component which, for the most part, has arisen from two factors: a.] Society, founded upon a Judeo-Christian tradition, has had a difficult time coming to grips with

sexual desire. b.] Society, because of this tradition, still holds negative attitudes towards homosexuality. The second part of this chapter, therefore, will show how these factors have given rise to a political element in AIDS prevention, and how this element has compromised its intended task.

The third part is devoted to the assumptions behind AIDS prevention efforts. In this research, I offer a different explanation for the origins of unsafe sex. I maintain that it is based not upon the degree of AIDS-avoidance information possessed but, instead, upon how this infomation is come by, examined, interpreted, and used. This has been largely ignored. Instead, educators have had implicit faith in the predominance of a particular mode of thought borne within and arising from our general assumptions about the nature of rationality. Not only has it been assumed that appropriate knowledge will result from appropriate information, but that appropriate knowledge leads automatically to appropriate behaviour. Much effort, therefore, has been devoted to the transfer of information.

1.] AIDS PREVENTION CAMPAIGNS, THEIR EFFECTIVENESS, AND THEIR LIMITATIONS.

By now, efforts to prevent AIDS have come from virtually every area of society where it is thought that someone can be reached. They range from the most sweeping as is seen on television or in magazines, to the more concentrated as in

the efforts of community based organizations to those of individuals. Since these efforts are too numerous to review here, I will concentrate on only three types: a.] Television campaigns by government health departments. b.] Gay community efforts. c.] Condom promotion. Although they have much in common, I have chosen them specifically for their different strategies and different levels of effectiveness.

Since television campaigns are the most visible and expensive prevention efforts, it would be easy to believe that they are also the most persuasive. Past studies of the use of television in combating other health problems [smoking, drug and alcohol abuse, etc.], however, have cautioned us against this. Although some have reported positive effects [e.g. Engleman, 1987], a number of others have reported just the opposite. Miers [1976], for example, cited a 1967 British survey on smoking behaviour which found that although 78% of the sample had heard of the connection between smoking and lung cancer from television, almost none quit or cut down because of it. As she states, although the media are excellent for the distribution of information, they play little part in changing behaviour. Richman, Perry et al. [1987] and Ben-Sira [1982] have come to similar conclusions.

When considering Baggaley's analyses of the AIDS-prevention messages of twenty-one countries [1988a, 1988b, 1989], this also seems to be the case with AIDS. His method was as follows: Sample audiences were obtained and asked to view one or more films. For each, members were given

electronic devices with four buttons marked "poor," "fair," "good" and "very good." When viewing the film, they were asked to press the appropriate button at each point their opinion changed. A central computer calculated the mean of their reac ons throughout. Baggaley had several findings. First, when complicated or melodramatic imagery was used [e.g. likening unsafe sex to a volcano eruption (England)], audience reactions went down. This was regarded as an attempt to sell something and, thus, made the audience defensive. When facts were presented in a straight-forward manner, on the other hand, the message was well received. Second, those films televised were least liked by the audiences. Those they liked, on the other hand, were rejected by the networks on the grounds that they were too explicit. Baggaley concludes that those films used are not only inappropriate for their intended purpose but may, in some cases, do more harm than good. He cites several reasons for this: First, classic studies upon audience reactions appear to have been ignored. Despite much past research in this field [e.g. Bauer, 1964; Brembeck & Howell, 1976:323-345], little of it has been considered. Second, the films are rarely pre-tested. The reason for this, Baggaley states, is that there is often pressure to put them into practice as soon as possible. Thus, time does not allow such measures. Third, the belief that a glossy expensive approach will result in a successful campaign is all too common. As he states [1988a:6]:

> The techniques to sell soap flakes and tooth paste do not sell ideas about disease.... [campaign designers] naturally prefer to create an expensively animated, dramatized TV announcement instead of a single head-and-shoulders shot with a simple message - for the florid style gives them artistic satisfaction, competitive edge, and the ability to charge larger amounts for their work. In the face of the AIDS threat, however, it is time to stop this charade, and to recognize that simple clarity is the best approach educationally, while fancy production values can do more damage to social attitudes than good.

Lastly, Baggaley and others [e.g. AIDSCOM, 1989; Hiramani & Sharma, 1989] warn against adverse effects of poorly produced television campaigns. Not only can they create new myths and unnecessary fears, but also evoke denial in some which will make subsequent prevention more difficult.

Chapter one showed that gay communities in North America rose rapidly and diversified during the 1970s. Since they were already thriving when AIDS appeared, the necessary conditions for a quick and efficient response were already present. Messages involving safe sex could simply be introduced into established sex environments such as bathhouses [Tivey, 1989], bars [Adrien & Carsley, 1987], and outside cruising areas [Lerro, 1989; Beckstein, 1989; Beckstein & Gunn-Mota, 1989]. These same messages were also publicized on community radio and television [e.g. Sobota, 1989] and the much trusted gay press. In view of the declining rate of seroconversion among gay men, there is no doubt that all of this has had an effect.

Direct intervention has also proven beneficial in changing gay sexual behaviour. This approach has several

advantages. First, it allows for face-to-face interaction. This makes it possible to deal with individual behaviour though a personalized approach. Second, since education can take place within a controlled environment, it is measurable. Not only can experimenters compare one approach to another but, ultimately, improve upon these approaches as well. Third, it allows for innovative intervention designs. Educators do not necessarily have to rely upon the transfer of information but can deal with this behaviour itself.

One example where these advantages have been effective is seen in the approach of Kelly, St. Lawrence et al. [1989]. Their procedure was as follows: One hundred and four gay men with a history of high-risk behaviour were randomly divided into two groups. The experimental group [N=51] participated in twelve weekly group sessions which included AIDS-risk education, behavioural self management, and assertion training. The control group [N=53] was put on a waiting list for this treatment. Four months later, behaviour differed significantly between the two groups. While the mean number of occasions of unprotected anal sex fell from 7.8 to 2.3 [70.5%] for the experimental group, it only fell from 11.0 to 8.3 [24.5%] for the other. Similarly, the means for anal sex with a condom rose from 2.6 to 5.8 and fell from 1.9 to 0.1, respectively. Clearly, their multifaceted workshop approach made a difference as it has in many other cases. [Tudiver, Myers et al. 1989; Caceres, Gotuzzo et al., 1989; Beeker & Rose, 1989; Wohfeiler, Frutchey et al., 1989; Rowe, 1989; William Palmer, 1989]

A further advantage of the workshop approach is its frequent use of peer leadership as opposed to intervention from outside. Since gay men have historically been subjected to stigma, government regulation of their sexuality [Kinsman, 1987], and heterosexually biased scrutiny from medical and social scientists, they are often distrustful of researchers, government officials and - one would think - educators as well. [Cuthbert, 1989; Boyd & Jackson, 1988; Joseph, Emmons et al. 1984] In view of this, peer leadership has high credibility and precludes such barriers. [Larson, 1986:36] It has therefore been used successfully in workshops [many of those mentioned above] for gays as well as other risk groups. [Lyons, Begley et al. 1989; Wortman, Rekart & Mearns, 1989]

The gay community has also taken strong initiative in the formation of community intervention groups [e.g. Commité SIDA Aide Montréal; Toronto AIDS Committee; Gay Men's Health Crisis]. Although they are normally not gay groups per se, they often cater by necessity to gay communities and are set up and run by lesbians and gay men. Education is often at the grassroots level where condoms are distributed, hotlines are set up, and speakers and street workers are sent out. There is no doubt that their hard work and strong presence have had a great effect upon local sexual behaviour. According to the consensus statement [1989] of the First International Meeting of AIDS Service Organizations last year, however, they are not without their problems. First, they are often not officially acknowledged. This leads to an under-estimation of their potential. Second, they are often impeded by government

regulation [e.g. laws against prostitution, censorship of safe-sex material] which compromises their efforts. Third, funding is often related to legitimacy granted to them by governments. Consequently, they must rely on private funds instead. In view of these limitations, an otherwise valuable source of AIDS intervention is under-used.

Although the approach of the gay community is effective, it is destined to reach only a limited number of homosexually behaving men. Studies such as that by Doll, Byers et al. [1989] have found that the potential to reach those at risk is often dependent upon their closeness and identification with the gay community. Unfortunately, this excludes most in the closet as well as those - described by Hencken [1984] - who behave homosexually but do not define themselves as such.

The third type of AIDS-intervention activity is condom promotion. Before the onset of AIDS, condoms were regarded primarily as a measure of birth control. As a result, they were not something gay men normally worried about. Now, since they are regarded equally as a measure of disease prevention [Centers for Disease Control, 1986], condoms are as much a gay concern as heterosexual.

Condom promotion differs from other AIDS-prevention measures in that it comes from two sources. First since they are effective in preventing transmission, their use is encouraged by health departments, community groups, etc. Second, since they are a product manufactured for profit, AIDS has given pharmaceutical companies a new market to tap.

Whether their motives are capitalistic, humanitarian, or both depends upon one's point of view. In any case, the result is the same. Condoms have a new legitimacy and, as a result, are used more than ever before. To confirm this, Moran, Janes et al. [1989] analyzed the sales data from a national sample of American drug stores. While annual sales rose only 0.6% from 1983 to 1984 and 1.2% from 1985 to 1986, they shot up 20.3% from 1986 to 1987. This sudden increase, they believe, was largely due to the Surgeon General's recommendation at the time.

Acccording to Saunders, Smith et al. [1989] and Breedlove, Beth and Martin [1988:347-348], pharmaceutical companies have resorted to numerous new marketing strategies. Condoms are now targeted specifically towards gay men, fear is used, and they are even manufactured in assorted colours [touted as "especially popular with teens"]. Promotion from AIDS-prevention organizations has been even more innovative. As a number of studies [e.g. Downer, Kelleigh et al., 1989] have found, humour is almost always positively received. Thus, it has been the thrust of a number of efforts. Slogans such as "It's raining men. Do you have your rubbers on?" have appeared everywhere; volunteers dressed as Santa Claus and his elves have distributed condoms in gay bars; and the gay press has often carried serial comic strips [notably, "Captain Condom" in GO Info (Ottawa) and Xtra (Toronto)]. Furthermore, condoms are endorsed by celebrities, distributed freely at gay bars, bathhouses and community centres, and encouraged in pamphlets and posters everywhere. The United

States even has a national condom week in February. All of this has given condoms a new visibility in the gay community and there is no doubt that it has contributed to a reduction in the number of seroconversions over the past several years.

2.] THE POLITICS OF AIDS PREVENTION.

AIDS is, first and foremost, a medical phenomenon. It is caused by a virus which breaks down the immune system and, as a result, lays it open to opportunistic infections which lead to death. With no possibility of a cure in sight, the only way to combat it is to change sexual behaviour. Since this involves homosexuality, premarital sex, sex between minors, prostitution, and drug use, however, AIDS is also a social phenomenon. As Tiexiera [1983], Conrad [1986], Velimirovic [1987], Bennett [1987], Gilman [1988] and, most powerfully, Sontag [1988] have pointed out, AIDS has become a metaphor for sin, perversity, hedonism and indulgence in activity that flouts family values. For the many who hold such views, it is seen at best as a consequence and at worst as a punishment for such indulgence. Indeed, this is well illustrated by news media rhetoric that refers to children with AIDS as "innocent" victims" or as contracting the disease through "no fault of their own." In true dialectic fashion, this social dimension has led to three types of prevention efforts: a.] Moralistic. b.] Non-moralistic. c.] Efforts that attempt to appease both. I will discuss each separately.

The moralistic point of view sees AIDS as a consequence of behaviour that rightly should not exist. Homosexuality is an illness, prostitution is a sin and sex before marriage is inherently wrong. Teaching methods of protection, therefore, is tantamount to endorsing sin. Efforts are therefore geared towards reaffirming established values. Such views are epitomized by the following letter to the editor appearing in The Toronto Star, February 5, 1987:

> I was rather amused by your headline, Catholic schools to teach own program on AIDS. It seems to me that when I went to a Catholic school many years ago, I was taught that I had two choices: I could be celibate or I could pick a single partner and cling to her for life. Sounds like the Catholic school system has been teaching pretty effective AIDS-prevention techniques for quite a few years.

Nowhere are such views more apparent than among the mormons of Utah where church and state are closely linked. As Watanabe [1988] says, abstinence until marriage and monogamy ever after are put forth as the only means to prevent AIDS. Even the mere mention of condoms in schools is forbidden. Although the seroprevalence rate in Utah is comparatively low [N=108], such attitudes are not without consequences. Since AIDS is severely stigmatized, those with the disease are unlikely to seek treatment until absolutely necessary. Often, this is too late. This is supported by the fact, as Watanabe points out, that 65% died compared to 58% nationwide.

Although the Catholic church has similar views, they are not without much reflection and, as a result, much dissent. One side strongly reaffirms church dogma maintaining that sex outside of heterosexual marriage is sinful. The other says

that modern-world realities must be faced. [Baum, 1989] The quandary, as a result, has been whether to compromise long-held standards [i.e. mention condoms] and preserve life at this cost or to maintain its stance. In this respect, the dissension is similar to that of birth control. Whether as an appeasement or not, the Catholic church has taken a leading role in an area of the pandemic it has no problem with - pastoral care of people with AIDS. [Bennett, Wood & Carnahan, 1989] As Yaeger [1989] points out, however, in his analysis of statements by prominent clerics and major articles in the religious press, their moralistic position [as well as those of other religious groups (see Palmer, 1989)] have very likely exacerbated the obstacles of AIDS prevention rather than helping to overcome them.

The consideration of the role of religion in AIDS prevention is no simple matter. Certainly its principle that abstinence is the best measure of protection is true. Its reification as an operative "method" of prevention, however, as is evident in a booklet for students by the American Red Cross [1987], is not. According to Gochros [1988], when those already sexually active deny their feelings completely, they often fail. And, when this occurs, feelings may be released with such passion that methods of safe sex are forgotten entirely. Furthermore, not only does this deny the realities of the secular world, but the incidence of teenage sex as well. According to an extensive survey [Kann, Nelson et al., 1989] in different areas of the United States with sample sizes from 778 to 7,013, the proportion of teenagers who had

sexual intercourse at least once ranged from 28.6% to 76.4%. Furthermore, 15.1% to 42.6% had three or more partners. In Canada, in a sample of 38,002 [King, Beazley et al., 1988], 31% of grade nine boys and 21% of grade nine girls had had sexual intercourse at least once. By grade eleven, these proportions rose to 49% and 46%, respectively. And this is only the general population. The risk factors of homeless youth [Radford, King & Warren, 1989], runaways [Hudson, Petty et al., 1989; Rotheram-Borus, Selfridge et al., 1989] and, above all, gay youth [Feldman, 1989; Reeves, 1987; Gross, 1987] make the probability of seroconversion even higher.

The major drawback of the moralistic approach is that it serves two masters. On one hand, it is concerned with curbing the spread of AIDS. On the other, it is concerned with the preservation of scripturally defined principles. Not only does the tension between the two mount with the degree of commitment to the latter but, when this tension becomes too great, the former is inevitably compromised.

The non-moralistic approach maintains that sex in general or needle sharing among addicts will occur despite any attempts to discourage them. Instead, therefore, it concentrates on making these activities safe by giving as much information to as many as possible. This approach is typical of gay communities and nongovernmental organizations and implicit in the seventh declaration of "The Rights and Needs of People Living with HIV Disease" read by activists at the Fifth International Conference on AIDS in 1989:

> International education programs outlining compresensive sex information supportive of all sexual orientations in culturally sensitive ways and describing safer sex and needle practices and other means of preventing HIV transmission must be available.

Advocates of the nonmoralist approach can be further divided into two subtypes: a.] Those who merely make no moral considerations in their prevention efforts and leave this to the individual. b.] Those who feel that sex, whatever its nature, is rightful and good and speak out against any attempts to restrict it. This is seen in the frequent reluctance to recognize abstinence as a viable measure of prevention. In this sense, this second type is the perfect antithesis of the moralist approach and, thus, is a moralist approach in its own right. Much AIDS education, therefore, comes out of a political battleground which determines its nature, concentration, and direction. Both have a number of drawbacks. First, not all are comfortable with all forms of sexual expression. To publicly advertise methods of safety during the more esoteric acts [see **APPENDIX ONE**] for example will inevitably meet with resistence. Since this is often powerful, it must be considered.

Second is the dialectical tension created by the language of sex. Instructions upon safe sex must, by definition, be understandable. To achieve this, they must be geared to the lowest common denominator. As Johnson and Belzer note [1973:152], for example, neither the United States military nor the public health department made any progress in combating syphilis or gonorrhea during World War

One because "no one was willing to use the word." Instead, messages were obscured by euphemisms ["Have you kissed an immoral woman lately?"]. The clearer instructions become, however, the more the resistence towards them. Again, this must be considered.

It must also be considered that resistent groups have the power to block instructions from a large segment of the population - namely, the young. Nowhere is this more apparent than in sex education. While this has always been controversial, it has been exacerbated by AIDS. While it is recognized that teenagers must be taught measures of prevention, if this is done too explicitly, a great many parents are likely to pull their children out of school. A compromise, therefore, must be reached by necessity.

This approach also has its drawbacks. First, for many reasons, society has never achieved consensus upon the place of sexuality. Resistence toward unconventional forms has always persisted. Although the nonmoralists recognize this, they have failed to consider its repercussions. Thus, they have not learned to deal with it. Thus, the dissemination of their frank message often seems like guerrilla warfare. Second, nonmoralists often miss the fact that no morality, by definition, is a morality in its own right. Once premarital sex, prostitution, or homosexuality meet with resistance, any stand upon their legitimate place is one of political advocacy. If AIDS was transmitted by other means, there would likely be no moral considerations to deal with. But, since this is not the case, morality as an issue cannot be avoided.

The third type of prevention has arisen dialectically from the tension created by the first two. Although the necessity for frank and complete education is recognized, it is also recognized that the moralists have powerful influence. The efforts therefore - typical of secular school boards, larger nongovernmental organization, and health departments - are attempts to appease both. As much information as possible is given without overstepping implied bounds. In this sense, this approach also serves two masters. First, it must prevent the transmission of AIDS. Second, it must do so within acceptable parameters. Again, the first task is compromised by the second and prevention efforts come across as skillfully choreographed dances of diplomacy. The "America Responds to AIDS" campaign tells us to "get the facts" instead of telling us what they are; expressions such as "body fluids" are used in place of sperm or blood; and anal sex is frequently mentioned only after much apology.

A common feature of this approach is an attempt, wherever possible, to avoid references to homosexuality. American Surgeon General C. Everett Koop [1987], for example, called for the presentation of accurate avoidance information to the young. With this task comes a recognition that homosexuality must be mentioned. Since it is difficult for the general public to acknowledge the existence of gay youth [Hetrick & Martin, 1987,1988], and since it is felt that such references would encourage the young towards this behaviour, strong objections are sure to arise. As a result, concerted efforts have been made to avoid offense to parents [Peterson,

1988; Harrington, 1987]. One way, according to Lenskyj [1989], is to mention homosexual transmission without mentioning homosexuality. Sex educators, for example, will often discuss "the penis," "the anus," and "the mouth" without mentioning the sex of the person these parts belong to. Although the information is given, in other words, it is done so in a pointedly neutered fashion.

The "de-gaying" of AIDS does have the advantage of making heterosexuals realize that they are susceptible. Certainly the belief that it is a gay disease has caused many to feel that they are not. [St. Lawrence & Betts, 1989; Strunin & Hingston, 1987; Paxton & Susky, 1988;] On the other hand, it diverts attention from the principle means of transmission. If education is sparing with its information on protective measures for anal intercourse, the probability that a segment of the population will remain at risk is increased. Those who maintain that such warnings should be reserved for targeted efforts miss the point. As Hencken [1984], Paxton and Susky [1988], and Ben Schatz of the AIDS Civil Rights Project in San Francisco [Smith, 1989] point out, the vast majority of homosexually behaving males never come into contact with the gay community. And, as at least two studies [Chetwynd, Horn & Kelleher, 1989; Connell, Baxter et al., 1989] have noted, this group is far more likely to engage in unsafe sex. Since they fall between the cracks of current prevention efforts, they remain at risk.

A second notable feature of such efforts is the precedence of the abstinence clause whenever and wherever

safe sex information is meted out. Although there is nothing wrong with abstinence per se, it often reads like a legal disclaimer to the dissemination of any preventative information at all. As one ad slated by The Ad Council [1988] for appearance in various magazines states:

> The surest way to avoid AIDS is to avoid sex. If you do have sex, your best protection is a latex condom with spermicide.

Such rhetoric has arisen largely due to the belief that safe sex instructions will encourage people - especially the young - to "experiment." When abstinence supercedes these instructions, therefore - even with its tautological truth - it appeases those who would believe this.

A third feature is the manipulation of safe sex information - either by skillful ordering or by the avoidance of certain other information - to discourage certain activities altogether. One example, taken from "AIDS Prevention Program for Youth" by The Red Cross [1987], is seen in **FIGURE ONE** on the next page. The format is a dialogue between a curious young person and an authority figure. First, anal intercourse and oral sex are described in such ways that they come across as both unappealing and uniformly unsafe. The fact that it is not necessary for the mouth to come into contact with the head of the penis, for example, is conspicuously absent. Second, condoms are mentioned as a measure of protection for "sexual intercourse." Considering what is said [and not said] about anal or oral sex, this intentionally comes across to mean only vaginal intercourse.

FIGURE ONE

Excerpt from "AIDS Prevention Program for Youth" [The Red Cross, 1987]

By choosing certain behaviors, you can protect yourself from any sexually transmitted disease [STD] and from AIDS in particular. The behaviors you can choose that will help protect you include -

- **Abstaining from** or **postponing** sexual activity.
- Being faithful to a long-term mutually monogamous sexual partner [sic] who is not infected with the AIDS virus. [Remember, major religions advocate that sex should not take place outside of marriage.
- Avoiding specific high-risk sexual practices.
- Using protection during sexual activity.
- Abstaining from illegal drug use....

What are high-risk sexual practices?

Now that you've asked, the activity with the highest risk is anal intercourse. Anal intercourse is the insertion of the penis into the anus. The lining of the rectum is very delicate so when the penis is inserted, it may cause tears and bleeding. If semen carrying the AIDS virus gets into the rectum, the virus can enter the bloodstream easily.

What else?

Oral sex, that is, contact of the mouth or tongue with penis, vagina or anus during sexual activity - can spread the AIDS virus from one person to another because the mouth can come into contact with semen, vaginal secretions, or blood. These are the fluids that are known to transmit the AIDS virus.

These are high-risk sexual practices to avoid. Why take chances?

Okay. So I know that not having sex is the best way to avoid AIDS. That's okay for me. But what about people who choose to be sexually active? How can they protect themselves?

One thing sexually active people can do is to [sic] use a condom. A condom [sometimes called a rubber] is a disposable form of protection that is used to avoid exposure to semen, blood, or vaginal secretions during sexual intercourse.

Do condoms really work?

Don't get the idea that condoms are 100% safe. To work, a condom must be free of holes, must be put on the penis prior to sexual intercourse, must remain in place during sexual activity, and must not break. The condom must be used from the start to the finish of sexual activity. Because condoms don't always work, it is best to avoid sex with anyone other than a faithful partner who is not infected with the AIDS virus.

Third, safe sex instructions are given for "people who choose to be sexually active" and "they" instead of the inquirer who's choice of abstinence is rendered academic. Fourth, condoms are presented as such risky and complicated gismos that it seems that anyone attempting to use them is doomed to failure. In short, the truth is ordered and presented in such a way as to render abstinence as the only sensible option there is. All other information is present but, as it seems, only as an appeasemnt.

It is likely that such manipulation may indeed deter some from sexual activity. It is also likely that it may encourage others towards it by sacrificing credibility. The diplomatic dances may have the advantage of getting information across. But if this information is watered down and distorted, it is of little value. Once diplomacy becomes an end in itself, the original end - in this case to prevent the spread of AIDS - takes a distant second place.

3.] FUNDAMENTAL ASSUMPTIONS OF AIDS-PREVENTION CAMPAIGNS.

The importance of education can not be overemphasized. With no cure in sight, it is the only method we have to fight AIDS. Educators have therefore put forth massive campaigns, made innovative use of fear [Rhodes et al, 1989], counseling [Quirk et al., 1989], experiential learning [Bargai & Shtarkshall, 1989], community outreach [Wallace et al, 1989],

street work [Biernaki & Broadhead, 1989], and a host of other methods to reduce risky behaviour. Any generalizations about them, therefore, should be made with much caution. Having said this and, thus, qualified my remarks, I will now go on to make a case for their underling weaknesses.

When information is given to people about the dangers of unsafe sex, it is to change this behaviour. If they are informed of the dangers, they will stop; if they are not, they will continue since they do not know. I call this assumption the "educational model" of AIDS prevention and define it as the systematic effort to impart knowlede of AIDS to the public to change sexual behaviour. Clearly, the effectiveness of this model has been questioned. In a consensus statement at the First International Conference for AIDS Education last year [Sy, Richter et al., 1989], it was recommended that efforts go beyond this and actually attempt to empower people to change their behaviour. Additionally, Stall [1985], Ross and Herbert [1987], Siegel, Bauman et al. [1988], Haston-Turner, McLaughlin et al. [1988], Ishii-Kuntz [1988] and numerous others firmly believe that while information does raise levels of knowledge, it does little to change behaviour.

Fineberg [1985] suggests several reasons for this. First, sex involves impulses that are difficult to resist. We have also come to believe that sex, to be good, must be spontaneous. Messages involving partner reduction, condoms, or abstinence, therefore, may be difficult to implement.

Immediate urges are also a problem for the drug addict. The discomfort of withdrawal may cause him or her to use the first means of relief available. Second, as I mentioned, the moral component of the message may alienate many and, thus, it is rejected entirely. Third, the degree of risk to the majority of people, due to disagreement among experts and much discussion in the media, is questionable. Many feel that the message does not apply to them. Fourth, the credibility of the message is impeded by much confusion over the nature of transmission. Some sources overestimate the risk involved in a particular practice [e.g. oral sex] while others underestimate it.

Hubley [1984, 1988] would not disagree with Fineberg. Speaking globally, he believes that AIDS education is futile if it contains irrelevant information or that incompatible with local beliefs and customs. When considering the distinct patterns of the gay community, this would well apply.

Trust in education in and of itself as a means of changing behaviour is misguided for several reasons. First, it assumes that most who continue unsafe practices do so because they are uninformed. Second, it assumes that everyone uses one superior rationalist method to make sense of the world. Third, it assumes that since everyone does use this method, the channels between the receipt of information and the resulting behaviour are fixed and automatic.

The first assumption - that people engage in unsafe sex because they are ignorant of the proper preventative measures - is on very shaky grounds. After a decade of

concentrated efforts, the public in general [and the gay community in particular] is already well informed of the dangers of AIDS. In Ornstein's Canadian survey [1989], 94% rated condoms as either very effective or somewhat effective as a means of protection. In a 1987 American survey of 17,696 adults [Soskolne, Schnell et al., 1989], over 90% knew that AIDS can be transmitted by sexual contact with an infected person. As for gay men, studies by Tindall, Nicholas and Cooper [1989] and Tielman and Polter [1989] among others, have both found knowledge levels very high. Most knowledge surveys do report varying degrees of misinformation, but it is generally that which overestimates risk [e.g. transmission through casual contact or blood donation]. To to assume that risky behaviour occurs due to lack of knowledge, therefore, is no longer valid.

The second assumption - that everyone uses one superior method in making sense of the world - is inextricably tied to the third - that the outcome of this method's application to any given problem is fixed. Both stem first from our conceptualization of rationality and, second, from our faith in its universality.

Rationality may be defined as the methodological application of deductive reasoning - or, more accurately, syllogistic logic - in order to solve problems. It is loosely synonymous with "common sense." This is, first and foremost, an ideal - one highly prized in classical Greece and then steadily since the renaissance. It is not, however, an inherent trait. There were also long periods in history

[i.e. mediaeval Europe] where little or no rationality as we know it was used. As a mode of thought, therefore, it is at best paradigmatic. Rationality may be preferable, but it is not intrinsic.

Thought, even when considered rational, need not follow common sensical channels as we know them. Weber, above all, has pointed this out in his introduction to The Protestant Ethic in the following [1958:26]:

> There is, for example, rationalization of mystical contemplation, that is of an attitude which, viewed from other departments of life, is specifically irrational, just as much as there are rationalizations of economic life, or technique, of scientific research, of military training, of law and administration. Furthermore, each one of these fields may be rationalized in terms of very different values and ends, and what is rational from one point of view may well be irrational from another. Hence rationalizations of the most varied character have existed in various departments of life and in all areas of culture.

Thought may also be based upon intuition, imagination, trial and error, faith, personal conviction, karma, luck and a host of other guiding frameworks. Not only is the paradigmatic mode of rationality not intrinsic, therefore, but it may be accompanied by or replaced entirely by other forms.

In view of this, the third assumption of a fixed outcome is also incorrect. Since forms of problem solving may vary, so may their outcomes. Furthermore, there is still no guarantee that the same methods of problem solving have the same results. First, this ignores the deciding potential of differential interpretation. Even when the message is fixed [and, at present, AIDS prevention messages are far from it], a particular understanding still depends upon the meaning

it holds for the individual. Second, even with a fixed message and identical interpretation, the past experience of the individual must also be considered. As human beings, we solve our problems based upon what has worked for us in the past. The rational method, therefore, may be coloured by past outcomes where similar methods were used successfully. If "making sensible choices" based upon the apparent personal disposition of sex partners has proven successful in the past past in avoiding physical attack, for example, it may also be thought to work with the avoidance of other types of danger - namely, AIDS. Third, even with a fixed message, identical interpretation, and identical channels based upon the outcomes of past experience [if this is indeed possible], there is still the potential for differential application in behaviour. Human life, complicated as it is, is rooted in limitless contexts which dictate where, when, how, and under what circumstances action may be realized. Although someone may conclude that condom use is the only viable measure of protection during intercourse, for example, he may see it as impractical and opt instead for "sensible" selection of partners. Others may be unwilling to bear the embarrassment of buying them. Thus, outcome, even with identical cognitive channels preceding it, may also be dependent upon succeeding factors - namely, the context in which it is to be applied.

To summarize, the educational model of AIDS prevention is based upon three main assumptions: a.] That people have unsafe sex because they are uninformed. b.] That all people

use a particular mode of rationality to interpret and act in their world. c.] That the channels between the receipt of AIDS-avoidance information and the resulting behaviour are automatic. This third assumption may be further divided into three more epiphenomenal assumptions: 1.] That the interpretation of a fixed message does not vary. 2.] That the resulting interpretation leads to a fixed channel towards outcome. 3.] That a fixed channel towards outcome leads inevitably to a fixed outcome. In each case, the human being is seen not as an acting entity interpreting and creating his own world but as a mere medium for the channeling of fixed processes. Behaviour, it is assumed, is dependent not upon the processes that follow given stimuli but upon the stimuli themselves. The central thrust of this thesis is to present evidence to the contrary. The human being is not a mere channeler of behaviour but, rather, its creator. If we are to be successful in changing sexual behaviour, therefore, we must look not towards the message we give out but the process by which it is interpretated. Unsafe sex takes place not because improper information has been received but, rather, because information has passed though a labyrinth of interpretive channels which lead eventually to the perception of it as safe. Since the human being is the creator of his own action, he has actively **made unsafe sex safe.**

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CHAPTER THREE

SYMBOLIC INTERACTION, ETHNOMETHODOLOGY, AND THEIR RELEVANCE TO AIDS AND BEHAVIOUR

But whether thus submissively or not, at least be sure that you go to the author to get at his meaning, not to find yours.

[John Ruskin, 1819 - 1900]

CHAPTER THREE

One of the main tasks of sociology is to explain action. For this purpose, structural explanations have been popular throughout most of the twentieth century. Action, as it unfolds, is the result of norms, values, role expectations, and the like standing over society, ordering it, and guiding actors on their courses. In recent years, two theories have emerged to challenge this - symbolic interaction and ethnomethodology. Rather than relying on the imposing forces of structure for explanations of action, they maintain instead that there is only one true determinant - the individual.

Symbolic interactionists, with few exceptions [notably, Stryker, 1980], see structural constraint as an illusion created by like action. Action, instead, is determined by people interpreting their own world. Even though stimuli can produce identical action, this is still determined by interpretation. No matter how consistent or how forceful the stimuli may be, the possibility of differential interpretation is everpresent. Society, therefore, is constantly created by interpretation of action - received, processed, and transformed into further action.

The ethnomethodologists would not disagree with this in principle. Their emphasis, however, is upon method. Although structure may indeed influence behaviour, any attention to it is misguided. Since its true nature can not be determined, it

is beyond reach. Society, instead, is possible because members typically use methods to interpret their experience and indicate these interpretations to each other with further methods. Sociology, therefore, can only learn about social phenomena by the study of methods - not disembodied from their respective fields but on-going and grounded in action.

These theories promise to reveal much about AIDS and sexual behaviour. The educational model has placed implicit faith in the power of the message. It has either ignored the interpretive process, presupposed it as fixed, or reduced its variability to pathological forms. Consequently, it has failed. In order to truly understand the determinants of risky behaviour, the importance of interpretation must be acknowledged. Since interpretation directly precedes action, and since it is indeed variable, it has the power of determination. Even if the safe sex message was concentrated, consistent and clear, differential interpretation may still channel it into differential action. People have unsafe sex, in other words, because their interpretation and methods of doing so makes unsafe sex safe.

In this chapter, I establish the explanatory potential of symbolic interaction and ethnomethodology with respect to AIDS and behaviour. In doing so, I divide it into four parts: The first and second look at each theory separately, the third establishes their compatibility with each other for practical theoretical application, and the fourth re-examines a number of behavioural studies on AIDS from their new perspectives. In many cases, while particular findings have

been arrived at through positivistic sociological means, they are also statements either of differential interpretation, individual method, or both.

1.] SYMBOLIC INTERACTION.

Although there are many variations of symbolic interaction [Stryker, 1980; Rosenberg, 1979; Meltzer, 1975; Kuhn, 1964; perhaps even Goffman], I choose to highlight the theories of Herbert Blumer [1969]. I do so not because of his adamant rejection of structure - this is an on-going controversy that will be with sociology for a long time - but because his is the most powerful statement upon the importance of interpretation.

Human beings have the unique ability to transform their experience into symbols. While animals react to their world with no more sophistication than an immediate "thereness," human beings **reflect** upon them. When a particular **object** - which Blumer defines as "anything that can be indicated, anything that is pointed to or referred to" [1969:10] - is reflected upon, it is done with the use of symbols. All objects are transformed into symbolic representations since our capacity for reflection precludes the "thereness" that animals experience.

'Blumer's theory truly enters the sociological arena when he states that human beings only learn symbols through interaction with others. Although interaction may at times be

on a stimulus-response basis - for example, when one person startles another with a sudden move - interaction as we know it is mediated by symbols. It is therefore symbolic interaction. Symbols are learned and created in interaction, in turn make interaction possible, and, collectively, make society possible.

Blumer divides objects into three types: a.] Physical objects - a pencil, a tree, a condom. b.] Social objects - a criminal, an aunt, a person with AIDS. c.] Abstract objects - a moral principle, fun, unsafe sex. Although objects typically have common meanings for two people, a group, or an entire society, the possibility of difference is everpresent. As Blumer says [1969:11]:

> An object may have different meaning for different individuals: a tree will be a different object to a lumberman, a poet, and a home gardener;... Individuals, also groups, occupying or living in the same spatial location may have, accordingly, very different environments; as we say, people may be living side by side yet be living in different worlds.... It is the world of their objects with which people have to deal and toward which they develop their actions. It follows that in order to understand the actions of people it is necessary to identify their world of objects.

When these principles are applied to AIDS and sexual behaviour, new light is shed upon the etiology of unsafe sex. If "safe sex" is an object to all who reflect upon it, it is one with different meanings for different people. While it may mean using a condom during anal sex with one, it may mean sleeping only with "people who don't have AIDS" to another, and not going to "that part of town" to still another. Similarly, a relationship is an object with safe meanings

while a one-night stand may mean the opposite. The same may be said for a bathhouse as opposed to a "bar where decent people go." Gay men, like all others, relate to their worlds on the basis of the meanings that they attribute to them. If we wish to know why some still have unsafe sex, therefore, then we must first learn the meanings safe and unsafe sex has for them. Furthermore, if we wish to change or stabilize these meanings en masse, it is **crucial** that we understand their nature, how they are maintained, and how they arise in the individual's relationship to his world.

Although we may come to understand much from carefully designed surveys, this understanding is limited and unidimensional. They may tell us how common some meanings are at a particular point, their proportions relative to each other, where they may be concentrated, or how they may be clustered individually. But we will not learn their substance, how they are encountered, how they arise in interaction, how they are transformed through interpretation, what already held meanings are used in this transformation, how they are disseminated and, most importantly, how they are used in action. This knowledge can only be gained in the field. We must not only enter the individual's world on his own terms but attempt to understand it as if it were our own. Then and only then will we be able to find out why some continue to have unsafe sex.

2.] ETHNOMETHODOLOGY.

The principles of ethnomethodology, or the study of people's [ethno-] ways [-method-] of making sense of their world, are more difficult for they do not lend themselves easily to formal theoretical statement. In fact, it is of such a complicated nature that several pages hardly do it justice. I confine this discussion therefore, only to a number of relevant principles.

The intellectual roots of ethnomethodology began with Edmund Husserl. Having become disenchanted with the epistemological domination of science in his time, he sought to revive philosophy by developing a method to determine the true essence of things. Alfred Schutz later adapted his principles to the social world [1932:1967] and Harold Garfinkel [1967], still later, adapted them to practical study. When ethnomethodology first appeared, it was dismissed as faddish and, thus, unworthy of recognition. This was partly due to it being championed mainly by young Californian graduate students amidst the social turmoil of the 1960s, and partly to their elitist attitudes. For the most part, however, it was dismissed because of its iconoclastic outlook towards traditional sociology which stemmed from a critique by Schutz. As Mennell, [1976:142] says, Schutz distinguished between two types of constructs - those of the first degree and those of the second. First degree constructs are formed as reality is experienced in direct form. Experience is temporally linked, compared, sorted out, and processed until

it is finally transformed into "typifications, classifications and categorizations." As Simmel [1908:1950], Huxley [1954], Allport [1954], and McCall and Simmons [1966] have all pointed out, this is necessary for survival since the alternative is cognitive chaos. Second degree constructs are what Schutz recommends for social science. Rather than presuming to interpret the "lifeworld" of others in direct fashion, researchers should instead look at the first-degree constructs of others - "typifications of typifications subjects make for their practical purposes." [Mennell, 142] Ethnomethodology maintains that sociology does not do this. Instead, it bypasses the individual and goes directly to his or her reality. It is therefore just another method with no qualitative difference from those used by lay people. As Zimmerman and Pollner [1971:82] put it, "sociology's typical concern makes sociology into an eminently folk discipline."

Ethnomethodology then is the study of first-degree constructs. While the nature of reality is epistemologically interesting, it is beyond reach and, thus, irrelevant. What is relevant is the methods people use to make sense of their perception of reality. As Garfinkel puts it [1967:1]:

> [Ethnomethodologists] seek to treat practical activities, practical circumstances and practical sociological reasoning as topics of empirical study, and by paying to the most commonplace activities of daily life the attention usually according extraordinary events, seek to learn more about them in their own right.

In the extreme, ethnomethodology makes no attempt to classify or generalize its findings since all methods are

unique to their context. For the most part, however, it is guided by a number of second-degree constructs which Rogers defined as "guiding principles which cannot be thoroughly validated but are accepted because they appear to increase one's understanding." [1983:92] Since they have important theoretical relevance later on, I explain the following four: a.] Accounts. b.] The documentary method of interpretation. c.] Reflexivity. d.] Indexicality.

A.] Accounts:

An account is a justification for action - whether in retrospect, in progress, or in potential. The notion was first popularized by Scott and Lyman [1968] who defined it as "a linguistic device employed whenever an action is subjected to valuative inquiry." [p.48] Their analysis, however, did not go beyond language. The ethnomethodological view expands upon this considerably. Accounts are all definitions of reality as it is perceived. As Rogers puts it, "all manners of describing, schematizing, analyzing, idealizing, arguing, believing, judging, etc." [1983:94] They are, therefore, methodological devices people use to make sense of their world. While Mead and Blumer say that objects are assigned meaning, ethnomethodologists say that they are accounted for.

To expand further, an account is synonymous with what Trayer [1967] called a "collapsed act" or a symbol of what would take place if an implied act were carried to completion. Since objects have meanings, in other words, they retrospectively give accounts of themselves by virtue of

having those meanings. An ashtray, by virtue of being an ashtray, implies the purpose of its being - as does a pencil, a house, or a condom. Furthermore, accounts are context dependent. No action would take place, in other words, if its account were not in keeping with it. If one goes to an opera, for example, the account of such action would be a desire to see it. It would not be thirst, hunger, or a desire to travel. Similarly, if a gay man goes to a bathhouse, it is likely because he wants sex.

What is important to note is that a person's account of his particular action may differ considerably from those of his observers. Ethnomethodology maintains that personal accounts rather than implied ones are the only relevant material for study. If we wish to know why people have safe sex, therefore, we must learn their accounts of their actions. It may well be that these accounts do not include any element of risk.

B.] The Documentary Method of Interpretation:

If people are to make sense of their experience as it comes, they must first organize it. According to ethnomethodologists, they do this with the use of the documentary method first mentioned by Mannheim [1952] and first applied to the social world by Garfinkel [1967]. As people experience their world, they become aware of an interrelationship among individual units of experience, or, as Garfinkel calls them, "indexical particulars." Once this happens, these indexical particulars are grouped together

within the construct of an "underlying pattern." Thomas S. Weinberg gives an excellent example of how this method can be used theoretically in his work on the social construction of gay identities. [1983] If the underlying pattern is "a homosexual," then the indexical particulars making it up might be "is attracted to his own sex," "goes to gay bars," etc. Similarly, for "a student," they might be "carries books," "attends classes," and so on. Experience, then, borne with a necessity to be meaningful, is arranged, grouped, sorted, resorted, and eventually assigned to a category which serves to guide, direct, legitimize and, eventually, parenthesize all further experience pertaining to it.

As experience comes, and as our lives progress, new underlying patterns arise. We may group new trends in behaviour [as in "a yuppie"], new political patterns or, indeed, people we believe are likely to have unsafe sex. Here, the indexical particulars may be "goes to bars a lot," "is preoccupied with sex," etc. Also, since all experience is unique, and since it often comes to us in peculiar ways, they may also be "has tattoos," "never wears a tie," "is muscular," or even "has long blonde hair." If we wish to know what gay men consider safe or unsafe, therefore, we must look at the make up of these underlying patterns.

C.] Reflexivity:

Reflexivity is a principle borrowed from linguistics and formal logic. In grammar, a verb is reflexive when its subject and object are the same ["I wash my face"]. In logic,

something is reflexive when it is equal to itself [A=A]. In the social world, however, all actions and accounts are reflexive. Not only do accounts point to what is accountable in a particular setting, but the setting, in turn, is composed of those very accounts. The account not only points to what is real, but it **is** that reality simultaneously. A tree is not only what it is by definition but, by virtue of actually being a tree, it gives meaning to what a tree is. Similarly, I say who I am and, at the same time, I am who I say I am. Even in action this relationship can easily be seen. I go to an opera and, by virtue of doing so, I make a statement about what going to an opera is.

The documentary method is both realized and maintained by its reflexivity. While a number of indexical particulars make up an underlying pattern, the underlying pattern, in turn, gives indication, quality, and meaning to the indexical particulars. As Garfinkel puts it [1967:78]:

> Not only is the underlying pattern derived from its individual documentary evidences, but the individual documentary evidences, in their turn, are interpreted on the basis of "what is known" about the underlying pattern. Each is used to elaborate the other.

This reflexive relationship has important implications for the social construction of reality. "A person likely to have unsafe sex" as an underlying pattern, for example, may have an indexical particular such as "goes to bathhouses." Those who go to bathhouses, therefore, may be reflexively regarded as likely to have unsafe sex. Furthermore, if people going to bathhouses display other qualities, then these other

qualities may be imputed to people likely to have unsafe sex. Thus, the underlying pattern is further constructed by reflexive build up.

In reality, such construction goes against the syllogistic rules of logic. If all A=B, it is not true that all B=A. Social construction, however, based on unique, often peculiar, and selectively perceived experience, does not always consider this. Secondly, as the underlying pattern becomes more complex, it is likely that the indexical particulars become ranked in accordance with their importance in its make up. If "goes to bathhouses" is far more important than, say, "wears a jean jacket," then it will likely carry more weight in the recruitment of new indexical particulars. Thus, not only may a particular underlying pattern vary considerably among individuals, but among some, it may have a peculiar colourful make up. Again, this has important implications for why some continue risky behaviour. It may well be that their underlying patterns of what is dangerous are constructed in such a way as to bypass the objective biomedical definition of the same.

D.] Indexicality:

In linguistics, expressions are indexical when they are dependent upon their context. The word "there," for example, is meaningless unless contextual information accompanies it. Similarly, "it is hot" has a different meaning when referring to reheated soup, a mid-August afternoon in Zaire, or a popular fashion trend. While linguistics distinguishes

between indexical expressions and objective language [e.g. "water boils at 100 degrees centigrade"], ethnomethodology does not. Rather, it sees all expressions, all accounts, and all actions as indexical. None can be disembodied from its contextual surroundings with its meaning fully in tact. As Handel says [1982:40]:

> The abstraction of one account from the rest eliminates information that contributed to the meaning of the abstracted account. In general, the participants in a social situation will have particular purposes, particular time references, particular resources available and particular skills. All these matters,... affect what will be accepted as an adequate account. These practical circumstances, and others, affect the meaning of accounts.

When considering those who engage in unsafe sex, indexicality has at least one important implication. safe sex is not objective in the sense that all apply it equally. Rather, it is indexical. For some, it may mean abstention from particular acts regardless. To others, it may mean having sex only with "safe partners" or perhaps only within a relationship. Safe sex to the individual, therefore, is dependent not upon the acts he performs but, rather, his account of their safeness, that of his partner, of that of the context within which they are carried out. Safe sex must be looked at not as a stable entity imported from outside, but one that becomes automatically indexical to the lifeworld of the individual.

3.] SYMBOLIC INTERACTION AND ETHNOMETHODOLGY: AREAS OF CONVERGENCE.

The similarities and differences between symbolic interaction and ethnomethodology have long been the subject of debate - one that has been on philosophical, methodological, epistemological, and even polemic grounds. While Gallant and Kleinman [1983,1985] and Perinbanayagam [1974] see their conceptual differences as highly incompatible, Turner [1986], Weinberg [1978,1983], Rock [1979], and Denzin [1969] see much room for convergence. The former arguments revolve around the fact that both concentrate on very different areas of emergence. While the symbolic interaction de-emphasizes structure, ethnomethodology looks at how it is made visible through interaction. Conversely, the latter arguments emphasize that both see social action as the result of interpretation. In this section, I concentrate not so much upon uniting the two fundamentally, but arguing for their complementarity. Although many of their principles come from different epistemological outlooks, not only are they not necessarily contradictory, but the findings of one can often add to those of the other.

Symbolic interaction sees action as dependent upon interpretation - in other words, upon how meanings are encountered, examined and processed through channels of already possessed meanings gained from past experience and, ultimately, used in behaviour. Although this says much in

itself about emergence, it lacks an explanation for the methods of interpretation. Here, the documentary method - together with its assumptions about accounts, reflexivity, and indexicality - is well able to pick up the slack. As Weinberg states in an attempt to justify the combination of both in his work on the emergence of homosexual identities [1983:8]:

> Although symbolic interactionists have correctly stressed that we should examine ordinary actors' interpretations of their world, they have paid little attention to the methods or procedures by which social actors construct and share their interpretations.... The "documentary method" is a basic interpretive procedure that can be jointly and concertedly used to arrive at, display and therefore share a particular imputation of social meaning.

As for the reasons for unsafe sex, symbolic interaction would maintain that they are largely because people have interpreted their actions as safe. This says little, however, about the component nature of this interpretation, the mechanics of its construction, or the methods used to arrive at it. The documentary method concentrates specifically upon these areas. It suggests that the construction of underlying patterns is based upon a perceived interrelationship among meanings, the indexical particulars. Furthermore, because of its inherent qualities of reflexivity and indexicality, it also suggests that meanings fall into place in specifically prescribed ways. The meaning of safe sex, therefore, is constructed and, thus, dependent upon a host of other meanings pointing to and embodying it. The interpretive orientation of symbolic interaction and the mechanical

construction of meanings in the documentary method, therefore, have no incompatible areas in this respect. In view of this, a theoretical model synthesized from both perspectives is not only possible but, because of its promising potential, preferable.

4.] AIDS, BEHAVIOUR, AND THE INTERACTIONIST PERSPECTIVE.

In this research, I am concerned with why people continue to engage in unsafe sex in spite of the well-publicized dangers. The reason, I maintain, is not ignorance of the proper preventative measures but, rather, that they have constructed the meaning of their sexual behaviour as safe through the process of interpretation. They **make unsafe sex safe**. When studies are re-examined under the interactionist perspective, this becomes more and more apparent. In this section, I highlight a few where the decision to have safe or unsafe sex is based not upon the recommended guidelines per se but, rather, upon circumstance, context, and the definition of the situation.

To begin, Hirschorn [1987] pointed out that one of the greatest obstacles to heterosexual's adopting safe-sex techniques is the belief that AIDS is a gay disease. Since it does carry this meaning for many, sex between males and females, no matter what its nature, is automatically regarded as safe. ["AIDS is contracted through homosexuality. I am not a homosexual. I will not get AIDS."]

Connell, Baxter et al. [1989], among others, found that unsafe sex occurs far more within a steady relationship. Here, the contextual definition within which the sex takes place renders it automatically safe. ["AIDS is contracted through anonymous sex. I do not have anonymous sex. I will not get AIDS."]

Joseph, Montgomery et al. [1987] found that some gay men in a sample had unsafe sex since they believed that medical technology would soon find a cure for AIDS. Although they knew the sex was presently defined as unsafe, it was made safe with the belief that whatever would be contracted could ultimately be cured. ["I may get AIDS from the sex I have. AIDS will be curable in time. The sex I have therefore poses no threat."]

Another safe-sex construction can be seen in a study of a sample living in a low-incidence area for AIDS [New Mexico] by Jones, Waskin et al. [1987]. Of 153 gay men, 107 had receptive anal intercourse in a twelve-month period and only 14 used condoms regularly. The authors believe this is because they tend to underestimate local risk. ["AIDS is mainly in large cities. I do not live in a large city. I will not get AIDS."]

In each case, the individuals are aware that AIDS is contracted through the exchange of body fluids. And yet, they did not define their actions as unsafe. Rather, they were made safe by meanings attributed to the contexts, circumstances, and situations within which they took place.

If these same actions were carried out under different contexts, circumstances, and situations, they could just as easily be regarded as unsafe. This leads once again to my central statement: If we wish to know why some people continue to have unsafe sex, then it is imperative that we pay attention to the construction of meanings that surround their sexual activity.

* * * * * * *

CHAPTER FOUR

THE SAFE SEX MESSAGE AND ITS POTENTIAL FOR DIFFERENTIAL INTERPRETATION

In a culture like ours, long accustomed to splitting and dividing all things as a means of control, it is sometimes a bit of a shock to be reminded that, in operational and practical fact, the medium is the message.

[Marshall McLuhan, 1911-]

CHAPTER FOUR

In the previous chapter, I discussed differential interpretation at length. Information surrounding a sexual encounter is assessed in interpretation and, depending upon the outcome, is regarded as safe or unsafe. Later, I will present a theoretical model to explain this process. Before, however, one task remains - to look at the safe sex message itself and show the various ways it can be interpreted. Since safe sex messages vary widely, and since they often are prey to moral struggles, polemics, and uncertainty, this is a considerable task - one too great to undertake fully here. I therefore forego any discussions of euphemisms or ambiguities and concentrate on what is most relevant to this research - the [perceived] encouragement to select **safe sex partners** and to have sex within **safe contexts** instead of or in addition to limiting oneself to **safe sex acts**. As it happens, many messages, whether on television, in posters, pamphlets, or newspapers, either inadvertently or intentionally encourage such choices. Often, it may be interpreted that a safe partner within a safe context cancels out the necessity for safe sex acts. When this is the case, a sexual encounter may be regarded as safe when in fact it is not. For example, if we are told not to have sex with "strangers," then some may believe that sex with people other than strangers is automatically safe regardless of the acts performed. This is entirely false. Furthermore, to some, the

status of stranger may be replaced by familiar other only after several weeks where as, to others, it may take only an hour or two. In this chapter, therefore, I look at the potential for these interpretations within existing safe-sex messages. I divide the discussion into two parts: a.] Educational media. b.] News media.

First, however, I must state that I in no way suggest that the potential for differential interpretation would disappear if the messages were made consistent and clear. Even though "don't do this" sounds clear enough, it will always be interpreted in different ways depending upon circumstance, context, situation and, ultimately, the meaning it carries for the individual.

1.] EDUCATIONAL MEDIA.

AIDS is transmitted by unsafe sex. The best way to avoid contagion is to have safe sex on all occasions. If this were done, the AIDS epidemic would soon be decimated. Many do not do this. People often engage in unsafe sex when they believe either that their sex partner or the context within which they have sex is safe. When this is the case, they further believe that the sex they have, regardless of the acts performed, is safe as well. A safe partner equals safe sex; or, a safe context equals safe sex with any partner regardless. Unfortunately, these judgments are often reinforced in educational media.

Although safe sex is encouraged for all occasions in many pamphlets - notably, those of many nongovernmental organizations [e.g. "Safe Sex! Safe...," 1985; "AIDS and You.," undated; "Safer Sex Can...," undated] - it is not in many others - notably, those of governmental organizations. Instead, it is encouraged either purposely or inadvertently, **only** under specific circumstances. The reader is told either a.] To make a proper choice of a partner based upon his sex history. b.] To avoid certain types of people altogether. c.] That sex is uniformly unsafe within specific contexts and uniformly safe within others. The first two imply that if these rules are followed, safe sex is unnecessary. The last implies that the context determines the risk of sex and not the sex acts themselves. The following are two examples of of the first rule, the first taken from AIDS: Let's Talk by the Ontario Ministry of Health [undated], the second from a series of posters entitled Don't Die of Embarrassment, by Park Place Group Advertising [1987]:

> don't have unprotected sexual intercourse with anyone who has had a number of sexual partners.... if you have sexual intercourse with someone who is infected or someone whose past you're not sure of, always use latex condoms with a water based lubricant.

DON'T DIE OF EMBARRASSMENT

> Don't be too embarrassed to talk about condoms. Condoms can help prevent AIDS. Insist on the use of a condom if you have sex with a person whose health and drug history is unknown.

In the first, the reader is told that condoms must be used with someone infected and, in both, that they must be used

with someone with an unknown past. As this implies, they are unnecessary with those "not infected" or with a "known" past. There are several serious weaknesses in this. First, knowing another's past is a matter of interpretation. How much information is necessary to make up a known past? What type of information? Over what period of time? To some, this may take months or years. To others, a couple of hours conversation after a bar room encounter will suffice ["I'm a good judge of character." "I can tell by their eyes."]. Second, people are typically reluctant to speak openly or truthfully about their past sexual experiences for fear of harsh judgment or rejection. They often lie and are often good at it. Third, not only is there usually no way of telling whether someone is seropositive but, unless tested, a person is not always aware of his own serostaus.

The second rule, to avoid certain types of people entirely, is best exemplified in the following two pamphlets. The first, AIDS in Canada: What You Should Know [1985], is distributed by the Canadian Department of Health and Welfare, the second, AIDS: Understanding AIDS [1989], by the Ministère de la Santé et des Services sociaux du Quebec:

> AIDS has occured mainly in very well defined groups of people. If you or your sexual partners do not belong to one of these groups [homosexuals and bisexuals], your chances of getting AIDS are virtually zero!
>
> .THE FOLLOWING ACTIVITIES ARE CONSIDERED DANGEROUS IF YOUR PARTNER IS INFECTED.
>
> - Sexual contact without protection (without a condom).
>
> - Anal intercourse.

> - Vaginal or oral intercourse with a drug user or person who habitually engages in anal intercourse.
>
> - Sexual contact with a stranger (one-night stand or prostitute), with someone whom you know has several partners, with a person who comes from a country with a high number of AIDS cases, or else with any new partner whose sexual habits you do not know.

In the first, one is virtually given carte blanche if his partners are not homosexual or bisexual. Heterosexuals, therefore, are told that safe sex is unnecessary. In the second, strangers, prostitutes, and others are named. Even though partners "whose sexual habits you do not know" are also named, the implication is that familiar, non-foreign people who are not prostitutes are safe bets. First, it is unclear why sex with only certain types of people is dangerous if they are infected. Surely this is so with anyone infected regardless. Second, the status of stranger is a matter of interpretation. Just as with knowing someone's sexual past, to some it may take months, to others a couple of hours. Third, the naming of certain groups paves the way for prejudice and scapegoatism. It has been emphasized time and again that it is not membership in a certain group that puts one at risk but, rather, the type of sex one performs. A homosexual, Haitian, or prostitute who does not have unsafe sex is no more at risk than those of any other group.

The third rule, that sex is uniformly unsafe within specific contexts and uniformly safe within others can not only be seen in the last example warning against "one-night stands," but in the following from Dating Safely [undated], distributed by the University of Miami School of Medicine:

> Know your partner: just because you work with or see someone every day, does not mean you know them. Ask about their past. Think of ways you can feel comfortable asking questions about their sex life or drug use before you decide to have sex with them. Do not participate in casual or anonymous sex!

One-night stands and casual or anonymous sex are not types of sex acts but contexts within which sex takes place. Depending upon the acts performed, it can be safe or unsafe. The antithesis of these contexts is the "relationship" which pamphlets and posters often encourage. Again, sex within it can be safe or unsafe. Even though contagion is likely less possible in relationships, it may still occur. Not only do many gay men have open relationships but extra-marital sex is common.

In summary, pamphlets, posters, and television spots often concentrate upon safe partners and safe contexts rather than or in addition to safe sex itself. Even though differential interpretation is always present in potential, such messages reinforce partner- or context-dependent definitions of safe sex. In view of this, people are often encouraged to believe that biomedically unsafe sex acts can be made safe.

2.] THE NEWS MEDIA.

Moral responsibility is part and parcel of reporting the news. Newspapers must consider the source of their news, its content, relevance, level of accuracy and, most importantly,

its impact upon their readership. In direct tension with these considerations are two distinct factors. First, just as the sociologist is part of the world that he [or she] studies, the reporter is part of the world he reports upon. Even though trained towards neutrality, he carries with him his own interests, perceptions of the world and, ultimately, his biases. Certainly a multitude of sins has been committed under the often dubious maxim of "the public's right to know." Second, newspapers, in order to survive, must sell. Here, accuracy, level of analysis, and responsibility are insufficient. The news must also be **interesting** and it is this above all that determines content, attention to a particular event, and the way in which it handled.

As Altman [1987] states, the media's first reaction to AIDS was to ignore it. Since it was seen as the private trouble of stigmatized groups, it was deemed unnewsworthy. During all of 1982, for example, only nine AIDS stories appeared in newspapers comprising the National Newspaper Index. [Panem, 1988] Reportage did not increase until mid-1983 when an article in the Journal of the American Medical Association, dealing with pediatric cases, called AIDS the "number one health priority." The disease was then seen as a threat to the general population and the sudden attention given it has caused much resentment in the gay community. Finally, when Rock Hudson announced that he had AIDS in 1985, media attention exploded. [Bébout, 1985]

The news media can not be underestimated as means for the dissemination of knowledge and the determination of

public opinion. As Temoshok, Grade, and Zich [1989] state:

> To the extent that information and awareness about health are widely recognized as prerequisites of successful health education - newspapers which both disseminate information and increase awareness - must be considered part of any public health education process.

In this respect, as Arredondo, Conde et al. [1989], Signorile and Voelcker [1989], Guzman, Blanca et al. [1989], Birchmeier, Richard et al. [1989] maintain, the media has done more harm than good. As these authors say, they have been contradictory, selective, prone to exaggaration, sensationalist, and largely responsible for creating an atmosphere of unnecessary fear. Although there is much to support this, I restrict myself to that part most relevant to this chapter - encouragement to see safe and unsafe sex in terms of sex partners and sexual contexts.

Beginning with partner-dependent definitions, the media has consistently portrayed the treat of AIDS in terms of "high-risk groups" rather than high-risk behaviour. As one doctor in a Montréal hospital emergency room told me, these groups are privately known as "the four H's" - Haitians, Homosexuals, Herion addicts and Hemophiliacs. This not only implies that contagion is dependent upon [or, indeed, inate to] membership in a certain group, but it has given those in unnamed groups a false sense of security.

AIDS is rarely mentioned in the media without homosexuality. [Altman, 1987; Seidman, 1988] When the San Francisco Chronicle reported Rock Hudson's announcement, for example, they called it "the litmus test that identified him

as gay." [Balfour, 1985] Herzlich and Pierret [1989] see such constructions as catalysts to the polarization of social relations. As they found in their study of AIDS reportage in France:

> Several articles stuck to the probabilistic concept of "risk group" much broader labels such as "homosexual community" or "homosexual life-style," as though these referred to a homogeneous reality. These labels were thus intrinsically tied to AIDS through a sort of causality.

As a result, heterosexuals typically do not see themselves at risk. [Janowitz, Bastos et al., 1989; Gaynor, Kessler et al., 1989; Stipp & Kerr, 1989] AIDS is seen largely as a gay disease and, thus, some believe that if they are not gay, they need not worry. In reality, the number of cases traced to heterosexual transmission is small - so much so that arguments have even been made suggesting the danger is exaggerated. [e.g. Brecher, 1988] It is, however, the fastest growing group [Buzby & Ramey, 1989] and, in Africa, the principle means of transmission. [Harden, 1986; Mann & Chin, 1988; Gordon, 1989; Airhihenbuwa, 1989]

Ironically, the naming of "homosexuals," "bisexuals," and "the gay community" as risk groups has even backfired in that many now believe that lesbian sex is also a means of transmission. [Hamilton, 1988] Since lesbians are also homosexuals, they have been brought into the discussion by default. In reality, woman-to-woman transmission is rare. [Ribble, Marte et al., 1989]

Discussions of the Haitian connection to AIDS originated in 1982 when the Centers for Disease Control announced that

thirty-four cases in five states were found among this group. None could be traced to homosexuality or intravenous drug use. [Hensley, Moskowitz et al., 1982] This as well as subsequent articles [e.g. Vierra, Frank et al., 1983] warned physicians caring for Haitians to be alert to HIV seropositivity. As a result, a number of other physicians [e.g. Greco, 1983] maintained that national origin as a risk factor was highly dubious and cited other possibilities. For one thing, homosexuality and drug use are severe cultural taboos in Haiti. They typically will not admit to such behaviour. Second, due to language barriers, medical history interviews were often not carried out. Third, as Patton [1986:40] says, mass innoculations with vitamins or antibiotics were common in Haiti. After constant pressure from Haitian community groups, the CDC finally removed Haitians as a risk category placing them instead in the "other/unknown" group. [Centres for Disease Control, 1985]

In Quebec, where a large number of Haitian immigrants live, 137 out of 920 cases as of September, 1989 are Haitian including eight from homosexual activity and one from drug use. The rate is thus 32 times higher than the province's general population. As Adrien, Boivin et al. [1990] believe, this is due to "pattern two" or heterosexual transmission as is evident in Haiti and several African nations. In other words, transmission is not dependent upon nationality per se but, rather, its national pattern.

This controversy, fueled by the media, together with the fact that blacks and hispanics are over-represented in North

American AIDS cases [Selik, Castro & Pappaioanou, 1988], has made people of colour - blacks especially - one more type to be avoided. To many, this is synonymous with avoiding AIDS. Risk is again defined in terms of sex partners.

Among the greatest problems the media have contributed to are fear and discrimination. AIDS has been blamed on gay men [for an extreme example, see Anchell, 1986], bisexuals [A perilous double..., 1987], Haitians, Africans and, as a result, people of colour as well. [City of New York, 1987; Panos Dossier, 1988; Sabatier, 1988; Nelkin and Gilman, 1988] Furthermore, people with AIDS have faced discrimination in housing [City of New York, undated], the legal system [Schatz, 1989], travel and immigration [World Health Organization, 1989] and, sadly, among their friends as well.

The media have also facilitated the belief that sexual contexts, in and of themselves, are means of transmission. With expressions such as "fast-lane sex," references to "thousands of partners," and a seemingly endless preoccupation with the most intricate details of gay sexual life, one is encouraged to believe that AIDS contagion results from gay life itself. Much of this can be traced to the popularity of two causal theories early in the decade: a.] That promiscuity leads to AIDS. b.] The overload theory.

The notion that promiscuity leads to an eventual breakdown of the body's immune system - a popular one still - fit well with the 1970s image of gay men as single-minded sexual athletes. Although gay men likely do have a greater number of partners over a lifetime [Lee, 1979], these numbers

are often greatly exaggerated. Years ago, in a CEGEP psychology class I attended, the instructor mentioned that some have "over two hundred partners a day." In any case, once it was found that AIDS is contracted through specific sex acts and not numbers of partners, the promiscuity theory was discounted. In view of this, it would be tempting to ally with sentiments against warnings to reduce one's number of partners. It is not far-fetched to speculate that such warnings come at least partially from moral entrepreneurship. The evidence shown by recent mathematical modeling [Peto, 1986; Wiley & Herschkurn, 1988; Eisenberg, 1989; Colgate, Stanley et al., 1989], however, does indicate that multiple partnering is a significant factor. And, since condom breakage does occur [Golombok & Rust, 1989], fewer partners - at least with those for receptive anal intercourse - will reduce individual risk.

With all the attention given to promiscuity, normative patterns have become such that multiple partnering is now unpopular. As a measure of this, controversies surrounding it have recently gone beyond the moral/religious sphere to the clinical one. While Quadland [1983,1985] makes a case for a condition he calls "sexual compulsion," Wedin [1984] and Levine and Troiden [1988] believe this is still reducible to moral choice. Nevertheless, such discussion shows an interesting reversal in attitudes. The same behaviour which drifted from the clinical sphere to be celebrated in the 1970s is now seen as a "condition." In doing this, it has made its way back to that same sphere.

Promiscuity not only describes a series of actions over time but individual ones as well. To have ten or twenty partners in a month may be considered promiscuous. To have one partner two days after a previous one, or to meet someone in a bar, or to have sex with someone else's lover, are also considered promiscuous. In these cases, promiscuity is not defined by numbers of partners but by circumstance. Its association with AIDS by the media, therefore, may lead some to believe that the act [or circumstance] of being promiscuous is, in and of itself, a means of transmission. Conversely, sex perceived as not promiscuous - after a week or two of acquaintance, with someone "properly introduced," between long periods of celibacy - may be seen as uniformly safe. In other words, if people do not see themselves as promiscuous, they may also see themselves as safe - regardless of the type of sex they have.

The overload theory also named promiscuity as a causative factor but, instead, approached it from a different angle. As it was believed, constant exposure to venereal disease, recreational drug use, and the ill effects to health associated with frequent bar going, all serve to overload the body's immune system and, consequently, destroy it. [Altman, 1987] In other words, the combination of factors associated with the much celebrated gay discos of the 1970s leads to AIDS. A parallel conclusion can be seen in recent media reports of the "yuppie disease" - lifestyle leads to illness. This theory was even more ephemeral than that of promiscuity since it suggested - among other things - that

AIDS is not infectious and, consequently, anyone who has it need not worry about passing it on. [Lewis, 1983]

In reality, the habitual use of amyl nitrate or "poppers" - until recently, popular among gay men as an aphrodisiac - is thought to be counterproductive to the body's natural resistance. [Goedert, Neuland et al., 1982; Haverkos, Pinsky et al., 1985; Vandenbroucke & Pardoel, 1989] And, lack of sleep together with long hours in a smoke-filled environment certainly does not help. The use of drugs and alcohol, however, are regarded as risky not for effects upon health but, rather, upon decision making during sex. As Carr [1988], Molgaard, Nakamura et al. [1988], Paul, Stall, and Davis [1989], McKirnan and Peterson [1989], and Leigh [1990] have all found, those using substances before or during sex are far less likely to take precautions. It is their role that makes a difference.

Albert's excellent analyses [1986a, 1986b] of AIDS reportage well illustrate how context-dependent interpretations of safe sex can arise. First, there have been constant references to the location of sex - bathhouses, washrooms, prisons, New York's Grenwich Village, San Francisco's Castro district. The following three quotes he cites [1986a] are typical:

> The gay mecca of San Francisco, Castro Street is where the action is and where AIDS is a constant threat.
>
> [People, February 14, 1983: 43]

> Investigators also believe that AIDS is principally a phenomenon of the raunchy subculture in large cities, where bars and bathhouses are literal hotbeds of sexual promiscuity.
>
> [Rolling Stone, February 3, 1983: 19]

> But clearly, urban gay life-style has put many homosexual males at risk. An infectious agent loose in the hothouse environment of a gay bath, where some men have as many as 10 sexual contants in one night...
>
> [Newsweek, April 18, 1983: 80]

Not only do such descriptions place AIDS within specific locations, but they help distance those not in these locations from the threat. Furthermore, such melodramatic imagery promotes misconceptions of transmission. AIDS is not a "constant threat" during unsafe sex but, rather, on Castro Street. It is "a phenomenon of the raunchy subculture in large cities" and "loose in the hothouse environment of a gay bath." The implications are that AIDS is loose, contracted in a bar or bathhouse, or even by loitering on specific streets. If these places can be avoided, it may be thought, AIDS can also be avoided.

With constant references to promiscuity, lifestyle, fast-lane sex, etc., the gay community itself has become morally polarized. A good example of this is seen in a study by Kowalewski [1988] who interviewed twenty gay men about strategies they use to cope with AIDS. The majority, he found, used various constructions to distance themselves from those perceived as susceptible - for example, references to

"them" or "they" rather than "us" or "we." Since homosexuality now has a double stigma - deviance and disease - many gay men have separated themselves from the latter by condemning those believed as behaviourally susceptible. Many also believe that AIDS has given rise to a new sexual ethic - one where monogamy is praised and sex without commitment and caring is condemned. I end this chapter with a quote by Garland Richard Kyle from his essay entitled "AIDS and the New Sexual Order" [1989]:

> The increasing pressures to adapt one's libido to this wave of sexual hegemony only confuses our tentative acceptance in a world already filled with the fear of our contagion. We are asked to continue our solitude to various forms of sexual inertia, remedying our physical and emotional desires with solitary acts of pleasure.
>
> Never before has gay men's sexuality been so indecently exposed to the world, as it has in the context of the AIDS epidemic. While many of us still struggle with our sexual identity in hopes of reclaiming an appreciation for our lives that once flourished, society points eerily to the culprits of a disease that has run amok. This conflict has led to the development of a deceptive sexual prototype.
>
> The "new sexual order" has marked the beginning of an era of sexual conformity, blended with the remnants of a historic liberation movement. The success of this coalescence still remains questionable; for even authoritarian leaders still rely heavily of the consent of their followers.

* * * * * * *

PART TWO

CHAPTER FIVE

SEXUALITY AND SOCIAL THEORY:

TOWARDS AN INTERPRETIVE EXPLANATION OF AIDS AND SEXUAL BEHAVIOUR

Sexuality today is, perhaps to an unprecedented degree, a contested zone. It is more than a source of intense pleasure or acute anxiety; it has become a moral and political battlefield.

[Jeffrey Weeks, 1985]

CHAPTER FIVE

In the four chapters of part one, I accomplished several tasks. First, I placed the gay ethos in teleological juxtaposition to the AIDS epidemic. Since no one event can be fully understood apart from the socio-historical field from which it emerges, this long disquisition was necessary. Second, I looked at the epidemiology of the epidemic as it is reflected by cohort studies, surveys, and venereal markers. Sexual behaviour has changed considerably, it would seem, but far from enough to render the AIDS virus extinct. Next, I looked at current efforts to combat AIDS. Although they have had some success, their effectiveness is hampered by two obstacles: first, the moral-political element of educational campaigns and second, the assumptions behind them. Gay men do not have unsafe sex because they lack exposure to AIDS-avoidance information. This has been disproven. Rather, they do so because they encounter, examine, interpret and use this information in a varieties of ways. In view of this, I chose the interactionist perspective as a means to develop a model of explanation. This was the fourth task and the subject of chapter three. Finally, I examined both educational and news media and showed how they encourage partner-dependent and context-dependent explanations of safe and unsafe sex. It is the presence, strength, and character of these alternative explanations that determine people's sexual behaviour with respect to AIDS, not their level of

knowledge. So far, this deterministic potential remains undiscovered.

These discussions serve as forerunners to this second part of the thesis in which I offer a theoretical response to the following research question: **Why do homosexually behaving males, fuly aware of the dangers of AIDS, continue to engage in unsafe sex?** The model I present in the next chapter accomplishes this. Before, however, I discuss the following three subjects in this chapter: a.] AIDS, sexuality, and social theory. b.] Alternative explanations for unsafe sex. c.] Towards an interpretive explanation. All are vital to the understanding of the model.

1.] AIDS, SEXUALITY, AND SOCIAL THEORY.

After years of concerted efforts, sociologically relevant literature upon AIDS is now extensive. We now know the social and psychological impact of AIDS [Deuchar, 1984; Hirsch, 1985; Stulberg & Smith, 1988; Flaskerud, 1988]; its effect upon the lives of people with AIDS [Geis, Fuller & Rush, 1986; Weiss, 1989]; general attitudes towards people with AIDS [Pargetter & Prior, 1987; Paxton & Susky, 1988]; which variables are associated with seropositivity [Coates, Stall et al., 1988; Onorato, Cray et al., 1990]; with those likely to become seropositive through their behaviour [Ebbesen, Melbye & Biggar, 1984; Ross, 1984; Dan, Bolan et al., 1989]; and the extent of AIDS knowledge, beliefs, and

attitudes among various segments of the population [Rich, Haskin et al., 1988; Rekart & Manzon, 1989; Hingston, Strunin et al., 1990]. We even have numerous studies and recommendations upon the prevention of AIDS by the modification of behaviour [Cho, 1987; Rose, 1989; Caceres & Gotuzzo, 1989; Magura, Shapiro et al., 1989].

While most of these studies do much to **describe**, they do little to **explain**. They have concerned themselves with the isolation of predictive variables, but they have failed to incorporate them into an larger framework. As a result, our present knowledge is overly quantified, often contradictory or repetitive, and fragmented. Questions of how people relate to a world suffused by AIDS, how they perceive the danger, how they work through these perceptions, and - most importantly - how they encounter, interpret, and use their definitions of safe sex are as yet unanswered.

Furthermore, we have little information upon the social mechanisms which influence this interpretation and use [notable exceptions are Exner, 1989; O'Reilly, 1989]. Kaplan Johnson et al. [1987], in their excellent review of sociological AIDS literature, point out such weaknesses in the following:

> Studies that explicitly address research questions relating to the onset and course of AIDS frequently consider too narrow a scope of explanatory factors. Even where the relevance of explanatory factors is clear, as in the influence of sexual behavior upon HIV infection, insufficient discriminations are made.... Studies of the onset and course of AIDS appear too frequently to allow us to ignore the social etiology of the factors that are recognized as more immediately relevant.... we require a greater understanding of the modeling and control mechanisms through which adults

> and peer groups influence maladaptive at-risk behaviors, and a more comprehensive understanding of how structural factors may influence maladaptive behaviors indirectly. In short, a significant limitation of the literature is that all the known or suspected predictors of risk for HIV infection and/or immune deficiency states have not been considered simultaneously within an overarching theoretical framework;... a broader net should be cast to capture the full range of significant explanatory factors.

Even though this presents a formidable task, the authors make a valid point. Sociology has grown much since the time of Durkheim and Weber. It now has the theoretical and methodological sophistication to capture and organize virtually any area of social reality within a vehicle that offers empathetic understanding, purposeful clarity, and practical consideration. It must therefore not stop at the mere investigation of the world as it presents itself but strive to determine its nature. In so doing, it must be able to incorporate it within a comprehensive theoretical framework. Since AIDS has and will cost us much in human life, we must work hard to understand the social mechanisms which pertain to it. And since understanding is the very quid pro quo of sociology, we must also work hard towards it.

If AIDS has taught anything to sociologists, it is that they must overcome their shyness and, in some cases aversion, to sexual behaviour as a legitimate area of scholarship. It is ironic that such an important and often strongly deterministic element of human social life was only afforded legitimate attention as late as the Kinsey era. It is equally ironic that this attention has progressed so little since then. While deviance, social stratification, race and ethnic

relations, and bureaucracy are part and parcel of any sociologist's repertoire of knowledge and interest, sexuality is still taboo. And, while these areas have countless scholarly journals as forums for their concerns, sexuality [let alone homosexuality] has no more than a handful. With the notable exceptions of some researchers in Indiana and California, very few have given it serious consideration. Indeed, to many, such preoccupations are considered frivolous. Such attitudes have acted as barriers to knowledge for far too long.

If anything, this should be humbling to sociology. Even though we have strived to rise above the constraints of society's moral legacy to achieve the widest spectrum of understanding, we have only managed to reflect it. In short, sexuality is as much a forbidden fruit to sociology as to society.

Because of such attitudes, we have now been caught with our pants down. AIDS has brought with it a strong demand for an understanding of sexuality - in particular, homosexuality - one that we can not offer. With the notable exceptions of Jay and Young [1977], Bell and Weinberg [1978], and a few others, we have little serious data to contribute. Consequently, we must now scramble about to make up for such neglect.

Homosexual behaviour has never been unknown. As shown time and again in studies such as those by Evans-Pritchard [1970], Adams [1965]; Arboleda and Murray [1985], Taylor [1985], Blackwood [1985, 1986], and scores of others, it is

found in all cultures. In some historical cases, it was even practiced by the majority of the population. [Eglington, 1964; Dover, 1978; Foucault, 1980, 1986] And, as Kinsey has shown us [although his sample was over-represented by middle-class white males], it is practiced at one time or another by thirty-seven percent of the population [1948]. Still, it is considered entirely marginal to social life. When sociology inherited homosexuality from medicine in the early 1970s, it carried on its tradition. Instead of extending the conceptual range of social and sexual behaviour to incorporate it, in other words, it merely it relegated it to a darkened corner of deviance. As Murray has shown in his excellent monograph entitled Social Theory, Homosexual Realities [1984], this placement, in and of itself, has affected the way we study it. Furthermore, as he maintains in the following, the study of gays - their emergence as a community, their daily lives - is often regarded as a lesser sociology:

> the main concern [of sociology] is world historical changes in systems of domination. Those to inhabit this center endeavor to explain how one system (e.g., capitalism) functions at a particular time and how one system arises from another (e.g., capitalism from feudalism). To those at the discipline's center, those marginal scholars chronicling the lifeways of "queers" have seemed to be engaged in a dubious enterprise unlikely to contribute to the building of a unified theory of society. Indeed, description of how people actually live has often struck those concerned with abstract, general theories of Society to be a diversion from the path of knowledge. And when the people described are homosexual, motives such as voyeuristic titilation of special pleading are suspected.

Instead, he recommends that we incorporate homosexuality into our major theoretical bodies. Rather than looking at

lesbians and gays from the narrowing viewpoint of deviance, we would do well to see them from that of emergence. Although homosexuality has been around in one form or another always, "gayness" as community and identity, is a product only of this century. We would also do well to incorporate their struggle into our study of power relations. While feminism has gained much ground in this respect, and while race and ethnic relations is a major area of study, lesbians and gays continue to remain obscurely deviant.

It anything, the persistence of homosexual behaviour through history and across cultures should be sufficient to guarantee it a legitimate place in the world. Again, sociology has great potential. Since AIDS poses a great threat, we must use this potential to its fullest.

2.] ALTERNATIVE EXPLANATIONS.

Why then, do homosexually behaving males, fully aware of the dangers of AIDS, continue to have unsafe sex? I point out that I use the phrase "homosexually behaving" rather than "homosexual" or "gay" since it has the widest definitional scope. Since not every homosexual is gay - a term usually reserved for identity - and not every male having sex with other males defines himself as either [Hencken, 1984; Carrier, 1985], this is the most accurate phrase to use.

Some answers may be dismissed immediately for their obvious bias. I have overheard a number of people state, for

example, that gays have a "death wish" or that their intrinsic self-hatred drives them toward destruction. Although such cases are not unknown [e.g. Francis, Wikstrom & Alcena, 1985], they are rare. Others have maintained that their sex drive is so strong that it is difficult to control. Such explanations are products of unfounded beliefs and they are not worth rebuttal.

I discussed the most common explanation in chapter two - the "educational model." To reiterate, it is assumed that those who do engage in risky behaviour do so because they lack the proper preventative information. This is highly unlikely. First, according to the American National Health Survey [Dawson, Cynamon et al., 1987] as well as other sources mentioned, basic AIDS knowledge among the general population is very high. Ninety per cent, for example, know that it is a deadly disease. When considering this along with the high concentration of AIDS cases among gays and the noteworthy record of their community in disseminating information, it can be safely assumed that gay men have even higher levels of knowledge. Thus, this model can not provide an adequate answer to the question.

Among the rare attempts to place risk behaviour within an explanatory model is that by Catania, Kegeles and Coates [1989]. Although not specifically addressing the above question, they do attempt to explain the process of change from unsafe to safe sex. Their "AIDS Risk Reduction Model" is divided into three developmental stages as follows: a.] Self labeling of high-risk behaviours as problematic. b.] Making

a commitment to changing high-risk behaviours. c.] Seeking and enacting solutions directed at reducing high-risk behaviours. In the first stage, people become aware that their activities are associated with HIV transmission and see themselves as susceptible. Since the former does not always lead to the latter, these are distinct processes. In the second stage, they commit themselves to change. Since this involves the modification of highly pleasurable activities, will power, and self efficacy, it is complex. In the third stage, they seek information, obtain remedies, and enact solutions. Although this is the general line of development, it is not meant to be fixed or unidirectional. Not all will go through all stages. A person may label his behaviour as problematic, for example, but still be unwilling to change.

While this model is insightful, it does not account for the many deviations from its path. First, it begins with people who seem genuinely unaware that their behaviour places them at risk. This assumes only two possibilities - knowledge, or the lack of it. It does not consider differential knowledge. Some, for example, may hold all sorts of firm beliefs, none of which is biomedically accurate. They are, nonetheless, knowledge to the individual and it is necessary to know their origin, nature, and use. Second, although it mentions failure to progress to the next stage, it does not carry this through. For example, it states that some become aware that their behaviour is problematic, perceive themselves as susceptible, but still take no action. Or, others will make a commitment to change, but do nothing.

In each case, it fails to explain how this takes place. How do these people interpret and come to terms with their situation? How do they deal with the conflicts of meaning? Third, when it states that sex partners, friends, or one's social circle may be instrumental in labeling behaviour problematic, it assumes this process to be unidirectional. Although it is indeed possible that a circle of friends may make someone aware that his behaviour puts him at risk, it is equally possible that they may serve to calm his fears instead. One scenario would be a group of friends in a low-incidence area [Saskatchewan or Idaho]. When one expresses concern because he does not always use condoms, the others may reassure him that this is not necessary since they are all far away from New York or Toronto [a contextual definition of safe sex]. In short, it depends what the beliefs of one's friends, acquaintances, or sex partners are. Here, we would do well to import such concepts as Sutherland's "differential association" [1924]. Fourth, and most important, there is no explanation of those continuing unsafe sex who still do not find their behaviour problematic. The model is useful, therefore, in implementing programs to assist in the process of change as it is laid out, but it does not take into account the virtually limitless interpretations that inhibit this process. while the model has considerable merit, it does not cast a wide enough net.

One more explanation should be mentioned - that of intoxication. Since drugs and alcohol impair judgment, this may certainly explain some risky behaviour. It is unlikely,

however, that it can account for all. Explanation must lie elsewhere. After an exhaustive search, I have found no other broad attempts - only partial ones. In view of this, the question of why people continue to have unsafe sex when they are aware of the dangers remains unanswered. It is therefore both timely and ripe for research.

3.] TOWARDS AN INTERPRETIVE EXPLANATION.

My model is based upon differential introduction, interpretation, and use of AIDS-avoidance information. People typically make unsafe sex safe through these processes. In this section, I highlight four studies and an article in the gay press which are most relevant to this hypothesis.

The first study, by Bauman and Siegel, entitled "Misperceptions among gay men of the risk for AIDS associated with their behavior" [1987], looks at people's assessments of risk based upon their behaviour and compares them to objective assessments of the same. In the thirty-day period prior to interviewing, the reported sexual activities of 160 gay men were classified as "high risk," "low risk," or "safe." The men were then asked to assess their own risk of contracting AIDS on a 10-point scale [1=lowest, 10=highest]. The behaviours of 42% were objectively classified as high risk, 33% as low risk, and 25% as safe. Personal assessments were quite different. Three quarters gave themselves a one, two, or three while nine per cent gave themselves a five or

more. Those with behaviours objectively classified as safe gave themselves realistic assessments [1 = 56%; 2 or 3 = 31%] as did those in the low-risk category [1 = 19%; 2 or 3 = 67%]. The personal assessments of the high-risk subjects, however, were only slightly higher [1 = 19%; 2 or 3 = 47%; 4 or 5 = 17%; 6 or over = 17%]. Thus, those having unsafe sex typically underestimated their degree of risk.

The authors explore three possible reasons for this underestimation - anxiety levels, unrealistic optimism, and health schema. With the first, they found that as anxiety levels decreased, the tendency to underestimate risk increased. Although they do not explain their decision for this particular time order, they found this consistent with their hypothesis that underestimation is, in part, an attempt to manage anxiety. In the second case, using Weinstein's [1980] scaling techniques of unrealistic optimism, they found that 51% rated their level of risk as below average. The third factor is most relevant to my research question and, thus, most interesting. The authors believe that health schema - or, beliefs [definitions, attachments of meaning] about what is safe and what is not - are major influences upon risk assessment. As they state:

> Many men evidently develop their own personal weighting scheme about which past and present behaviors put them at risk or protect them from developing the disease.

To examine this, they looked at beliefs in three largely ineffective practices: inspecting one's partner for lesions before sex, showering before sex, and showering after sex.

For those believing that none of these was effective, 15% underestimated their risk. For those believing in one, two, or all three, 42%, 45%, and 46% underestimated their risk, respectively.

The authors touch upon a crucial concept. Those who believed that any or all of the three practices makes a difference did not see themselves at risk as much as those who did not. To carry this one step further, inspecting one's partner before sex or showering before or after can be looked at as alternate definitions of safe sex. They are examples of individual interpretations of reality that guide behaviour. If someone sincerely believes that people with AIDS usually have lesions [which they generally do not], then he will likely also believe that he can reduce his chances of contagion by such inspection. Similarly, if he believes that people with AIDS are usually thin and look unhealthy, then h may also attempt to reduce his risk by seeking only well-built, healthy looking partners. Since it is true that AIDS can not be contracted from people not seropositive, then any attempt to avoid such people - however defined - are seen as ways of having safe sex. This becomes epidemiologically significant when considering that with the presence of such partner-dependent definitions, the effectiveness of biomedical guidlines against unprotected anal sex or otherwise are seriously weakened. Yes, this is normally dangerous, one may think, but **not in this case** since my partner does not have AIDS. Whatever I do with him, therefore, is safe.

In May, 1986, an article by Rick Bébout entitled "The prophylactic lover," appeared in The Body Politic, a now-defunct Canadian gay newspaper, began by asking the reader to consider the lives of the following three men:

> **ADAM** used to go to bars, occasionally picking up men, but he was never really satisfied with one-night stands. At a small party two years ago he met a handsome flight attendant and things clicked. A month later, they were living together, lovers in a monogamous relationship that has lasted ever since.
>
> **BOB** has a lover, too - the same one for the last 15 years. They still have great sex with each other, and long ago realized that their relationship wasn't threatened if either of them had the occasional fling with somebody else. So they do. But Bob has decided to stay away from the baths.
>
> **Conrad**, on the other hand, loves the baths. Three or four times a month he can be found there, wearing nothing but his favourite pair of leather chaps (except in the steamroom where its nothing at all). He may skip one of his regular bath nights in good weather: he goes to the park instead.

The question immediately following asked who was most likely to get AIDS. Most, Bébout thought, would have picked Conrad.

This adds yet another dimension to partner-dependent definitions of safe sex. Not only is it possible for some to discriminate on the basis of physical appearance, but others may do so according to habits, goals, topics of conversation, and past and present relationships. As I mentioned, such definitions are typically encouraged in pamphlets when they give such advice as "ask direct questions about past relationships" or "know your partner's history." With this in mind, it is likely that people would prefer Adam as a sex partner first, Bob second, and Conrad last. Once people judge

partners as "safe bets," they may also judge biomedically safe sex as unnecessary. When this happens, acts such as unprotected anal intercourse are **made safe** by overriding act-dependent definitions ["To heck with the condom. He's been in a relationship for two years and hates bars. He's safe!"]. Later, Bébout accurately points out that likelihood of seropositivity is not dependent upon types of relationships or places one frequents but, rather, the type of sex. Those only having safe sex, no matter with how many partners or under what contexts, will remain uninfected.

The second study, by Horn, Chetwynd, and Kelleher, entitled "Changing sexual practices amongst homosexual men in response to AIDS: who has changed, who hasn't and why?" [1989], comes from New Zealand. So far, it is the most comprehensive examination of interpretive definitions of safe sex I have found. Fifty men were interviewed in depth between August, 1988 and February, 1989. Thirty-four were contacted at an Aukland bathhouse and the remainder through snowball sampling. The interviews were generally unstructured and focused on sexual practices concerning AIDS and related information. For those who practiced unsafe sex, four broad areas were found to be associated: a.] Personal characteristics. b.] The nature of intimate relationships. c.] Changing life circumstances. d.] Relapses for idiocyncratic reasons. I will mention only those relevant to the discussion.

Among the most interesting personal characteristics was self definition related to homosexuality. A number of men saw

themselves as bisexual, even though they had not had sex with women for years. Because they related AIDS risk with "being gay" rather than with particular sexual activity, they saw themselves as exterior to it. Since AIDS is a gay disease and I am not gay, they thought, then I will not get AIDS. Unsafe sex is defined by sexual orientation rather than activity; an alternative definition overrrides a biomedical one. It would not be far-fetched to say that this particular one may be a by-product, at least in part, of the media's constant association with AIDS and gay men.

What is often seen as "social denial" can also be seen as an alternative definition. Fullilove [1989], for example, reports upon a conversation by a group of New York teenagers who flatly deny that AIDS is a threat to them. As one said, "Man, I don't give a f--- about AIDS. That's faggot stuff." [censoring the author's, not mine.] Similarly, last summer, a sexually active woman told me that she rarely worries about AIDS. As she said, "Gays wouldn't be interested in me and I go for real men, not bi's [bisexuals]." In both cases, the individuals deny that their group is at risk. The belief that AIDS is the scourge of another group - gays, whites, "promiscuous people," or any other - is frequently used in these ways to form definitions of safe sex. Other definitions in the sample were equally as intriguing in their construction. Echoing Bauman and Siegel, the authors mention that:

> Some had adopted a colourful array of criteria for deciding who was safe, and had greater confidence in their ability to choose such partners than would be objectively warranted. One man would surreptitiously feel under his potential partner's armpits for lymph gland swelling. Several felt that their own "choosiness" about partners was protection. Basically, they avoided partners whom they saw as too sexually promiscuous. Others felt reassured to have unprotected sex with those they deemed to be a "safe bet" or "clean".

Again, an assessment of the partner's likelihood to be infected is the criteria used to define the riskiness of sex, and not the sex itself. In another anecdote, the authors touch upon a second type of safe sex definition - that pertaining to social context:

> One man saw it as unwise to have sex at the sauna [bathhouse] but would occasionally have unprotected sex with men he took home from there, rationalizing this by viewing his partner as not just a casual encounter if he was prepared to make the effort to go home with him.

Here, once the person agreed to go home with the man, the context of the encounter changed from that of casual sex to a deeper level. It was safe because it was not casual sex which he likely defined as uniformly unsafe. The change of context made the sex, no matter which acts were performed, safe.

In the last chapter, I discussed the role of educational and news media in encouraging context-dependent definitions. Sex is safe in a relationship, it is often said, but not when casual. Similarly, some may feel that it is sex in a bathhouse, or a cruising park, or for that matter, in any place that has a reputation for frequent anonymous sex, that is unsafe and not the particular sex acts themselves. Others

may believe that sex only in high-incidence areas [or perhaps with people coming from such areas] is unsafe. In each case, the riskiness of sex is defined by its social context and not its nature.

The third study comes from the same area of the world as the last - this time, Australia. In Gold, Skinner, Grant and Plummer's "Places, times, reasons" [1988], situational variables associated with refraining from or engaging in unsafe sex were examined along with rationalizations for doing so. Respondents, solicited from bars, bathhouses, etc. were asked in a questionnaire to recall one encounter in which they had unprotected anal intercourse and another in which they resisted a strong desire to do so. The encounters were divided into: a.] When the "evening" began. b.]When the respondent met the partner. c.] The beginning of sex. d.] During sex. Of 279 returned questionnaires, 219 men were able to recall an unsafe encounter and 181 recalled both. Among the factors distinguishing encounters were a greater desire for unprotected sex at the start of the evening, greater physical attraction, and less communication about safe sex.

In 95% of unsafe encounters, the men knew that unprotected anal intercourse is a high-risk activity. The rationalizations they reported, however, strongly indicate that not all were likely to go by known biomedical definitions. With a factor analysis, Gold, Skinner et al. found that two types tended to occur together: a.] Bargaining or special pleading [e.g. "I'll have one last

fling."] b.] "judging a partner's antibody status from readily-perceivable characteristics - his appearance, behaviour, etc." The latter group consisted of the following five rationalizations [or, perhaps, definitions of safe sex]:

> This guy looks so healthy, he can't possibly be infected.
>
> This guy is so beautiful, he can't possibly be infected.
>
> This guy seems such a nice person - he's got a lovely personality - so he can't possibly be infected.
>
> This guy seems intelligent/well-educated, so I'm sure he's been careful. So he can't possibly be infected.
>
> If this guy was really infected, he's be a lot more careful about the risk he's taking now. The fact that he's willing to fuck without a condom means he can't be infected.

In each case, partner-dependent definitions cancelled out biomedical ones. In the first four, safe sex was defined as that with people who are healthy, beautiful, nice, intelligent, or well-educated. In the last, ironically, it was defined as that with people who are willing to have biomedically unsafe sex. I in no way suggest that these are necessarily set rules carefully thought out in advance and methodically used on all relevant occasions. It is well arguable that they are situationally dependent or perhaps merely other forms of special bargaining. This does not, however, detract from the fact that they are also partner-dependent definitions of safe sex. It is also well arguable that they are merely rationalizations formed after the fact to justify unnacceptable behaviour [in similar fashion to cognitive

dissonance]. Still, they are definitions overriding others. And, it is unlikely that all are bargaining devices or post-behavioural rationalizations It is equally possible that they may be may be carefully thought out in advance.

The fourth and final study I highlight, Kowaleski"s "Double stigma and boundary maintenance: How gay men deal with AIDS" [1988], presents a different aspect of the topic - the interlinkage of biomedical definitions and interpretive ones. First, the "double stigma" Kowalewski refers to is that of homosexuality and AIDS. Since one stigma is preferable to two, he believes that gay men typically construct ways to separate themselves from others who have or are likely to get AIDS. He interviewed a sample of twenty obtained from snowball sampling to explore this. Among the comments he reported were the following two:

> People getting AIDS... do drugs every weekend, then go out to (an after-hours bar), then go to a bath house. My personal experience, what I see, is the element of our community who lead lifestyles of being gay in the fast lane... its no surprise to me that they get sick.

> I don't worry about (AIDS).... I've always been a healthy person.... I know, though, that my friend who had AIDS had a poor diet, didn't go out and go for a walk or get any air. He had very peculiar sleeping habits.

Both statements are separations as Kowaleski contends. The men describe characteristics they perceive as reflective of other gay men who have or are likely to get AIDS [the second stigma] and imply that they are ones not applying to them. The same phenomena can be observed commonly in stigmatized groups. Gay men can hold very damning attitudes about others

who pursue young boys. Single mothers with low incomes can be very critical of others whom they perceive as neglecting their children. Or, people who attempt to justify company theft or the purchase "hot" merchandise will often righteously condemn those who steal from friends. All, including Kowaleski's cases, are as if to say yes, I am a member of this group but a good one - not one of those.

Siegel and Bauman [1987] also note this separation which they see as consistent with Kahneman and Tversky's [1972] "representativeness." As Siegal and Bauman state:

> people tend to imagine a stereotype of the kind of person to whom a specific negative event might occur, such as AIDS, and compare themselves to that stereotype. Because they tend to view themselves as deviating greatly from that stereotype, they manifiest unrealistic optimism in assessing their own risk.

In keeping with my own theme, these separations can also be looked at in terms of individually constructed context-dependent or partner-dependent definitions of safe sex. In the first case, people who have AIDS are perceived as ones who "do drugs," "go to a bath house," and lead lifestyles in the "fast lane." Since the subject infers that he does not do these things, he infers simultaneously that his risk of contagion is much lower. This is not to imply that he necessarily believes that AIDS can be contracted by merely going to a bathhouse, only that he associates the two. When such associations are strong enough, it is likely that they become deeply interlinked and, at times, inseparable. To give one example, male ballet dancers are often thought of as

homosexual. To some, therefore, being a ballet dancer is synomymous with being gay whereas, in reality, this is entirely dependant upon sexual orientation. Even though those who make such associations generally know this, they nevertheless give it the added characteristic of a particular career choice. Similarly, many associate poor health with atypical sleeping hours. Those who sleep during the day are perceived to be not as healthy as those sleeping at night. In reality, many people work graveyard shifts and must sleep during the day. Even through they may get plenty of sleep and at regular hours, however, they are still seen as less healthy. Thus, when going to a bathhouse is cognitively linked to having unsafe sex, then unsafe sex carries with it the added context-dependent definition of going to a bathhouse. The same can be said for strong linkages to promiscuity, having casual sex, cruising parks and washrooms or, for that matter, frequenting a particular bar.

The second quote emphasizes what the individual does not associate with HIV contagion as well as what he does. Since people with AIDS are perceived as having poor diets, not getting air, or with peculiar sleeping habits, those not at risk are [antithetically] those who eat well, get plenty of sleep, etc. They are, as implied, healthy. Thus, risk is defined in this way. In this respect, the possibilities are endless. Linkages to safe sex can be made with being in a relationship, "knowing" your partner, sex with an attractive or intelligent person, a well-dressed person, after being "properly introduced," or anything else conceivable. Again,

this does not imply that such meanings will necessarily override biomedical guidelines. It is more likely that one definition exists, to a greater or lessor degree, alongside the other. However, once this is the case, the possibility that the context-dependent or partner-dependent definitions will dominate and, thus, cancel out the biomedical ones is everpresent. If the circumstances of a particular sexual encounter lend themselves readily to this, it may be realized. The alternate definitions may be used to the exclusion of the biomedical ones.

In summary, considerable thought has already been given to alternative definitions of safe sex. Together with similar studies on subjective definitions of risk for other phenomena such as health in general [Bauman, 1961; Natapoff, 1978; Harris & Guten, 1979; Colantonio, 1988] or crime [Lotz, 1979; Lawton & Yaffe, 1980; Sacco, 1982; Warr, 1984], they make up a growing tradition in such concerns. An interpretive answer to the research question will not only add to this tradition but, of greater importance, serve as a potential contribution to the understanding of AIDS behaviour, and transmission.

* * * * * * *

CHAPTER SIX

MAKING UNSAFE SEX SAFE:

THE SOCIAL CONSTRUCTION OF SAFE SEX

AMONG HOMOSEXUALLY BEHAVING MALES

Grau, teurer Freund, ist alle Theorie und grun des Lebens goldner Baum.

All theory, dear friend, is grey, but the golden tree of actual life springs ever green!

[Johann Wolfgang von Goethe, 1749 - 1832]

CHAPTER SIX

I now address the research question directly. Once again, I propose that gay men continue to engage in unsafe sex because they make unsafe sex safe. They do this through differential introduction, examination, interpretation, and use of AIDS-avoidance information. I contain these processes within a model which, for reasons to be explained, I call the **SAFE-SEX-LIMIT MOTILITY MODEL**. It is based first upon the premise that sexual activity is tridimensional - made up of sex acts, sex partners, and sexual contexts - and, second, upon twelve statements or propositions. First, I discuss the three dimensions of sex - their character, limitations, interlinkages, and theoretical implications. Second, I present each proposition separately. Afterwards, I discuss the model's scope, limitations, and compatibility with empirical reality.

Theories of sexuality have been dominated for years by implicit faith in a biological imperative. The fact that we, animals like others, desire sex and actively seek to engage in it is fundamental to the propagation of the species. Such desire is therefore central, placed carefully by nature, and instinctive. This biofunctionalist explanation has not only been endorsed by science but, whether as a direct result or not, by ideology in the form of unquestioned truths, accolades to its purpose in life [e.g. Van de Velde, 1928],

and culturally sustained metaphors. Sex is "natural," a craving for it is to have "normal urges," we come to manhood, and we see old men smile at the ever-turning cycle of life as pubescent boys look upon girls with mixtures of excitement, awe, and confusion. The metaphors go even further. Our testosterone "rages," we feel stirrings in our genes/jeans, parents plant seeds during the night, birds do it/bees do it, and as if cursed, some of us even get the seven-year itch.

Sex has been no less the preoccupation of philosophy, theology, and ethics - disciplines that have affixed to it various forms of essentialism, mystification, divine plan, and a need for regulation and control. Most, however, still held the biological imperative as supreme and, rather than questioning it, devoted themselves to the development of epiphenomenal issues instead. When psychoanalysis entered the discussion, it seemed to promise new developments. In the outcome, however, the biofunctional urge still dominated. Freud and his contemporaries merely relocated nature to the "libido," pluralized it with penis envy, and gave it direction by the oedipus complex.

Although sociology should not actively seek to dislodge biofunctionalism, as if driven entirely by polemics, it should at least be able to cast it into phenomenological doubt. And, if in the synthesis, nature can not give way to nurture, it must at least be able to exist alongside of it in the common ground of sociobiology. I say this not because the biofunctional explanation can necessarily be disproved, but because of the plethora of data sociology now holds in

support of theories of agency and emergence. [Kinsey et al., 1948; Gagnon and Simon, 1973; Ambert, 1976; Victor, 1978; Foucault, 1980, 1985; Plummer, 1982; Murray, 1984; Weeks, 1985] Human sexual desire can be channeled towards different ideal types by societal norms or variations of norms; it can be limited as to place, time, and sequence by expectations; and it can be regulated by structure, aroused by symbols, and made variable by culture. Second, not only have we found sexual desire in many nonprocreational forms, but unexpected ones as well. Women's desire was not given credence, ironically, until Kinsey's study of it [1953] and the concept of women as sex objects to other women was commonly not thought of at all until just prior to the turn of the century. [Faderman, 1981] Third, as has been well illustrated by Cassidy and Porter [1989], sexual satisfaction is acheived everywhere in many nonorgasmic, nonpenetrative, and nonheterosexual forms. Determinists such as Desmond Morris [1967, 1971] may argue that all animal copulation involves the ritual of foreplay. However, oral-genital contact, analingus, erotic massage, and whatever else imaginable are far too often the intent and focus of sexual activity instead its prelude. Even if such behaviour could be explained as foreplay, it is still far too variable, far too "civilized" and, thus, far too social to be reduced to biological determinism.

The purpose of my discussion on sexuality, however, is not to challenge the biofunctionalist view. Instead, I wish to show the uniquely social properties of sex by looking at

it as a tridimensional phenomenon. Due to some tautological qualities of sexual activity, I make a number of assumptions. This discussion serves as a basis for my Safe-Sex-Limit Motility Model which I present immediately afterwards.

1.] THE TRIDIMENSIONALITY OF SEX.

All sexual activity is composed of three dimensions: a.] sex acts. b.] Sex partners. c.] Sexual contexts. Although it would be preferable to define and present each separately before discussing their inter-relationships, this would be difficult. Each is inseparably linked with the others and, thus, gains from them its meaning, parameter, and spacio-temporal demarcation. The presentation of each, therefore, will not be so much a separate discussion as an emphasis upon their role and their value in the overall social structure of sexual activity.

Sex acts, first of all, are what one does sexually. They may be as common as penile-vaginal intercourse, as obscure as apotemnophilia or "amputee love" [Money, Jobaris, & Furth, 1977], or as context dependent as or kissing. Although some acts are almost always considered sexual and others not, this meaning is **not** dependent upon the act itself but, rather, the context within which it is performed. Sex acts, in other words, are not sexual unless in a sexual context. Conversely, acts not considered sexual become sexual in a sexual context. As an example of the former, an adult male teaching a teenage

boy to masturbate is a context normally considered sexual. In institutions for the mentally handicapped, however, when boys do not know what to do with their feeling of arousal and, thus, rub up against others at random, this may be done so they learn an acceptable outlet. Years ago, I worked with mentally handicapped people and discussed this with male staff members who had done this. In these cases, masturbation is taught in the same way eating, dressing and grooming is taught - hand over hand. Those teaching it do not consider it a sex act since the context is not sexual. As for the latter, acts such as vomiting, or diapering and bottle feeding, are not normally considered sexual. When both parties consider them as such, however, as in the cases described by Bethell [1974] and Stoller [1982], they become so by virtue of their context. A sex act, therefore, is dependent not on its nature but its context. With this in mind, I offer the following definition: **A sex act is any act performed with a sex partner in a sexual context.** Their variability and number, therefore, are unlimited.

Sex partners are those whom one engages in sexual activity with. They may be divided into four categories. First, a sex partner may be any person in the world. In this respect, there are more than five billion possibilities. Second, they may be any combination of two, three, fifty or more people - ménages a trois, orgies, etc. The possibilities then become astromomical. Third, they may be any object other than a human being - an animal, a fetish

object such as a pair of silk stockings or a wet shoe [Epstein, 1975]. Fourth, a sex partner may be any person or object one imagines or believes oneself to be having sex with - a fantasy lover, invading aliens, etc.

The last two categories may stretch the imagination a little. To some, it may be difficult to imagine a shoe or a ghost as a sex partner. Others define them only as those who give informed consent - thus excluding sexaul assault. It must be remembered, however, that human beings have the unigue capacity for reflection and, thus, an ability to take the perspective of the other. [Mead, 1934] This allows them to go beyond the spatio-temporal parameters of the here and now and interact with any object - living, inanimate, or imagined. A famous literary example can be found in Albee's play Who's Afraid of Virginia Woolf? [1962] where a childless couple were engaged in a loving relationship with an imaginary son for twenty years. The emotions that came out when he was "killed" well illustrated the couple's conviction to the relationship and, thus, the son. Another example is found in animistic religions where human qualities are given to inanimate objects such as trees or rocks. [O'Toole, 1984:52]. These qualities are real in the minds of believers; thus, any interaction with those objects is also real.

Sexual activity is considered as such by those who engage in it as well as those who witness or conceive of it. In the interpretive tradition, it is the former which defines the activity for people and not, at least in the immediate sense, the latter. Thus, if one believes he is having sex

with an object or person, then, to him, he is having sex with that object or person. The fact that others may not see this is irrelevant. One example of this is found in the medieval concepts of incubi and succubi - male and female demon agents, respectively. It was believed that these agents visited people at night and copulated with them. [Summers, 1956:89-103; Shumaker, 1972:95-97] Since they did believe this without question, to them it was real.

The most common examples of reflective sex partners are those of masturbation. Although the person masturbating is normally alone, there is much literature to support the presence of fantasy objects or persons during this act [Kinsey et al., 1948; Ford & Beach, 1951; Abramson & Mosher, 1979; Billingham & Hockenberry, 1987] Others [Hessellund, 1976; Sue, 1979; Crépault & Couture, 1980] have noted that they are also present while people have sex with others. Thus, since people imagine themselves engaged in sex with an object or person, this object or person, in turn, is their partner. In view of this, I offer the following definition of sex partners: **A sex partner is any person or object, or combinations of persons and/or objects, real or imagined, whom or which the individual engages in sexual activity with.**

The third dimension of sexual activity is the context within which it takes place. It is the most complex dimension for two reasons. First, it defines the activity as sexual. When the context is sexual, then **any** act with **any** partner is also sexual. If it is not, then regardless of its nature, **no**

act within it is sexual. This factor alone allows me to offer a definition immediately: **A sexual context is any context which defines the acts taking place within it as sexual.**

The second reason contexts are important is that they give the activity a specific character. Sex may take place within a loving relationship or an anonymous encounter. It may be promiscuous, within a prostitute-client relationships, a first date, a tenth one, a marriage, or an extra-marital affair. It may be heterosexual, homosexual, incestuous, exotic, "normal," "kinky," or "perverted." It may be intergenerational, interracial, or illegal. It may be within rape, statutory rape, or fully consentual. It may be socially acceptable or not. The possibilities are, in fact, too numerous for a full inventory. Instead, therefore, I devote the rest of this discussion to a few qualities important to its nature and substance, or the actors' perceptions of them.

First, sexual contexts are temporally located. They are dependent not merely upon present circumstances, but their immediate past and perceived future as well. If sex occurs between two people who have courted each other for a month, then it may be thought of as both an important step in a relationship and the first encounter of many to come. If, on the other hand, it is between two people who met each other an hour ago in a bar, then it may be defined as a one-night stand with no promise of repetition. If the bar was regarded as "cheap," then so may the encounter. If it was after being introduced by a mutual friend whom both parties respect, then it may be the beginning of a relationship in spite of its

nature. In short, the immediate history defines the context of the present and, to a large extent, molds the expectations of the future.

Contexts may also be defined by location. Sex in a bathhouse is almost always regarded as quick, anonymous, uncomplicated, and utilitarian. The same may apply to sex in a public washroom, a cruising park, or an alley. Sex in a bed, on the other hand, is likely to be seen as more intimate - and even more so when it is the bed of one of the partners as opposed to that of a motel. Sex with a stranger while on vacation may be thought of as exotic, in a log cabin during the winter as romantic, or on a roof top as naughty.

Third, the relationship between partners has a strong influence on the context. Sex between married couples has the qualities of regularity, stability, usually love and caring, and the like. Sex between strangers is fleeting, anonymous, and casual. Sex between blood relatives is incestuous, between friends often accidental and regrettable, etc.

Fourth, sexual contexts are largely defined by social acceptability. Heterosexuality is natural, homosexuality is deviant, incest is severely prohibited, sex between adults and minors is sick or perverted, between classes it is "slumming," etc. All encounters take place within a larger social structure and, thus, they become defined by it.

It is interesting to note that while some contextual factors play major roles in some encounters, they may be negligible in others. Geographic location may be definitive in casual sexual liaisons while not so much among married

couples. Sex between cousins may be forbidden in one society while not in another. Homosexuality is expected in the gay community but not elsewhere. Again, the list goes on. In short, factor "A" may override factor "B" in one situation, each may have equal weight in another, and only one may be most important in still another. Since this is the case, it raises many questions. Among them: Which factors are likely to be more important than others as contextual definers? What types of encounters are likely to have particular contextual definers and which ones are likely to have others? And, do structural factors always carry more weight than circumstantial or individual ones? Such questions promise much understanding and are ripe for future research.

If this discussion shows anything, it is that it is difficult if not impossible to define and elaborate upon any one dimension without invoking the others. Any reference to one, automatically makes a statement about the others. They are, thus, inseparable. In view of this, I make the following assumptions:

STATEMENT ONE: **For sexual activity to be regarded as such, all three dimensions must be present.**

First, any act outside a sexual context, no matter what its nature, is not sexual. Second, one can not have a sex partner with no sex acts since there would be no sexual activity to speak of. Third, no act may take place without a sex partner. Some may say that this last statement is

immediately challenged by masturbation. It is a sex act within a sexual context, but with no partner. Even though sex partners may also be imaginary, and even though there is much evidence supporting the presence of fantasy partners while masturbating, this act is still a problem in the statement. Some sources stand by the universality of fantasy during masturbation. [Katchadourian & Lunde, 1975; Ellis, 1976] Others report them only in the majority of their samples. [Kinsey et al., 1948; Clifford, 1978]. Not only does this go against common sense, however, but the most fundamental principles of symbolic interaction as well. I say this for two reasons. First, since human beings have the capacity for reflection, it follows that they must reflect upon every voluntary act they perform. To masturbate with no consciousness whatsoever, therefore, experiencing only the immediate "thereness" of this action, is impossible unless it is somehow involuntary. Thus, even though sex partners may be ephemeral, ever-changing, and in any conceivable form, they are still present. Second, since all acts are reflexive, they are, by definition, accounts of themselves. Those who masturbate, in other words, do it with themselves and oneself can be regarded as a sex partner in the absence of others.

STATEMENT TWO: **All three dimensions are inseparably interlinked: a change in any one will result in a change in the other two.**

By change, I do not necessarily mean from one act to another, one partner to another, or even one context to

another. Moreover, I mean a change in the way each is regarded. Certainly, anal sex with Bob in a bathhouse is the same mechanically and contextually as it is with Bill, Brian, or Brad. Because it is with Bob, however, it is regarded in this unique way. With this in mind, I will explain the statement. This is best done first by creating the following scenario, and then referring back to it:

> Jim, a 47 year old salesman from Albany, attended a footwear convention in Montréal last June. He is married with three teenage daughters. He is also attracted to men and occasionally has sex with them. However, he keeps this a closely guarded secret for he loves his wife and would never jeopardize his marriage. One night during the week, he went to a gay bar and had a few drinks. Around midnight, began talking to a good-looking man of about 22 whom he later learned was named Hal. The conversation soon turned to sex and, within an hour, Hal had agreed to sleep with Jim. Jim did not want to risk bringing Hal back to his hotel so he took him to a tourist room instead. They removed their clothes quickly and got into bed. Jim ran his hands over Hal's well-proportioned body, savouring his youth, and then fellated him. Hal seemed contented to have all the attention and hardly touched Jim at all. An hour later, they got dressed, shook hands, and went their separate ways.

This story contains a number of variables. From Jim's perspective, the sex acts are body rubbing and fellatio, the partner is a well-shaped stranger twenty-five years younger than he, and the context is a furtive homosexual one-nighter in a tourist room in a foreign city. If the location was changed from Montréal to his home city of Albany, he would regard his partner as less exotic and more of a threat since he was still "in the closet." The sex acts would be more of a declaration of his secret. If he had taken Hal to his hotel instead, the same might apply. If Hal was nearer to his age, the sex acts would not have been regarded as a savouring of

youth but, rather, in some other way. Jim may have also been less willing to accept Hal's passivity. Finally, if the sex acts were more esoteric - spanking, "fisting," of otherwise - Jim would have regarded Hal differently and, thus, the context would have been different as well.

Thus, any change in one dimension immediately points to a change in the others. Sometimes it will be barely noticible. Because of the inseparable interlinkage of the three dimensions, however, it is impossible for any one to remain exactly the same when another changes.

This can be well applied to real situations. As Garfinkel [1967] maintains, contexts and meanings change constantly when new information arises. If, for example, Jim believed that Hal is essentially uneducated and then learns later that he is a third-year medical student, the context would change as would the sex acts in the way they are regarded. These changes would not only be immediate but retroactive as well. To paraphrase Garfinkel, later appearances indicate what past ones "really meant." So far, I have discussed sexual activity as if it was frozen in the present. In reality, it is a an on-going process changing constantly as new meaning arises. Thus, any change in one necessitates corresponding changes in the other two.

STATEMENT THREE: **The greater the change in one dimension, the greater the changes in the other two.**

Admittedly, this statement is likely destined to remain at the theoretical level since the strength and direction of

change in any one dimension is essentially immeasurable. Since body rubbing, fellatio, Jim, Hal, a tourist room, and Albany all belong to nominal categories, such a statement is meaningless. This, however, is in the objective sense. From the perspective of the individual who defines change and its strength and direction in his own peculiar way, however, the statement regains its meaning. Typically, we make constant references to nominal change. We take steps backward, we are in a better situation, we have gained more ground, this person sinks lower than that one, and so on. Even though it is possible to operationalize these concepts, different people still measure them in different ways. The criteria they use is based solely upon the way the categories are regarded. Thus, Jim may well consider the change from body rubbing to anal sex as greater than that to fellatio because of the way he regards the three acts. Thus, if one change in the sex-act dimension is greater to him than another, then the resulting changes in the other dimensions will be greater as well. This is held as true since, once again, all three dimensions are inseparably interlinked and dependent upon one another for form, demarcation, and parameter.

A summary of the tridimensional theory of sexual activity appears in **FIGURE TWO** on the next page.

FIGURE TWO

THE TRIDIMENSIONALITY OF SEX
[Summary]

1.] MAIN PREMISE:

All sexual activity is composed of three dimensions: a.] Sex acts. b.] Sex partners. c.] Sexual contexts.

2.] DEFINITIONS:

a.] Sex acts: A sex act is any act performed with a sex partner in a sexual context.

b.] Sex partners: A sex partner is any person or object, or combinations of persons and/or objects, real or imagined, whom or which the individual engages in sexual activity with.

c.] Sexual contexts: A sexual context is any context which defines the activity taking place within it as sexual.

3.] AXIOMATIC STATEMENTS:

Statement One: For sexual activity to be regarded as such, all three dimensions must be present.

Statement Two: All three dimensions are inseparably interlinked: a change in any one will result in a change in the other two.

Statement Three: The greater the change in one dimension, the greater the change in the other two.

2.] THE SAFE-SEX-LIMIT MOTILITY MODEL.

Once a model is constructed, it is laid over top of the reality it professes to explain. If it is a good model, the majority of cases remain within its parameters. If it is not, many stray outside. Indeed, the acid test of a model is the number of cases that it is able to contain and, thus, its ability to foresee unique patterns of human behaviour.

I construct the Safe-Sex-Limit Motility model with exactly this in mind. When extraneous behavioural factors point to cases with the potential to stray outside the explanatory boundaries, I attempt to account for them. If I cannot, I readily admit it. Human behaviour is as varied as there are people in the world. The model accounting for every single case within a particular area of reality, therefore, is as elusive as the pot of gold at the end of the rainbow. To use Durkehimian terms, even the most exhaustive models must admit to pathalogical types. And, certainly, their ability to let them stand is yet another measure of its theoretical integrity.

The model is one of process. It consists of twelve propositions beginning with people's first awareness of the dangers of AIDS and ending with their likelihood of contracting it. Its foundations lay immediately upon the tridimensional theory of sex and then, ultimately, upon the fundamentals of symbolic interaction and ethnomethodology. First, I explain each proposition, then I discuss the models strengths and weaknesses.

PROPOSITION ONE: **If self preservation is important to people, they will not knowingly place themselves at risk.**

People value their lives. They will therefore take deliberate steps to avoid danger. They will not walk in areas of high crime at night, they will look both ways before crossing a street, drive carefully, and handle sharp objects with care. They will also take deliberate steps to ward off disease. Once they become aware that AIDS is dangerous, therefore, they will regard it as something to be avoided.

Although these statements would generally be accepted as true, they are immediately challenged by the costs-benefits principle of exchange theory. As Homans's value proposition states, "The more valuable to a person is the result of his action, the more likely he is to perform the action." [1974:25] If the benefits are worth the risk, in other words, people will willingly enter into dangerous situations. They may dart haphazardly across busy streets if late for appointments, consort with dangerous people to buy drugs, sleep in crumbling city tenements for a night's shelter - and, occasionally, have unsafe sex. This risk-for-gain principle can even be taken to extremes, as in the case of altruistic suicides described by Durkheim [1897]. With a closer look, however, it becomes arguable that consciously placing one's life in peril for immediate gratification - let alone doing so on a regular basis - is not as common as would be expected. To explain this, it is first necessary to look at what is meant by terms such as risk. Although psychology [e.g., Zuckerman, Kolin et al., 1964; Klausner,

1968] and suicidology [e.g., Firth, 1961; Farbarow, 1980] offer much on this subject, sociology, according to Short [1984] and Lyng [1990], has all but ignored it. I therefore offer my own interactionist definition with the following example. Bicyclists regularly go through red lights. Because they do, it is commonly thought that they are taking a risk, endangering their lives, acting rashly, and so on. Risk, in this sense, means a significant increase in the probability of injury or death. Implicit in this is the assumption that the risk takers **know** this. This would certainly be justified for cyclists who go rapidly through intersections, eyes straight ahead, as if the lights were not there at all. No apparent assessment of the danger is carried out in advance and it is, therefore, "blind risk." In reality it is more likely that as the vast majority do approach intersections, they slow down, look both ways to satisfy themselves that no cars are approaching, and proceed with caution. The danger is minimized by calculating and recalculating it constantly. It is therefore a "calculated risk." In interactionist terms, a calculated risk can be regarded as synonymous with a "definition of the situation." The individual interprets and defines the situation - in this case going through a red light - as risk free [or very nearly so] and to him therefore, there is no risk involved.

In short, the element of risk involved in a specific action should not be weighed in the objective sense but, rather, from the point of view of the individual. People do not calculate the risks of their actions with identical

yardsticks. While one may see great danger in a particular action, another may not see any at all. This has been noted by Warren [1979] in her study of labelling the mentally ill as dangerous, and Lee [1983] in his examination of the risk involved in gay sadomasochism.

When I say that people will not knowingly place themselves at risk because they value their lives, therefore, I mean risk as they define it. Certainly there are cases, as documented by Horn, Chetwynd and Kelleher [1989] and Skinner, Grant and Plummer [1989], where people have unsafe sex even though they acknowledge the risks. Since it is they who define their situation, however, it is likely that in the majority of cases, this risk has been sufficiently minimized so as to define the behaviour involved as safe.

A statement antithetical to this first proposition is that people who do not value their lives will place themselves at risk. Even though it was touched upon earlier, the question of whether this can account for a significant number of cases of unsafe sexual behaviour must be addressed. Where this occurs, there would be two principle types: a.] Intentional suicide. b.] General self-destructive behaviour.

Common sense would dictate that deliberately contracting AIDS as a means of committing suicide is most innefficient. First, people who do commit suicide almost always use methods that bring about death immediately. [Stengel, 1954:38; Health & Welfare Canada, 1987:21] AIDS, however, promises at least two years from seroconversion to death and, more often than not, beyond that or not at all. Second, documented cases of

AIDS as a means to death are extremely rare. The only one I found is that reported by Francis, Wilkstrom and Alcena [1985] Here, the suicidal individual deliberately sought out partners whom he perceived as seropositive. This is qualitatively different than merely disregarding risk in sexual behaviour. Unsafe sex as a means of suicide, therefore, is an idea that may be dismissed.

The second general type is synonymous with what Menninger [1938] called a "death wish" and what Schneidman [1963] called "death hastening." The possibility of these motivations being present in many who continue unsafe sex can be well argued. If anything, the results of parallel studies such as Selzer and Payne's correlational findings on suicidal behaviour and car-accidents [1962] would seem to support this. In view of the newness of AIDS, however, this explanation is far too opportunistic. One reason is the bias towards gay multiple-partnering. Since this has rarely been understood within its proper socio-historical context, it is typically viewed negatively and, thus, as dually symptomatic of self hatred and self destruction. Without a verstehen understanding, this bias can easily be associated with risky behaviour in general.

Second, since gays are stigmatized, it has long been common to view them negatively and, thus, as self destructive. Not only has this been perpetuated in popular novels such as The City and the Pillar [1948], Finistère [1951], The Children's Hour [1961], and The Boys in the Band [1968], to name a few, but psychiatry as well. One early

study by O'Connor [1948] attributed as much as fifty per cent of suicides to homosexual causes. And, as D.J. West said during the same era [1955:54]:

> This liability to depression and suicide may indicate an underlying instability of temperament, but of the other hand, the social difficulties encountered by homosexuals are also quite sufficient to account for it.

In the first chapter, I mentioned some of these social difficulties as well as the changes that took place after the Stonewall riots. These changes were rapid and significant and would seem to indicate that West's comments simply do not apply to the same extent anymore. Although social difficulties still exist, they are nowhere near the severities lesbians and gays experienced in the earlier decades. It must be assumed, therefore, that unsafe sex as subconscious death hastening can not account for a significant number of cases either.

PROPOSITION TWO: **When people perceive themselves to be at risk of contracting AIDS, they will actively seek out AIDS-avoidance information and/or be receptive to it.**

Perceived risk is no doubt the strongest motivation for seeking information. Not everyone, however, sees himself as at risk. For many reasons such as media emphasis upon high-risk groups, many feel exterior to the disease's grasp. Heterosexuals may look upon AIDS as a gay problem and, thus, not theirs. People of colour may see it as a white problem. Those in steady relationships may see it as a problem of those who are not. Similarly, some may also feel

invulnerable. They feel that their good health will protect them, or they believe that bad luck is the fate of others, or that God will look after them. This is not to say that feelings of exteriority or invulnerability necessarily preclude direct seeking or receptiveness to information. For one thing, they must gain enough to confirm to themselves that they are not at risk. Other than that, they may also want to know more for the sake of curiosity, interest, or otherwise. This, however, is different than feelings of susceptibility which, due to a desire for self preservation, initiate information seeking more than anything else.

Can perceived exteriority or invulnerability account for a significant number of cases of unsafe sex? First, it must be emphasized that such feelings are indeed perceptions. They may occur at this pre-informational stage or at any point thereafter. Many may later perceive themselves as exterior because of their chosen behaviour - and, often, quite rightly so. Exteriority at the early stage, however, is not based upon behaviour but, rather, group membership. Since gays are statistically the highest risk group, and since it is unlikely that many do not know this, it is also unlikely that many feel this way. As for invulnerability, when people do not have sufficient information about transmission, the reasons they hold for their invulnerabililty may certainly reign supreme. In view of the present high level of knowledge among gays, however, this too can not account for a significant amount of unsafe sex.

Thus, information seeking and/or receptiveness is

initiated by perceived susceptibility to AIDS. People who do not feel susceptible are far less likely to seek out AIDS-avoidance information or to pay attention to it.

PROPOSITION THREE: **Each time people encounter AIDS-avoidance information, they will interpret it: in other words, they will assign it particular meaning after examining all aspects of it and channelling it through already possessed meanings gained from past experience.**

First, I must explain what I mean by "AIDS-avoidance information." I do not mean merely the biomedical guidelines for safe sex but, rather **any** information indicating a way to avoid AIDS. Although this can well be "wear a condom during anal intercourse," it can also be "have sex only with 'uninfected' people," "don't go to that bar," or "pray to God." AIDS-avoidance information, therefore, may be accurate or not. Even if it is not, it is still information nonetheless.

People generally have no trouble finding AIDS-avoidance information. The disease is discussed constantly on the radio and television, and in newspapers and magazines. Posters are seen everywhere and pamphlets are easily accessible. If this is not enough, the concentration is even greater in the gay community. Messages are found in bars, bathhouses, washrooms, sex shops, community centres and the gay press. Slogans ["Men use condoms or beat it!"] appear on bumber stickers, t-shirts and lapel buttons and many wear safety pins to indicate their commitment to safe sex. Even talk of AIDS is constant. It may cover any aspect, be humourous or serious, and engaged in directly or overheard. With such a carnival of information,

the continued frequency of unsafe sex is even more of a mystery. Why haven't these people "gotten the message?"

One answer to this question is found in its last three words - "gotten the message." It has been too often assumed that the message carries with it a specific meaning which people must, in fact, **get**. Two errors are made here. First, it is taken for granted that everyone shares a "reciprocity of perspectives." When people interact, it is assumed that the world looks the same to one as it does another. Implicit here is that if any two people changed places, their experiences would be identical. [Turner, 1986] When a message is sent out, therefore, it is taken for granted that those who come by it will see it the same way.

The second error is the assumption that meaning is an intrinsic quality of objects themselves. Blumer points this out very well in the following [1969:3-4]:

> [One way of accounting for meaning is to regard it] as being intrinsic to the thing that has it, as being a natural part of the objective make up of the thing. Thus, a chair is clearly a chair in itself, a cow a cow, a cloud a cloud, a rebellion a rebellion, and so forth. Being inherent in the thing that has it, meaning needs merely to be disengaged by observing the objective thing that has the meaning. The meaning emanates, so to speak, from the thing and as such there is no process involved in its formation; all that is necessary is to recognize the meaning that is there in the thing.

The safe sex meaning, then, is thought to be packaged within the safe sex message. It is almost never regarded as something people give to it. When someone imputes a different meaning than the one intended, he has not "understood" it. He has somehow thought that it has a different meaning than the

one it "really has." What actually happens is quite different. Message givers give certain meanings to their messages as they send them out. Message receivers do **not** merely release that meaning into their minds upon receipt as though it were flavour from a fresh stick of chewing gum. Rather, they **give** it a meaning of their own. It may be similar to the one intended, or it may not. If we wish to know how people perceive and, ultimately, use AIDS-avoidance information, therefore, then we must not assume that safe sex messages are borne with intrinsic, unilateral meaning. Nor should we assume a reciprocity of perspectives. We must instead give the interpretive process its own integrity and acknowledge meaning as ultimately dependent upon it. It is not what people are told that guides their behaviour but, rather, their interpretation of what they are told.

This contention would be useless if reduced to a mere comprehension of the english [or french] language. Certainly almost anyone with an adequate knowledge of standard usage will understand what is being said. Interpretation, however, is a consideration of much more than this. Since all meanings are indexical to their contexts, contextual elements play key roles in their construction. people will consider factors pertaining to the message's source [gay community, religious institution], credibility [motivation, loyalties], history [gay community oppression, government action] media [poster, overheard conversation], and so forth. If, for example, the message "anal sex is dangerous" is seen in a pamphlet showing pictures only of heterosexual couples, it may be viewed as

more of a proscription against homosexuality than the act per se. Or, if an acquaintance who maintains that oral sex is safe is seen as informed and intelligent, his message may be seen similarly as reliable. People do not blindly accept messages as they are given. Rather, they consider all elements and construct its meaning accordingly. When considering the many ways people come by information - each within a general context as well as a specific one - it can be seen that meanings attributed will vary considerably.

A second consideration as to why so many have not gotten the message is the framework within which meaning takes place - namely, a labyrinth of already possessed meanings gained from past experience. As Blumer maintains, all meaning arises out of interaction with others. [1969:4-5] A person assigns meaning to an object based upon the ways in which other people act towards him with regard to that object. This is a continual social process lasting throughout life. At any point, a person is in possession of an incalculable number of meanings, all harmoniously connected, and all on reserve for the processing of new meaning. This is his storehouse of knowledge. Meanings may be generally held such as "a chair is an object to sit on" or or particular to the individual such as "pregnancy results from too much kissing." This is not to suggest that meanings, once interpreted, are static. Interpretation is a continuous process. Meanings are constantly being examined, checked and weighed against one another, grouped, regrouped, reprocessed, discarded, intensified, and so forth. When new information comes along,

it is not merely assigned meaning before it enters the storehouse but, rather, usurped into this symbolic labyrinth and processed according to the elements making it up. Old meanings are used to make new meanings; both are used to make still newer meanings, and so on. Meaning begets meaning begets meaning. For example, a person may picture people with AIDS as being about 35 years old since this has been the case in all pictures he has seen. He may also believe that schools discourage sex among teenagers because adults are jealous of the care-free life of youth. A message encouraging teenagers to remain celibate until marriage, therefore, may be seen as nothing more than a scare tactic arising from jealousy. Or, if someone believes that tans are a sign of health, he may see tanned men as less likely to be seropositive. Meaning, in short, is formed by considering other meaning. People will make sense of their world based upon what they "know."

In summary, receptiveness to AIDS-avoidance information or even purposefully seeking it out is no guarantee that biomedically correct information will be encountered or even interpreted as such. There are, in all, four reasons for this: a.] People come by AIDS-avoidance information in many different ways. b.] The contextual elements of information are key determinants of interpretation. c.] Interpretation is further dependent upon the nature of already possessed meanings gained from past experience. d.] The information encountered may be concordant or discordant with the biomedical guidelines for safe sex. In view of these factors, it is likely that the encountering, examining, and processing

of AIDS-avoidance information will result in considerable variations of meaning.

PROPOSITION FOUR: **As meanings surrounding sex acts are gathered, these acts become polarized.**

Sex acts are those performed within a sexual context. As soon as people learn about sex, there will be a range they will know of. They may carry out some and not others; they may find some pleasurable while others distasteful. Once they see themselves as susceptible to AIDS and, subsequently, seek information, they will also regard some as safe and others not. Admittedly, information seeking is no guarantee that people will necessarily encounter or internalize such knowledge. However, considering that "safe sex" and "unsafe sex" have become household phrases, it is likely that almost all eventually will.

Perceiving some sex acts as safer than others is, by definition, to form a continuum of these acts from least safe to safest. Eventually, all acts given such meanings, whether held as desirable or not, will be placed on this continuum. An example appears in **FIGURE THREE** [*] on the next page.

First, this continuum is an abstraction. It is not to suggest that distances between acts are equal. Any one may be placed at any point on the continuum - even to the degree where two or more will occupy the same position. It may well be that many are considered equally safe while only one is

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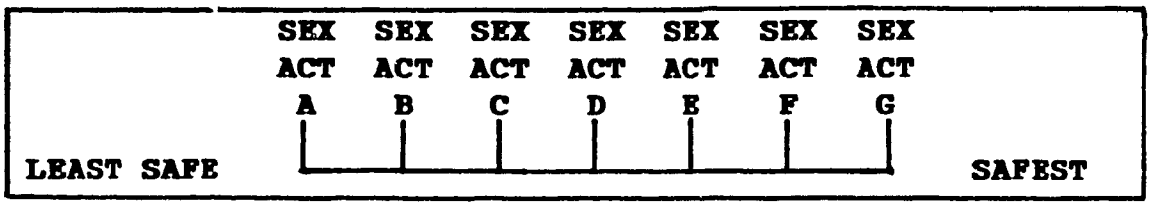
[*] Although I realize that a continuum of safest to least safe is less awkward, I place it in the opposite direction for reasons that will become clear in the 11th proposition.

considered unsafe. Second, the acts on the continuum are not necessarily based on biomedically accurate information. This

FIGURE THREE

THE SEX-ACT CONTINUUM



depends upon which information they encounter and how they interpret it. One person may consider anal intercourse the least safe act; another of medium risk; and another entirely safe. Conceivably, some may have never heard of it at all. In view of the evidence however, as well as the concentrated educational efforts towards gays, it is likely the majority possess more or less accurate information. Third, an act can only be placed on the continuum when it has been interpreted as safe or unsafe. A person may know of a number of acts but but have no idea about their risk. Such acts lie in wait, so to speak, until their respective values are placed upon them. Fourth, this does not suggest that the safe-sex continuum is fixed. Since new meanings constantly arise affecting those already possessed, acts can be added at any point.

The safe-sex continuum is admittedly a reification of individual experience. It is also an ideal type. While many do not think in these terms, the thoughts of others may take

different channels altogether. A continuum, however, is not only an applicable framework for thoughts holding some acts as safer than others, but a good one for the understanding of such thoughts as well. I maintain, therefore, that once these meanings arise, people - consciously or not - have polarized sex acts and, by definition, formed a safe-sex continuum.

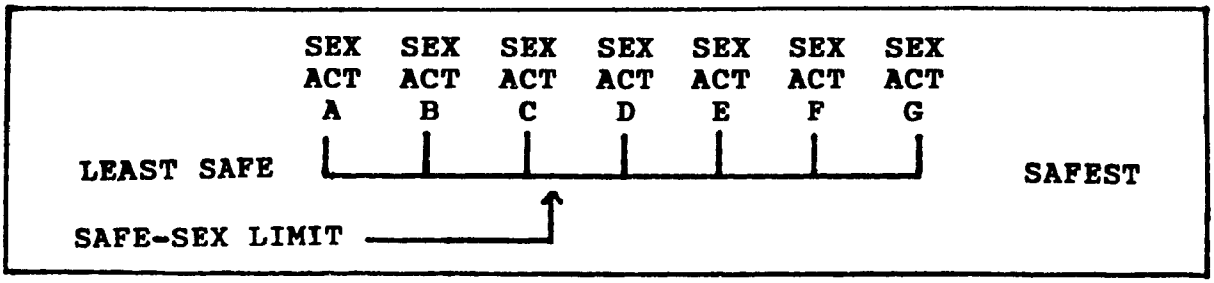
PROPOSITION FIVE: **Once the safe-sex continuum is formed, people will consider how far along this continuum they should go in sexual activity.**

As mentioned, the continuum of some will consist only of the safe and unsafe extremes. Others will have more elaborate continua from safe, to more or less safe, to more or less unsafe, to not safe at all. The number of interpolar gradations is one less than the number of points upon which the acts rest. Again, the fixity of any arrangement is dependent upon the nature of new meanings that arise. The consideration of where to place an act, however, is also a consideration of whether to perform it or not. Since all meanings surrounding action are potential acts in and of themselves, such consideration is part of these meanings. To consider an act more or less safe is to consider the same for its performance. In view of this, a continuum of acts gives rise to what I call the **safe-sex limit** - that point which divides acts into those a person considers carrying out and those he does not. It is shown in **FIGURE FOUR.**

It is important to explain fully what I mean by "consider carrying out." This is not to say that a decision is made determining all future action. Indeed, the continuum

FIGURE FOUR

THE SAFE-SEX LIMIT



may consist of some acts that will never be carried out, safe or unsafe, since they are thought abhorrent. Consideration is only in potential with regard to their degree of risk of contracting AIDS, and nothing more. To consider an act as safe, therefore, whether it is desirable, attainable, or even conceivably possible, is to consider its performance as safe as well. The safe-sex limit, therefore, is present on the continuum by definition and acts as the focal point for sex-act polarization.

PROPOSITION SIX: **When people perceive themselves as susceptible to AIDS, they will polarize potential sex partners.**

Regardless of whether people see themselves as susceptible to AIDS, they will know that there are some who have the disease and some who do not. This is guaranteed by their perception of their own serostatus as negative. If they believe that they do not have AIDS, then they are likely to believe that others do not either. Thus, with the exception of the rare case of a person who believes that he and everyone else has AIDS, every person will come to see a

simple dichotomy - people with AIDS, and people without.

For those not seeing themselves at risk, the dichotomy will generally stop here. Since people with AIDS are not seen as threats, there is no need to go any further. This is not the case of those who do see themselves as susceptible. Since they believe they may contract AIDS through their sexual behaviour, which by definition is with others, people with AIDS are seen not merely as external entities but as potential threats to safety. The dichotomy therefore develops into a polarization of potential sex partners - safe ones and unsafe ones.

This proposition appears after the fourth one stating that sex acts become polarized. This does **not** suggest, however, that polarization of acts necessarily precedes that of partners. Since AIDS-avoidance information is encountered, examined, and interpreted differently, it is equally possible that either could polarize before the other or that this could occur simultaneously. Most probably, partners will polarize first since it is likely that people are seen as threats before what is done with them. The sequence, however, is unimportant. What matters is that polarization **will** ultimately take place for both.

PROPOSITION SEVEN: **Since it is rarely possible to know the serostatus of a potential sex partner beyond question, meanings arise pointing to safe partners or unsafe partners.**

Even if people follow safe-sex guidelines, it is likely that most, given their choice, would not want to have sex with someone seropositive. Even if they would not mind, they would at least want to know. How then, can we know a potential partner's serostatus? Since those infected often appear healthy, unless a person is in the advanced stages of the disease, no true indicators exist. Pamphlets recommend we ask direct questions before sex, one of them presumably being "Do you have AIDS?" Can we then rely upon a person's own perception of his serostatus? Although most would accept someone's word if they answered yes, many would [or should] not accept the opposite. How does he know for sure? Many are unaware they are seropositive. Furthermore, could he be lying? Since AIDS is stigmatized, many are not willing to reveal themselves. [The roving..., 1989] With so much at stake, people are likely to want further evidence. They will therefore seek out additional indicators - meanings pointing to or away from a potential partner's likelihood to be seropositive.

As mentioned, meanings given to objects are dependent upon the nature of already possessed meanings gained from past experience. Put another way, we make sense of the world on the basis of what we "know." This knowledge is brought to new experience and used to examine it, define it, and understand it. A safe or unsafe partner, therefore, is one interpreted as such on the basis of all that points to and

indicates this meaning. I will give two examples: the first where already possessed meanings point to an unsafe partner, the second where they point to a safe partner. 1.] John sees people with no goals as unstable. Since he comes from a goal-oriented family, he has internalized this. He further believes that unstable people live only for the moment. Thus, they do not consider the consequences of their actions. He meets a man 25 years old who is not in school and has been unemployed for eight months. He is attracted to the man but decides not to make advances. His situation indicates that he does not care about his future and, if this is so, he does not care about safe sex either. 2.] Randy is a neat, tidy person who likes fine clothes. When he sees others well-dressed, therefore, he sees them as being the same way. They care about their appearance and, thus, they care about themselves. He meets a man impeccably dressed in a bar who propositions him. He accepts. By the look of the man's clothing, Randy concludes that he cares about himself. People who care about themselves would naturally be conscientious about safe sex.

In both cases, already possessed meanings were used to interpret and give meaning to new experience. Since our possessed meanings are all different, the possibilities are endless. Whether a potential partner is regarded as safe or unsafe, therefore, is ultimately dependent upon the individuals interpretation of that partner.

These meanings arise from a need for self preservation. Since potentially unsafe partners are seen as threats, people

will use What they know to avoid them. I do not maintain that the **use** of these meanings is universal. There are those who believe that adherence to safe sex acts only is sufficient and whether or not a partner is seropositive is irrelevant. Others will perform safe acts only since they are unsure of their own serostatus and do not want to risk infecting others. I do maintain, however, that their **possession** is inevitable. Even though they are not necessarily used to guide behaviour, they are present just as are meanings indicating a professor, a police officer, a lazy person, or a dishonest one. This applies to **all** people who regard themselves as at risk and are aware that not all have AIDS.

PROPOSITION EIGHT: **Meanings pointing to safe or unsafe partners will give rise to further meanings pointing to safe or unsafe sexual contexts.**

Since many want to avoid unsafe partners, they will also want to avoid unsafe contexts within which these partners are present. This need gives rise to meanings pointing to such contexts which, antithetically, give rise to ones pointing to safe contexts. To explain, safe or unsafe partners are interpreted as such on the basis of what is known about the individual. He may be safe because he is conscientious, intelligent, or opposed to casual sex. He may be unsafe because he frequents bars regularly, or dresses in a manner accentuating his sexuality, or otherwise. The second axiom in the tridimensionality of sex states that all three dimensions are inseparably interlinked. Not only does a change in one suggest changes in the others but, more importantly, the

character of one points to or indicates that of another. Having sex with a safe or unsafe partner, therefore, points to a safe or unsafe sexual context. And, a context within which a safe or unsafe partner is found, known to have been in, or otherwise, is also one safe or unsafe.

As an example, someone may see people engaging in anonymous sex as unsafe. Since a bathhouse is a place where this takes place, this location, in turn, is an unsafe context. He may further view men who go to bathhouses as unsafe. Sex with someone who goes to bathhouses, therefore, is sex within an unsafe context. Similarly, another may believe that intelligent people, being more aware of the dangers of AIDS, make safe partners. To meet someone at a graduate seminar, therefore, and to have sex with him, is to have sex within a safe context.

Partner meanings give rise to context meanings. Although this may be the most logical direction, however,it is not the only one. The opposite is equally possible. A person may hear or read that bathhouses are "breeding grounds for the AIDS virus" and then conclude that those going there would be unsafe partners. Here, a context meaning gives rise to a partner meaning. In reality, this relationship is reflexive. Partner meanings point to context meanings which point to partner meanings and so on. The time order therefore - or whether the egg comes before the chicken - is unimportant. What is important is that partner meanings **necessitate** context meanings. Since unsafe partners are to be avoided and safe ones sought out, the contexts within which either are

found arise as essential indicators which point to, justify the existence of, and add substance to such meanings.

PROPOSITION NINE: **The degree of conviction to partner- and context-dependent definitions of safe or unsafe sex, and the degree of commitment to act-dependent definitions, together with the circumstances of a sexual encounter, determines the potential of these alternative definitions to override act-dependent ones in sexual activity.**

To review briefly, act-dependent definitions arise in those perceiving themselves as susceptible to AIDS. Most possess more or less accurate knowledge in this respect. Partner- and context-dependent definitions, which together I will call **alternative definitions**, also arise. This leads to the question of which ones will be used in behaviour act-dependent ones or alternative ones? Since there is often a conflict between the two, as in the case of performing safe acts only with someone strongly believed to be seronegative, there must also be a resolution. When does this resolution favour sex acts and when does it favour alternative definitions?

The answer lies in three **deterministic** factors: a.] The degree of conviction with which alternative definitions are held. b.] The degree of commitment to act-dependent definitions. c.] The circumstances of a sexual encounter within which these definitions arise.

All people hold alternative definitions of safe or unsafe sex. This may be assumed if they are aware that not everyone is seropositive and that a sex partner's seropositivity is a necessary prerequisite for transmission.

Unless these definitions are held with conviction, however, they have little or no potential for use. For example, some may believe that religious people, being less promiscuous, are less likely to be seropositive. Or, they may believe that men over forty, having participated in the sexual celebration of the 1970s, have more unsafe sex since they would find the necessary adjustment difficult. These beliefs, however, are only speculations of probability. They may also feel that since there are too many exceptions to the rule and that too many other variables come into play, it would be rash to use such beliefs in behaviour. Others may hold these beliefs with far more conviction. Although they may also be aware that they are no more than probabilities, the exceptions may be thought so rare as to be inconsequential. When this is the case, the potential for their use in behaviour arises.

The second factor is the degree of commitment to act-dependent definitions. Here, there are a number of factors to consider. First, it is possible that many have decided in advance to perform safe acts only, regardless of other convictions or circumstances. For one thing, they may be uncertain of their own serostatus and not want to risk passing the virus on. Or, they may have strong political convictions and want to exemplify proper behaviour within the gay community. Or, they may genuinely feel that alternative definitions render risk to judgment which can not always be trusted. In these cases, act-dependent definitions are far more likely to win out. Second, a person's sexual history must be considered. While some gay men have been sexually

active for decades, others are only beginning. Those who were active before AIDS had no restrictions and have since been faced with the necessity for change. They have enjoyed "unsafe sex" before and may have difficulty adjusting. Conversely, those who became sexual during the epidemic have likely faced the issue of safe sex immediately. Here, the likelihood of conviction to act-dependent definitions is greater. Third, personal taste in sex must be considered. For those who prefer acts that happen to be safe and find unsafe ones distasteful, their is little danger of alternative definitions overriding - even if they are held with high degrees of conviction. For those who enjoy unsafe acts and find safe ones unsatisfying - perhaps feeling that condoms reduce pleasure - there is far more motivation to place trust in alternative definitions. The degree of commitment to act-dependent definitions, therefore, is multifaceted. While I mention only several factors, there are no doubt many more. When the commitment is strong, however, the likelihood of alternative definitions overriding is minimal. When it is weak, the door is open for these definitions to be used.

Third, if alternative definitions are to be used, the circumstances of a sexual encounter must be conducive to them. This is obvious. If someone believes that religious people do not have AIDS, then, for this conviction to come into play, a potential sex partner must be perceived as religious. The same applies for intelligent people, athletic people, or otherwise.

A final factor to consider is the copresence of many

alternative definitions in a sexual situation. If a potential partner is perceived as religious, intelligent, young, healthy, and from a small isolated town, and all of these factors point to a safe partner, then each will give strength and meaning to the others. One factor pointing to a safe partner may be sufficient to disregard safe acts; five or more makes this all the more likely.

PROPOSITION TEN: **The probability of HIV contagion is assessed for each sexual encounter. As new information becomes apparent, this assessment is re-examined continuously.**

Once people consider having sex with someone, that someone becomes a potential sex partner. This may take place after two weeks acquaintance, upon first meeting, upon sight, or in fantasy. If the consideration carries with it the possibility of sex actually taking place, which in fantasy it often does not, the probability of HIV contagion is assessed. This assessment is continuous. It begins when sex is perceived as possible, continues as it is arranged, and continues still as it takes place. The person examines all relevant information as it arises, organizes and classifies it, assigns it meaning, and governs his behaviour accordingly. He will enter into sexual activity only if he believes that contagion is avoidable. When he does, he will perform only those acts which preclude this possibility.

This contention would seem to render all risk-avoidance behaviour as unilateral and calculated. By itself, however, it is an oversimplification. There are a great many

considerations, ramifications, and exceptions needing explanation. First, I will treat risk assessment as an **ideal type**. Once this is done, I will discuss other contingencies.

All new experience is assessed with old experience. When someone is faced with a possible sexual encounter, he brings with him a host of already possessed meanings gained from past experience. This is his storehouse of knowledge which he uses to examine and interpret all new situations. HIV-contagion assessment begins once another is regarded as a potential sex partner. Since the individual wants to avoid contagion, he looks for all relevant information. This process is best understood by the documentary method. The underlying patterns he seeks are a safe sexual encounter or an unsafe sexual encounter. His assessment is based upon the presence or absence of indexical particulars pointing to or indicating these patterns. For example, if he believes that intelligent people are less likely to be seropositive, and this partner-dependent definition of safe sex is significant to him, then this is an indexical particular to a safe partner. Taken further, the potential partner's, manner of speech, facial expressions, topics of conversation, education, career position, and so forth are all indexical particulars to the underlying pattern of an intelligent person. Conversely, if promiscuity is seen as an indexical particular to an unsafe partner, then manner of looking at other men, favourable attitudes towards bathhouses, and perhaps even clothing accentuating sexuality, may all be indicators in this respect. An indexical particular is

significant in assessment when it is significant to the individual. It may be commonly agreed upon as significant or wholly particularistic. In other words, it can be anything imaginable. When relevant indexical particulars are detected, they will be ultimately considered in risk assessment. This is not to imply that assessment is always consciously calculated. This may certainly be the case with some. Others, however, may only be **receptive** to relevant indexical particulars. If they carry meaning for the individual, and they arise, they will be considered. Nevertheless, for those who see themselves as susceptible to contagion, indexical particulars pointing to a safe or unsafe encounter will **always** arise. For if they do not, he would not know how to govern his behaviour with respect to risk.

A possible argument against risk assessment is that not all need do so since they have decided in advance to always perform safe acts. This is, however, an assessment in itself. The person is still faced with a potential sexual encounter and he still must indicate to himself that there is no risk involved. He does this merely by indicating to himself that he will perform safe acts. The fact that this is predecided is irrelevant since it must still be confirmed each time to be carried out. "I have safe sex only" is a meaning brought into the assessment; it does not preclude it.

Assessment is no more or less than determining the meaning of a particular situation in order to direct action. It occurs with each new situation and constantly throughout. Each time we carry out action, no matter how tedious or

familiar, we must indicate to ourselves its meaning. If we did not, we would never do anything at all. If we give meaning to a particular situation, therefore, we must base our action upon that meaning. If we did not, that meaning would not exist.

In view of this, risk assessment **must** take place by definition. If a person perceives himself as susceptible to AIDS, and he is aware that AIDS is sexually transmissible, then he must determine this meaning with each sexual encounter. If he does not, then he does not perceive himself as susceptible and HIV contagion, as a meaning for him, does not exist. Furthermore, if we did not assess and act accordingly to risk we are aware of, we would all be dead - for we would blindly walk off the edges of buildings, put our hands in fires and, certainly, have unsafe sex.

What determines whether someone has unsafe sex, therefore, is risk assessment. This is based not upon his knowledge of the biomedical guidelines, for he may be well informed. Rather, it is based upon the meanings each sexual situation have for him. These meanings are not based upon objective characteristics but his awareness, examination, and interpretation of them. Finally, this is based upon the meanings he already possesses gained from past assessments of other situations - sexual or otherwise. The research question is therefore answered. Why do gay men, aware of the dangers of AIDS, continue unsafe sex? Because they have assessed the risk of this action and determined it to be minimal. They have **made unsafe sex safe.**

What role does the tridimensionality of sex play in risk assessment? I mentioned that all three dimensions - acts, partners, and contexts - are inseparably interlinked. A change in one results in a change in the others. If this is true, it must also be true that the character of any one will point to and indicate the characters of the others. A partner may be regarded as safe because he appears within a safe context; an unsafe context may render a partner unsafe which in turn renders the acts unsafe; safe acts may render the context safe and thus the partner as well, and so on.

Assessment of a sexual situation can begin with any dimension. People may first look at the partner [as in meeting someone in a bar], the context [as in going to a bathhouse], or the acts [as in knowing in advance to perform safe ones only]. When one points to the other which in turn points to the remaining one, there are twelve possible sequences shown in **FIGURE FIVE** on the next page.

For a sexual encounter to be seen as safe or unsafe, all three dimensions **must** be seen in the same way. One cannot perform safe acts with a safe partner in an unsafe context. Nor can a partner be regarded as unsafe when the acts and context are regarded as safe. A safe or unsafe situation virtually always points to a safe or unsafe partner, a safe or unsafe context, and safe or unsafe acts, respectively.

People will generally not go through with sex if their assessments follow **SEQUENCES ONE** and **TWO**. If they do, it suggests two things. First, the person may have little or no degree of self efficacy. When sex begins, he knows he will

FIGURE FIVE

SEQUENCES OF ANALYSIS OF A SEXUAL SITUATION

1.]	**Acts** [unsafe] → **Partner** [unsafe] → **Context** [unsafe]
2.]	**Acts** [unsafe] → **Context** [unsafe] → **Partner** [unsafe]
3.]	**Partner** [unsafe] → **Acts** [unsafe] → **Context** [unsafe]
4.]	**Partner** [unsafe] → **Context** [unsafe] → **Acts** [unsafe]
5.]	**Context** [unsafe] → **Partner** [unsafe] → **Acts** [unsafe]
6.]	**Context** [unsafe] → **Acts** [unsafe] → **Partner** [unsafe]
7.]	**Acts** [safe] ⟶ **Context** [safe] ⟶ **Partner** [safe]
8.]	**Acts** [safe] ⟶ **Partner** [safe] ⟶ **Context** [safe]
9.]	**Partner** [safe] ⟶ **Acts** [safe] ⟶ **Context** [safe]
10.]	**Partner** [safe] ⟶ **Context** [safe] ⟶ **Acts** [safe]
11.]	**Context** [safe] ⟶ **Partner** [safe] ⟶ **Acts** [safe]
12.]	**Context** [safe] ⟶ **Acts** [safe] ⟶ **Partner** [safe]

ultimately carry out unsafe acts since he can not resist, he is easily led, or otherwise. Second, he may regard all acts as having at least some degree of risk - condoms break, the virus will get into him somehow, medical experts do not know enough about transmission yet, and so on. These perspectives indicate either little knowledge of transmission or an exaggeration of risk. It would not be far fetched to speculate that some AIDS-prevention messages contribute to this. For example, when it is said that abstinence is the

"best method of protection," it may be concluded that anything other than this always has some degree of risk.

Conversely, **SEQUENCES SEVEN** and **EIGHT** suggest a high degree of self efficacy, a high degree of faith in safe sex acts, and a strong decision to adhere to these acts in advance. When this is the case, the partner is automatically regarded as safe as is the context within which he is found. This holds true **regardless** of his serostatus. These sequences are the ideal objective of educational efforts. Notwithstanding inaccurate knowledge of safe acts, if all if eveyone assessed sexual situations in this way, the epidemic would soon be decimated.

SEQUENCE THREE to **SIX** and **NINE** to **TWELVE** are ones where alternative definitions override act-dependent ones. The partner or context is first assessed as safe or unsafe and, as a result, the acts are regarded as safe or unsafe as well. When the partner or context is regarded as unsafe initially, it is again unlikely that people will go through with sex. When they are regarded as safe, it is likely that they will. **SEQUENCES NINE** to **TWELVE**, therefore, are those where **unsafe sex is made safe** and, thus, those where HIV transmission is enabled. This is best illustrated by once again telling a story and then referring back to it:

> Ian was a student in language studies at Eastville University. Since he is gay, he wanted a place to meet other gay students on campus. He came across an ad by Gay and Lesbian Eastville [GALE] asking for new members. He decided to go. The thing that most impressed him about the meetings was how conscientious all of the members were about safe sex. There were posters all over the room encouraging it, everyone wore a button saying "I'm a Safe-Sex Slut," and there was

rarely a conversation that did not mention it. Naturally, he concluded that GALE members were all advocates of safe sex. As the semester progressed, he found his school work more and more demanding and eventually had to stop going to the meetings.

Months later, after a grueling exam, Ian felt he had to unwind. He therefore went to the Eastville Club, a gay bar, to have a beer. Later, a handsome man named Ron began talking with him. Ron had had also taken language studies at Eastville, graduated last year, and was now teaching french at Eastville High. He had also been a member of GALE.

At midnight, Ron asked Ian to spend the night with him. Ian did not normally do this but thought it would be a pleasant diversion and agreed. Later, while they were making love, Ron entered him anally with no condom. Ian was well informed about safe sex because of the GALE talks. He knew what to do and what not to do. In this case, however, he knew that he didn't have to worry. Ron used to go to GALE meetings regularly. He was therefore very conscientious about safe sex. How could he not be with all those talks going on? Since this was the case, Ron was no doubt a safe person to have sex with and a condom was not really necessary.

Even though Ian engaged in what he knew to be an unsafe act, he did not regard it as such **in this situation**. Since Ron had also attended GALE meetings - a safe context - he was automatically perceived as a safe partner and, thus, seronegative. Even though Ron was willing to engage in an unsafe act with a stranger, the retrospective context of the GALE meetings took precedence in giving meaning to him as a partner. Ian's assessment is an example of **SEQUENCE ELEVEN**. A safe context pointed to a safe partner which, in turn, rendered an act safe.

If a partner is indeed seronegative, people who make such assessments are luckily accurate. When he is seropositive, however, and when people engage in biomedically unsafe acts, they are likely to become seropositive themselves. If we wish to combat AIDS, therefore, we must do two things. First, we must re-examine safe-sex messages and

strip them of all encouragement to see sex partners or sexual contexts as safe or unsafe. Second, we must take direct action to prevent such definitions - especially those leading to **SEQUENCES NINE** through **TWELVE**. If we do these things, we may be able to reduce the current rate of seroconversion and, thus, curtail the epidemic.

Sequential analysis is not without its theoretical difficulties. In personal correspondence, John Alan Lee [1989] raised some important issues pertaining to the continuing flow of risk assessment in a sexual encounter. As he states:

> There are numerous considerations, along the line of "I've gone this far, why not a little farther?" ("In for a penny, in for a pound") so that, like a mountain climber, the risk of a distant peak seems less after he has scaled the foothills.... [Similarly] a sexual partner reads the signals and information about the encounter, and decides to risk more, or to risk less than even the initial "calculation" suggested.

I am indebted to Dr. Lee for pointing out to me that risk assessment is indeed continuous. On-going interpretation of information is in fact an important principle of both the documentary method and symbolic interaction. Each time significant information arises, it is examined. New meaning always affects relevant previous meaning retroactively - either by confirming it or indicating what it "really meant." For example, someone may see rapid weight loss as a strong indicator of having AIDS. He spots a friend he has not seen in a while, notes that he is thirty pounds lighter, and

strongly suspects this. Later, in conversation, he learns that he has been following a new regimen of diet and exercise and never felt better. The new meaning of weight loss indicates what the old one, AIDS, really was. On the other hand, he spots a purple lesion on his friend's neck. In this case, new meaning strengthens old meaning by complimenting it. In similar fashion, indicators may arise constantly throughout a sexual experience. They are considered each time and, thus, taken into account.

The issue of risks once taken making succeeding ones appear less so is more complex. It may be characterized by "I've already done this, why not that?" Or, "The condom probably broke while I was in him, I may as well not use one when he's in me." Although this type of reasoning does not detract from sequential analysis, it does threaten to override it as an explanation. It makes it arguable that unsafe sex can be better explained by the effects of serial-risk assessment rather than assessment itself. The question to resolve, therefore, is which is the stronger influence.

There are several arguments in favour of risk assessment - some weak, others stronger. First, although sex acts are placed on a continuum from safest to least safe, they are not continuous in themselves. They are discrete acts each with its own interpreted degree of risk. The flow from low- to high-risk ones, therefore, can be looked at as a continuous climb but as a series of steps. Although it is true that an act of medium risk, once carried out, makes a high-risk one

seem less so, it is unlikely that this would explain its performance. If indeed a person sees a particular act as life-threatening, he will generally try to steer clear of it. We may go further and further on to thin ice, but we will reach a point where the risk becomes too great. Or, we may climb higher and higher up a tree, but we may reach a point where we believe that the bough is too frail to hold us. The fact that the bough immediately below can still do this is irrelevant. Certainly the next risk would seem less once the last one is taken. But we are likely to reach a point where we will go no further. The reason is that we almost always keep a perspective of the point where we began. Going a hundred miles an hour is only ten more than ninety, but we still know that it is a hundred from zero and that the impending crash is that much more likely to kill us. A high-risk act is only a bit more than a medium one, but we still know it is a great distance from the zero risk where we began.

The tendency to take greater and greater risks can be better explained by what is called "the heat of the moment." We temporarily abandon our rational perspective and are driven instead by desire. Here, risk assessment is suspended until academic. When dealing with a life-threatening situation, however, it is unlikely that this is common. People may "slip" occasionally, but not as a habit.

Certainly cognitive dissonance would play a key role here. We are about to take a risk previously assessed as high and, in order to perform it, we alter its meaning to reduce

the impending discomfort. [Mussen, Rosenzweig et al., 1973; Wittig & Williams, 1984] This, however, is not a motivation to take a risk in itself but, rather, a result of it. The motivation must still be explained.

The strongest argument against continuous risk assessment can be found in the nature of alternative definitions of safe sex. Although I discuss all types of assessments, I maintain that we must concentrate upon those of **SEQUENCES NINE** through **TWELVE**. These are the ones where an unsafe act is made safe. If people base their behaviour upon partner-dependent and context-dependent definitions, they are in fact consciously suspending act-dependent ones. Yes, anal sex with no condom is normally unsafe, one may think, but **not in this case** since this guy can't have AIDS. The more certain one is of this, the more he is likely to label the acts safe as well. Logically, this would hold true for **all** acts since there would be no such thing as a low-, medium-, or high-risk act with a seronegative partner. Thus, once alternative definitions take over, stepwise risk taking is precluded by definition.

A word must also be said about bargaining, the "use of magic and religion," and fatalist attitudes. In the first case, people may knowingly have unsafe sex saying "I deserve it after being celibate for so long" or "I'll have one last fling." This does not rival risk assessment because it is part of it. The bargain is a meaning brought to the sexual situation and is therefore an alternative definition. Yes I am doing something normally risky, but there is no risk

because of this bargain I strike with myself. Magic, is defined by Albas and Albas [1989] as follows:

> an action directed toward the achievement of a particular outcome with no logical relationships between the action and the outcome or, indeed, any empirical evidence that one produces the other.

They have noted that students typically use charms, wear their hair a certain way, or otherwise during exam time to bring about "luck." Parallel behaviours have been noted among athletes [Gmelch, 1971], gamblers [Henslin, 1967], and even hospital staff to ward off disease [Roth, 1957]. In view of this, it is likely, therefore, that some use magic to ward off AIDS. Still, this is part of the overall assessment since magic is also a meaning brought into the situation. The same may be said for any faith in religious doctrine - "God will protect me." Lastly, fatalism may be characterized by "If I get it, I get it" or "Tonight we dance for tomorrow we may die." Although this does not cancel out assessment, it is, moreover, a psychological predisposition towards risk. It is therefore an exception. Still it is likely that most take the greatest care to preserve their lives. It is therefore not sufficiently common to be a rival explanation.

PROPOSITION ELEVEN: **If alternative definitions override act-dependent definitions, "safe-sex-limit motility" will take place. The greater the degree of movement to the left, the greater the probability of unsafe acts being carried out.**

As information about sex acts is gathered, these acts become polarized. They are positioned along a continuum from

least safe to safest. This, by definition, is to regard the performance of the acts as unsafe or safe as well. Thus, each continuum has a safe-sex limit - that point dividing the acts into unsafe and safe. This limit exists for all who polarize sex acts. It exists prior to any sexual encounter and is thus meaning brought into it. When people assess risk, they consider all significant aspects - those pertaining to context, partner, and the acts to be carried out. Alternative definitions may override act-dependent ones, or they may not. Assessment will have three possible outcomes with regard to act-dependent definitions: a.] No change. b.] Change to less safe. c.] Change to safer. I explain each separately.

When there is no change in act-dependent definitions, alternative definitions have had no effect upon them whatsoever. The person is aware of them - as is everyone - but he is not willing to let them override the act-dependent ones. Most commonly, he decides in advance to perform safe acts only and is sticking to this decision regardless. Assessments in these cases follow **SEQUENCES ONE, TWO, SEVEN** and **EIGHT** of **FIGURE FIVE.**

When acts become less safe than they were originally, alternative definitions are such that they indicate this. Yes this act is normally low risk, someone may think, but since the person I'm considering sex with is highly likely to be seropositive, its riskier **for this situation.** With this kind of assessment - following **SEQUENCES THREE** through **SIX** - he will either decide not to go through with sex, or place high restriction upon what he will do if he does.

The third possibility follows **SEQUENCES NINE** through **TWELVE**. Alternative definitions override act-dependent ones in such a way that acts, normally considered unsafe, are redefined as safe **in this situation**. Unless a person is luckily accurate in his assessment, HIV transmission is enabled. It is not in the other two possibilities.

The effects of the three possibilities upon the safe-sex limit are shown in **FIGURE SIX**. When there is no change in the meaning given to sex acts, the safe-sex limit stays as is. There is no movement in either direction on the continuum. When acts are considered less safe than originally defined, it moves to the right - **DEXTRAL MOTILITY** [*] takes place. Finally, when acts are considered safer, it moves to the left - thus, **SINISTRAL MOTILITY**. [**] I call this movement potential **SAFE-SEX-LIMIT MOTILITY**. HIV transmission is dependent first upon whether the partner is seropositive and, second, upon the motility of the safe-sex limit.

PROPOSITION TWELVE: **The probability of HIV contagion for each individual is determined by the number of times safe-sex-limit sinistral motility takes place divided by the number of different partners multiplied by the proportion of them who are seropositive.**

As mentioned, **SEQUENCES ONE** through **EIGHT** preclude HIV transmission. People will either perform safe acts only or not have sex at all. In **SEQUENCES NINE** through **TWELVE**, however, sinistral motility enables HIV transmission.

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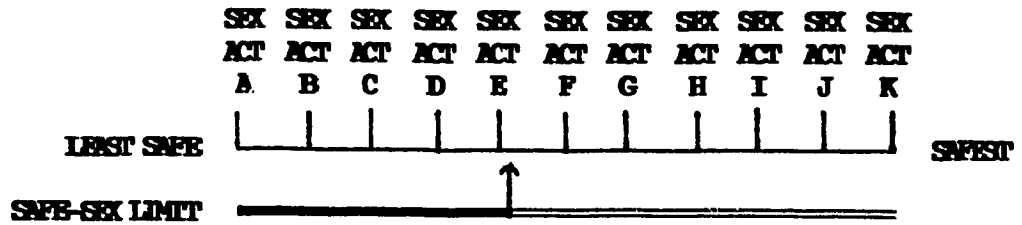
[*] and [**] Since the word "sinister" is cognitively associated with negative events, I arrange for it to represent the redefining of unsafe acts as safe. See footnote on page 156.

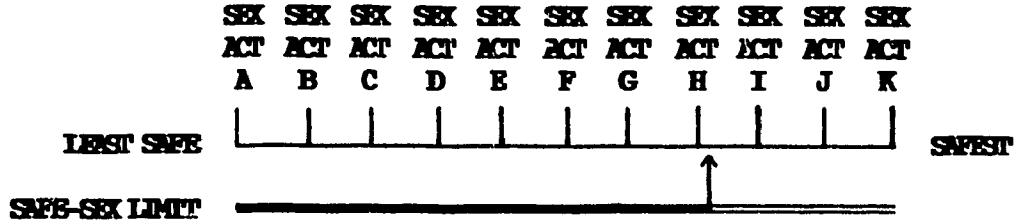
FIGURE SIX

SAFE-SEX-LIMIT MOTILITY

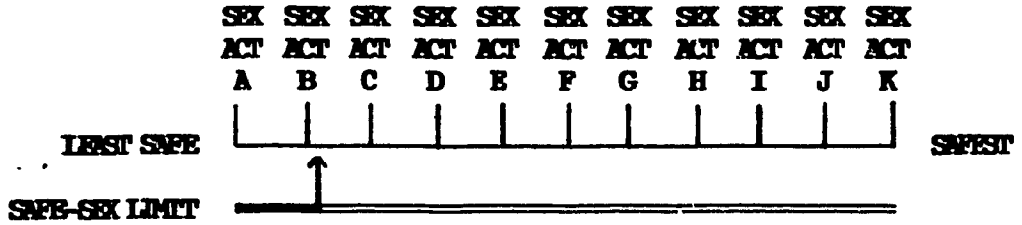
FIRST POSSIBILITY: No Motility.
[Sequences one, two, seven, and eight of FIGURE THREE]



SECOND POSSIBILITY: Dextral Motility.
[Sequences three through six of FIGURE THREE]



THIRD POSSIBILITY: Sinistral Motility.
[Sequences nine through twelve of FIGURE THREE]



Since not everyone is seropositive, the individual may be luckily accurate in his assessment. If he interprets the partner as seronegative, and indeed he is, HIV transmission is not possible, **regardless** of the acts performed. Such luck, however, is rarely always the case. Therefore, the probability of HIV contagion for each individual is determined by the number of times safe-sex-limit sinistral motility takes place divided by the number of different partners multiplied by the proportion of them who are seropositive. This may be expressed in the the following way:

$$\text{Pr.[HIV Contagion]} = \frac{\text{\# [SSL Sinistral Motility]}}{\text{\# Partners}} \times \text{Proportion of Partners Seropositive}$$

For example if someone has **36** partners in a year, **9** of them [or ¼] were seropositive, and safe-sex-limit sinistral motility occurred **19** times, then the probability of HIV transmission taking place would be **19/36 x 1/4** or **.132.**

This formula is useful at the individual level. It can not, however, be used for general epidemiological purposes. Many other variables must be taken into account. However, when it is incorporated, it may well lead to more accurate predictions. The spread of AIDS is not contingent upon the amount of sexual activity in a population but, rather, the amount of unsafe sexual activity. When unsafe acts are carried out with an unsafe partner, transmission is enabled; when they are not, it is precluded.

3.] DISCUSSION AND CONCLUSION.

The Safe-Sex-Limit Motility Model is designed to explain why gay men, fully aware of the dangers of AIDS, continue to have unsafe sex. It is based on twelve propositions which, in turn, are based upon three tautological statements of the nature of sexual activity. These three statements are summarized in **FIGURE TWO** and the twelve propositions in **FIGURE SEVEN** on the next page. The model proposes that HIV contagion is dependent upon the channels of analysis with which people interpret sexual situations. There are twelve possible channels as shown in **FIGURE FIVE** and, in four of them, transmission is enabled if the sex partner is seropositive. In this section, I discuss the model as a whole.

People first begin with an awareness of AIDS. Since we are now a decade into the epidemic, and since there is a high concentration of AIDS information in the gay community as well as society in general, virtually all homosexually behaving males have reached this point. Next, they must regard themselves as susceptible to contagion. If they are sexually active, this will happen unless overridden by feelings of exteriority, invulnerability, or otherwise. Third, if they value their lives - which some do not - they will actively seek out AIDS-avoidance information and/or be receptive to it. They do this to ultimately change their feelings of susceptibility. Each time they encounter

FIGURE SEVEN

THE SAFE-SEX-LIMIT MOTILITY MODEL

PROPOSITION 1: If self preservation is important to people, they will not knowingly place themselves at risk.

PROPOSITION 2: When people perceive themselves to be at risk of contracting AIDS, they will actively seek out AIDS-avoidance information and/or be receptive to it.

PROPOSITION 3: Each time people encounter AIDS-avoidance information, they will interpret it: in other words, they will assign it particular meaning after examining all aspects of it and channelling it through already possessed meanings gained from past experience.

PROPOSITION 4: As meanings surrounding sex acts are gathered, these acts become polarized.

PROPOSITION 5: Once the safe-sex continuum is formed, people will consider how far along this continuum they should go in sexual activity.

PROPOSITION 6: When people perceive themselves as susceptible to AIDS, they will polarize potential sex partners.

PROPOSITION 7: Since it is rarely possible to know the serostatus of a potential sex partner beyond question, meanings will arise pointing to safe partners or unsafe partners.

PROPOSITION 8: Meanings pointing to safe or unsafe partners will give rise to further meanings pointing to safe or unsafe sexual contexts.

PROPOSITION 9: The degree of conviction to partner- and context-dependent definitions of safe or unsafe sex, and the degree of commitment to act-dependent definitions, together with the circumstances of a sexual encounter, determine the potential of these alternative definitions to override act-dependent ones in sexual activity.

PROPOSITION 10: The probability of HIV contagion is assessed for each potential sexual encounter. As new information becomes apparent, this assessment is re-examined continuously.

PROPOSITION 11: If alternative definitions override act-dependent definitions, "safe-sex-limit motility" will take place. The greater the degree of movement to the left, the greater the probability of unsafe acts being performed.

PROPOSITION 12: The probability of HIV contagion for each individual is determined by the number of times safe-sex-limit sinistral motility takes place divided by the number of different partners multiplied by the proportion of them who are seropositive.

information, they will examine it and interpret it. The outcome is dependent upon their already possessed meanings gained from past experience - their storehouse of knowledge. Since the components of this storehouse vary considerably from one person to another, it is likely that the same information will yield considerable differences in interpretation.

Once enough information is gathered, people will polarize sex acts. In other words, they will place them on a continuum from safest to least safe. To regard an act as safe or unsafe is, by definition, to regard its performance as safe or unsafe. This reflexive feature gives rise to a safe-sex limit - that point on the continuum dividing sex acts into those they will perform and those they will not.

If they are aware that not everyone has AIDS, they will also polarize potential sex partners. They will assess the probability of each being seropositive based upon their interpretation of all meaningful information surrounding him. Again, this interpretation is dependent upon the components of their storehouse of knowledge. Finally, they will polarize sexual contexts. Since they are part of the information pointing to and indicating the probability of partners being seropositive, they will also be regarded as safe or unsafe. Once all three dimensions of sex are polarized, each will give substance and meaning to the others reflexively.

When all three dimensions are polarized, people are in possession of two things: a.] A safe-sex limit based upon the meanings attributed to sex acts. b.] Alternative

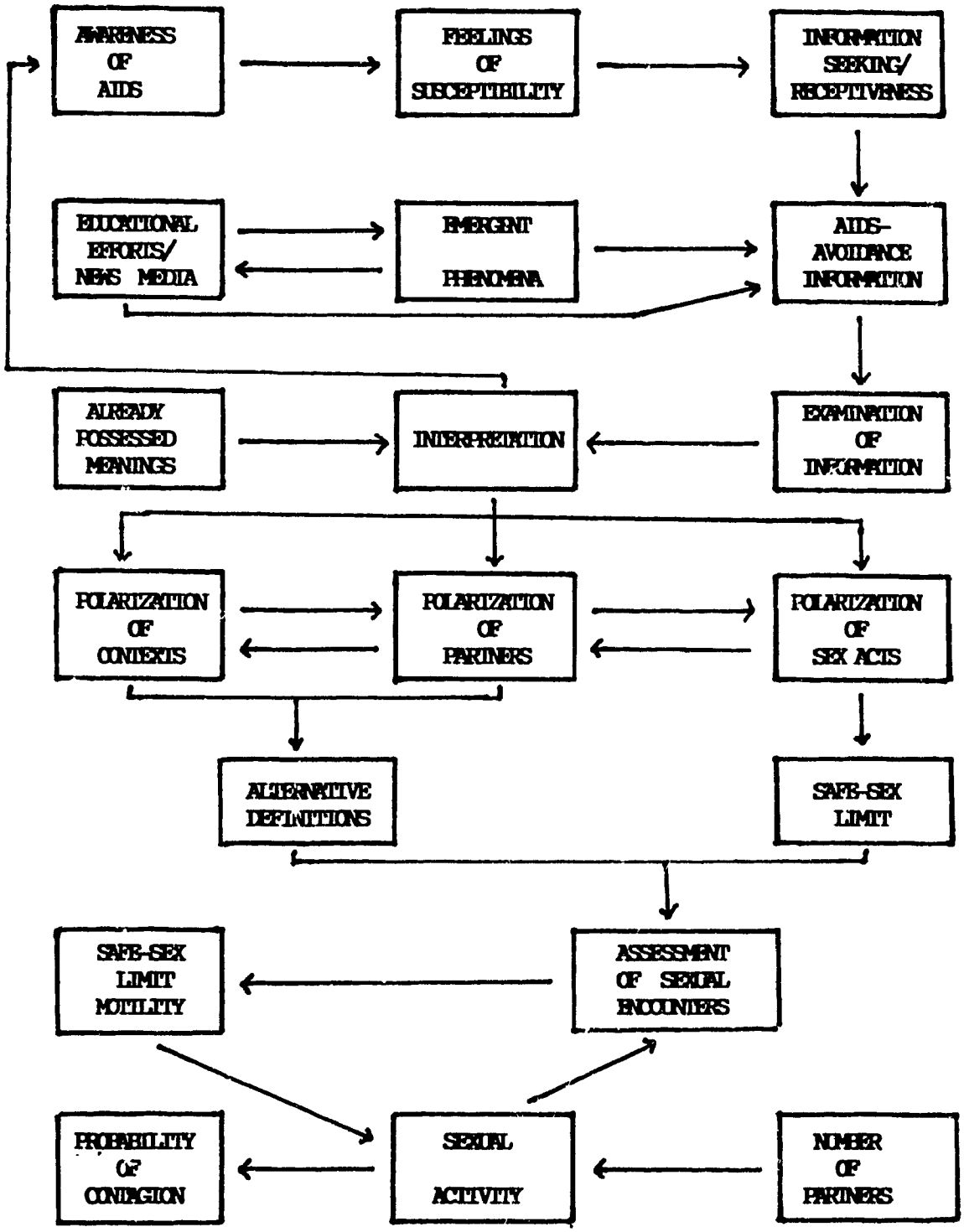
definitions of safe sex based upon partners and contexts. Both are brought into the assessment of any sexual situation encountered.

Depending upon the convictions held toward the safe-sex limit and alternative definitions, and depending upon the perception of a potential sexual encounter, three types of assessments are possible: a.] Adherence to act-dependent definitions [sequences one, two, seven and eight]. b.] Alternative definitions will override act-dependent ones making safe ones unsafe [sequences three through six] c.] Alternative definitions override act-dependent ones making unsafe sex safe [sequences nine through twelve]. In the first, there is no safe-sex-limit motility. Acts regarded as safe or unsafe are regarded equally so during sexual activity. For the second, there is dextral motility. The safe-sex limit will move to the right. For the third, there is sinistral motility. The safe-sex limit moves to the left.

The first two outcomes preclude HIV contagion. Providing act-dependent definitions are biomedically accurate. People will either have safe sex or no sex at all. The third outcome enables contagion. Unless one is luckily accurate in his assessment, he is likely to perform unsafe sex with a seropositive partner. The more people he has sex with where safe-sex-limit sinistral motility occurs, and the greater the proportion of them who are seropositive, the more he is likely to become seropositive himself. This model is depicted in **FIGURE EIGHT** on the next page.

FIGURE EIGHT

THE SAFE-SEX-LIMIT MOTILITY MODEL
[Flow Chart]



What are the weaknesses of this model? There are several. First, it is a reification. It takes human action and organizes, classifies, and typifies it. By doing so, it objectifies and transforms it into something other than what it is. Action is no longer understood on its own terms but within a theoretical framework. As Berger and Luckmann [1966:89] state:

> The objectivity of the social world means that it confronts man as something outside himself.... Typically, the real relationship between man and his world is reversed in consciousness. Man, the producer of the world, is apprehended as its product, and human activity is an epiphenomenon of non-human process. Human meanings are no longer understood as world-producing but as being, in their turn, products of "the nature of things."

Admittedly, the model is guilty of this - as are all abstractions of everyday life. The question, therefore, is not whether this is avoidable, but whether it is counterproductive to the model's purpose.

Certainly, implicit faith in social theory for its own sake may lead one to lose sight of the action upon which it is built. We are well warned of this by proponents of the "sociology of everyday life." [notably, Douglas, 1970; Zimmerman and Pollner, 1970] When expediency and practicability are considered, however, reification is often unavoidable. If a social problem exists, we are not only morally bound to end it, but as soon as possible as well. When we ask "How can we prevent this?" therefore, we inevitably guide ourselves to the most utilitarian response. A theory designed to combat undesirable action should not be

judged upon the extent to which it encases this action but, rather, the extent to which it can accomplish its intended task.

A second weakness - or, more aptly, an impending criticism - is the model's overreliance upon cognitive processes. It may easily be regarded as psychologically reductionist. First, it must be determined what is meant by this phrase for it has often been hurled like an epithet at micrological explanations. If it is an insistence that social theory, to be such, must steer clear of all human internal processes, then it is no more than a purist attitude grounded in polemics. If anyone, Blau [1964] has provided us with a solid case against this. If, on the other hand, it means that a theory has reduced emergent phenomena to internal processes, this is certainly valid. What must be determined, therefore, is whether or not the model is guilty of this.

First, what are these internal processes? Essentially, there are four: a.] The examination and interpretation of information. b.] The formation of a safe-sex continuum with a fluctuating limit. c.] The development of alternative definitions. d.] The assessment of a sexual situation. All are ultimately reducible to the social world. People examine, interpret, assess, and organize information not because of any fixed internal predisposition but on the basis of what they **know** from previous interaction with others. What takes place internally, therefore, ultimately begins externally and, in turn, contributes to it. Interaction is transformed into meaning which leads to further interaction, and then

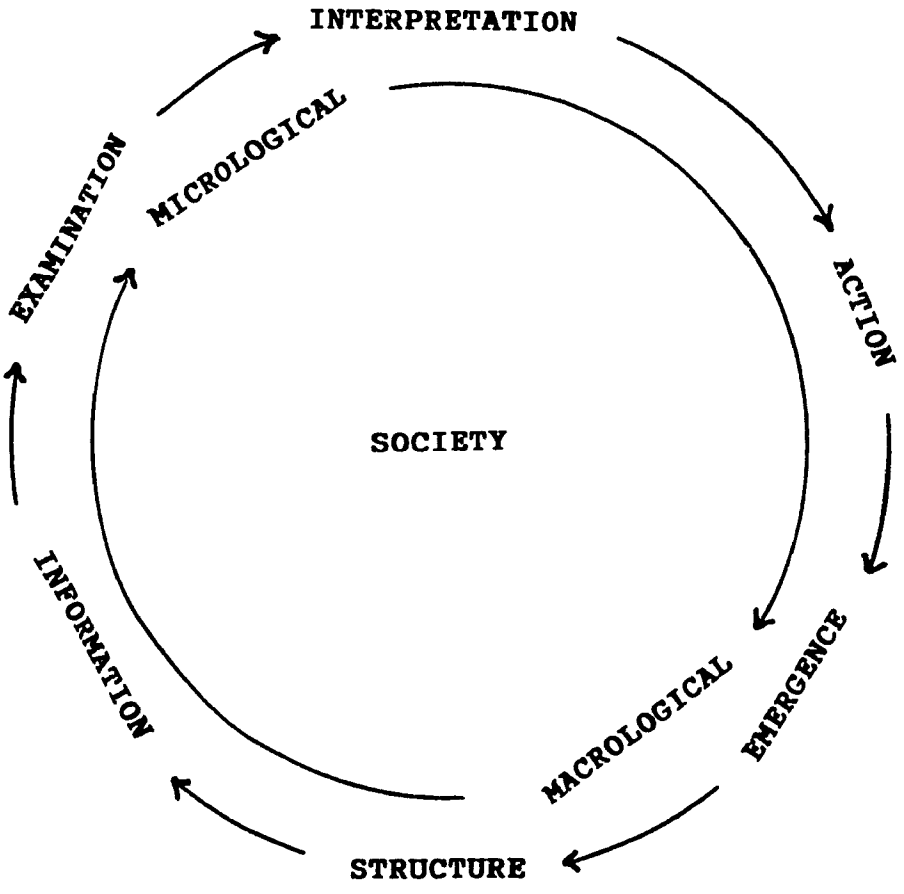
further meaning, and so on. The model is therefore not psychologically reductionist. It merely devotes itself to one section of a never-ending cycle of social action.

This leads to a third criticism - the model is overly individualistic. It ignores the influence of emergent social phenomena upon behaviour. Most interactionist explanations are guilty of this just as structuralist explanations are guilty of ignoring the creative role of the individual. The former reduces action to individual interpretation - as if all it draws from is uniformly inert; the latter begins with structure - as if it sprang from nothing.

The "micro-macro link" has become an important theoretical concern over the past two decades. Giddens [1976, 1984], Alexander [1982] and Habermas [1984] have all called for the incorporation of both emergence and the individual in social theory. Their concerns are certainly valid. If action was solely dependent upon interpretation, it would either be random or driven by internal predispositions; if dependent upon structure, if would all be alike and people would be mere mediums for its performance. Obviously, it is both and I am not insensitive to this. Society is best seen as a cycle as shown in **FIGURE NINE** on the next page. Once people examine and interpret information, they decide upon the most appropriate action. This action often becomes repetitive and, in turn, leads to the emergence of norms, values, institutions, large systems, and so on. These emergent forms are a large part of the information people encounter which they examine, interpret, and transform into action once

FIGURE NINE

THE MICRO-MACRO LINK BETWEEN INTERPRETATION AND STRUCTURE



again. To reduce action to emergence or interpretation, therefore, is to distort the cycle of society. Action is not only equally dependent upon both, but just as much so upon all "stages" before and after each.

The model does **not** deny the determinate nature of emergent phenomena, therefore. It merely devotes itself to a particular segment of the cycle of society. If other research was to find safe or unsafe sex to be dependent upon a group of norms, the political climate, or a particular communal structure, it would in no way be incompatible with the safe-sex-limit motility model. For all of this is still information which people come by, examine, interpret and, ultimately, transform into action. Blumer [1969] has brought to our attention the influence of interpretation more than anyone else. His adamant denial of structural influence, however, is unnecessary. For in no way does structure weaken the determinant nature of interpretation, and in no way does interpretation detract from that of structure. Each is an intergral part of a cycle and neither one alone can fully explain what we see around us.

Although the model itself has not mentioned structural determination, I have dealt with it in this thesis considerably. In chapter one, I discussed the socio-political climate in the gay community over the past four decades. Oppression, political unrest, emergent sexual norms and values, and gay pride have all contributed directly to sexual behaviour as we know it. In chapters two and four, I discussed AIDS education and the news media. The stigma of

homosexuality, family values, political expediency, the moral dialectic, and capitalism have again had influence. Collapsed into the categories "educational efforts/news media" and "emergent phenomena," they appear in the second row of **FIGURE EIGHT**. They are information examined and interpreted, and ultimately transformed into action. To say that structure has **no** influence because people interpret it differently is not logical. Many do interpret it in the same way and this is what makes society possible. Structure **can not** bypass interpretation however. It can only influence it by nature.

A third criticism may be that the model makes assessment of sex partners seem conscious and calculated - as though one were buying a car or inspecting a peach for ripeness. To address this, it is first necessary to look at the meaning of these words. When people assess a situation, they are, in effect, interacting with themselves. They must point out its components to themselves, examine them, attach meaning to them, imagine the various ways they can act, disregard some, choose others, decide upon one, and so on. To the extent that these processes take place, assessment is certainly conscious and calculated. They do not, however, necessarily suggest a sort of "slow conscious dialogue" such as: "Well, let me see. Does this guy have AIDS? Well, this could indicate that he does. Then again, this says that he doesn't. Hmmm." Since we must **always** interpret a situation before knowing how to act, assessment must take place. Often, however, this takes place instantaneously as meaningful symbols arise. To say that it has a dialogue-like quality is to misrepresent it.

Finally, it can be said that the model does not deal adequately with sexual desire. We may calculate the probability of contagion for each sexual encounter, but how is this calculation influenced by intense sexual attraction, "horniness," or even love? We know from past research that people are more likely to attribute positive traits to someone perceived as attractive. [Berscheid & Walster, 1972; Cash & Janda, 1984; Kaczorowski, 1988] This can certainly account for a great deal of this effect. But what about cases where meaningful indicators are acknowledged but somehow ignored, suppressed, or whitewashed? ["Yes he's promiscuous and wild but he's so attractive and I haven't had it for so long that I don't care!"] The risk is acknowledged but accepted for future gains. Here, Homans's value proposition [1967:25] would well apply. Since this goes against my primary assumption about risk [Proposition One], strong sexual desire can well be a rival explanation to why people have unsafe sex. It is the desire, in other words, that leads to this and not the assessment of low risk. In these cases, I suggest that a form of bargaining takes place. ["Yes I'll go through with it, but I'll be damned careful."] In this way, meaning is still attached to risk so as to minimize it. Unsafe sex, in other words, it still **made safe.**

The Safe-Sex-Limit Motility Model promises to account for a great many cases of unsafe sex. It does not assume that this happens out of ignorance of the biomedical guidelines

but, rather, through differential interpretation of meaning before and during sexual encounters. It suggests two things: First, we must re-examine all AIDS-avoidance messages for their potential to encourage alternative meaning construction. It may well be the well-intentioned messages encouraging people to see partners or contexts as safe or unsafe actually encourage unsafe sex. Second, we must cease to see people as mere mediums for fixed action intitiated by external stimuli and, instead, as actively constructing this action through interpretation. To say that everyone is different is a platitude. It is this difference in and of itself, however, that leads to differential behaviour. If we wish to understand this difference, therefore, we must look at the different ways in which people see their everyday lives.

* * * * * * *

CHAPTER SEVEN

RESEARCH METHOD AND METHODOLOGICAL ISSUES OF RESEARCH

All sociology necessarily begins with the understanding of everyday life, and all sociology is directed to either increasing our understanding of everyday life or, more practically, to improving our everyday lives.

[Jack D. Douglas, 1970]

CHAPTER SEVEN

In the introduction to this thesis, I told the story of Mike and his assessment of a young man he saw in a bar. I did this to show that the safe-sex-limit motility model comes ultimately from everyday life. The journey from Mike to the model has been long and strained - punctuated by much reflection, re-examination, and revision. Now that the journey is finished, the model floats in an abstract world as far away from everyday life as possible. It is now time to bring it back - to pack it up intact, lay it atop of the empirical world, and see if it performs the function it was built for - to explain! If it is a good model, action will take place comfortably within it; if it is not, this same action will strain at its sides and eventually destroy it.

What then do I want to test? The model makes several statements. First, when people feel susceptible to AIDS, they will seek, examine, and interpret information and eventually polarize sex acts. This leads to a safe-sex limit. What must be determined, therefore, is whether sex acts are indeed polarized and if a safe-sex limit has formed. This is the topic of Chapter Eight. Second, the processes from information seeking to interpretation lead to the formation of partner- and context-dependent definitions based on already possessed meanings gained from past experience. I discuss these alternative definitions in Chapters Nine and Ten, respectively. Third, people assess the risk of each

sexual encounter on the basis of meanings apparent to them. They do this with the the documentary method and on the basis of several principles put forth in the tridimensionality of sex. This is the subject of Chapter Eleven. Finally, HIV contagion is dependent upon both the number of different partners and safe-sex-limit motility. I discuss these in Chapter Twelve.

To see if these things actually take place, I must return to everyday life - namely, the gay cruising world - and gather data. I must look at what people do and talk to them about their sexual experiences. This chapter, therefore, is a discussion of how I have done this. I divide it into five sections: a.] Overall method of data collection. b.] Operationalization of concepts. c.] Sampling. d.] Interviewing. e.] Field observation. Each has its unigue set of problems as well as advantages. In the discussions, I emphasize both.

1.] OVERALL METHOD OF DATA COLLECTION.

In total, I interviewed 35 homosexually behaving males. I did this in two time periods - January to March, 1988 [N=20] and November to March, 1990 [N=15]. I solicited the first group for work done in an honours seminar as a precursor to this thesis. Since the nature of the interviews are similar, the data are well usable. Also, since the epidemic was already several years old in 1988, the essential

polarizations had ample time to develop. I solicited the second group specifically for this thesis.

The entire sample ranged from 18 to 55 years of age with a mean of 27.8 years. Some had been sexually active for decades while others less than a year. Thirty were able to recall the exact amount of time making the mean for this group 11 years. They came from a wide variety of socio-economic levels and backgrounds [prostitutes to medical scientists] and had varying levels of education [some high school to post-doctorate]. As with many convenience samples [Higbee & Wells, 1972], students are over-represented. A summary of the sample appears in **APPENDIX TWO**.

I interviewed each person for 30 to 60 minutes. I used a schedule with about twenty questions but did not rigidly adhere to it. This method emulated Lee's [1979] style in his study of gay sadomasochism where he encouraged his sample to "tell his own stories." I interviewed most in person and was able to tape-record almost all. I transcribed each interview coded all relevant sections.

Although the interviews are the main source of data, I augmented them with field observations. On several occasions each, I visited cruising bars, bathhouses, and outside cruising areas of four major cities - three Canadian and one American.

With polarizations, assessments, safe-sex-limit formation and motility in mind, I draw extensively from the interviews and to a lesser degree from the field observations in the analysis.

2.] OPERATIONALIZATION OF HOMOSEXUALITY.

As Cass [1983/84] says, researchers have shown little concern for precision in terms related to homosexuality. Consequently, definitions are often ambiguous and sweeping. Up to now, I have used the phrase "gay men" as if it were synonymous with all men having sex with men. I have done this and will continue to do so for convenience. In reality, homosexual identity and behaviour are complex issues. The term "gay" denotes a specific way of regarding homosexually behaving males. It refers to an acquired identity [Weinberg, 1978, 1983; Lee, 1979; Troiden, 1979, 1988] drawn not only from such behaviour, but a specific attitude toward the social and political oppression it faces as well. It is a concept only of this century and, before, it did not exist. [Foucault, 1986] To refer to Socrates or Leonardo da Vinci as gay is to be temperocentristic. With this in mind, it can be seen that only some homosexually behaving males are gay. The rest either see themselves as heterosexual, as do many male prostitutes [Reiss, 1961; Allen, 1980; Boyer, 1989], or find various ways to avoid such self definition. Hencken [1984] describes 16 techniques of neutralization for this purpose [e.g. "Its not really sex"] not unlike those Cressey [1953] describes used by embezzlers.

Bisexuality is another problematic concept. Although it is often thought to mean "half homosexual, half heterosexual," it is, rather, a full potential for both. A bisexual male may be attracted to men equally or even more so than a homosexual one. One orientation in the same person

does not necessarily dilute or halve the other. [Blumstein & Schwartz, 1976] Second, bisexuality has often been met with suspicion. Rather than being a legitimate coexistence of orientations, it is seen as an attempt to be heterosexual [West, 1955; Beiber et al., 1962] or a way to avoid the full stigma of homosexuality. [Altman, 1971; Austin, 1978] Lastly, unless having sex with at least two people, there is no such thing as a "bisexual experience." Sex is either homosexual or heterosexual.

For my sample, I was not so much concerned with identities or labels as I was in actions and intentions - for it is these that enable AIDS and not any way of regarding oneself. I therefore considered any male who had sexual experience with other males or with a strong desire to do so. As it happened, most identified themselves as gay, several as bisexual, and one as heterosexual even though his sexual experience with men was considerable. The sample also includes one 18-year-old male with a strong gay identity but no previous sexual experience.

3.] SAMPLING.

Much social research infers characteristics of a population from those observed in a probability sample. [Williamson, Karp et al., 1977; Babbie, 1989] This method has yielded high levels of accuracy and is undoubtedly a useful one for generating knowledge. Even though general inference

would often be best, however, it is not always possible. Probability sampling has at least two prerequisites that limit its use: each member of the population must be readily identifiable and each must be readily available. Neither is the case with homosexually behaving males. First, as I showed above, this is a concept eluding definition. [Bell, 1975; MacDonald, 1984; Suppe, 1984] If we look only at those who behave homosexually, we exclude others whose orientation is such but behaviour is otherwise. Married men often have strong homosexual desires but never act on them. If we look at erotic orientation, we exclude those who behave homosexually but are otherwise heterosexual. Included here are prison inmates [Richmond, 1978; Propper, 1981] and many male prostitutes. And, if we look at identity, we exclude all who behave homosexually but consider themselves heterosexual. Second, homosexuality is stigmatized. Many, therefore, will never admit to homosexual feelings, behaviour, or otherwise.

Past attempts at generalization have often been methodologically unsound. Beiber, et al. [1962], for example, concluded that homosexuality is caused by an over-attachment to one's mother and/or a weak, inneffective father. His sample, however, not only came from psychoanalysts' files but were chosen for their potential to display the expected characteristics. [Paul, 1984]

Research upon sampling elusive populations [Sudman & Kalton, 1986; Sudman, Sirken & Cowen, 1988; Watters & Biernacki, 1989] but has rarely mentioned homosexual males. A notable exception is the recommendations of Weinberg [1970]

used by Jay and Young [1977], Tudiver, Myers et al. [1989] and others. Subjects are obtained from a multitude of sources [bars, bathhouses, magazines, parks, recommendations, etc.] so that the sample includes many different types. Even so, this still cannot include the large group "in the closet."

In view of these problems, universality cannot be statistically inferred. Although this is preferable, however, it is not essential. The model does not imply characteristics of gay men but, rather, ways of making sense of a particular area of everyday life. My purpose is not to demonstrate universality or determine correlations with other gay-related variables but, rather, to show the existence and nature of polarizations, assessment, and safe-sex-limit motility. If their universality is to remain theoretical, then judgment of this must depend upon the quality of theoretical logic and not statistic inference.

Since probability sampling was not possible, two choices remained - snowball sampling and convenience sampling. The first had at least two problems. First, as a long-time member of the gay community where I would obtain the sample, I would likely run into people I know. Any interviews in these cases would be on dubious ethical and methodological grounds. Second, since the nature of the interviews is highly intimate, subjects knowing others in the sample would be counterproductive. If one had had sex with another, for example, this may colour his responses. Lesnoff [1956] described similar problems where interviewees tried to get him to take sides in quarrels. Convenience sampling avoids

such problems and this is the method I used. I solicited both groups [1988 and 1990] through ads in various nespapers. Since gays are often distrustful of researchers' motives [Warren, 1977; Joseph, Emmons et al., 1984], I specifically mentioned my own sexual orientation ["Gay sociology student seeks..."] to avoid this. Lastly, although the response was overwhelming, the number of serious ones was not. I interviewed thirty-five people in all.

4.] INTERVIEWING.

The purpose of the interviews was to obtain data upon the meanings and relationships of sex acts, partners, and contexts. Much was therefore intimate in nature and problems were anticipated. Would the person refuse to answer certain questions? Would others make him feel uncomfortable? Would his responses be coloured by anticipation of my judgment? These are the steps I took to reduce the chances of such problems. First, during screening, I told each that questions would involve AIDS and sexuality. As I said, I want to know what people think and do. Those who agreed to be interviewed, therefore, expected intimate questions. Second, I made my own sexual orientation known. This minimized embarassment and anticipation of judgment. Third, I made every effort to conduct the interviews in a relaxed atmosphere - usually my home or theirs. Fourth, I chatted with each about twenty minutes before interviewing. This further put them at ease.

Lastly, if I sensed anyone having difficulty using frank sexual language [e.g. "blow job"], I made a point of using such terms in subsequent questions. This seemed to put them at ease more than anything else. Whether due to these safeguards or not, the flow of intimate information was not a problem. This would seem to support contentions [DeLamater & MacCorquodale, 1975; Johnson & DeLamater, 1976; Darrow, Jaffe et al., 1986] that these obstacles are greatly exagerrated.

While lack of familiarity with the subject matter of research does have its advantages - for instance, no biases or preconceptions about what is important [Glaser & Strauss, 1967] - the opposite is also true. Since I am familiar with the folklore of the gay community, I was able to elicit stories that would have otherwise not been told. One person, for example, related a bar experience based on inside information. Had I not already known this information, the story's meaning could not have been conveyed. Others used terms such as "not well" or "camp" with indexical meanings learned by experience rather than definition. Again, familiarity paid off. Most of all, however, familiarity proved to help greatly in reducing anxiety. Since the subjects saw me as having had similar experiences to theirs, they were able to feel comfortable.

About a third of the interviews were carried out over the telephone. These people were reluctant to meet me for various personal reasons. Although this provides some barriers, it also has the advantage of anonymity which is conducive to the flow of intimate information. Second, this

group differs from the others in openness, its inclusion is sure to give additional diversification to the sample.

As I mentioned, I used an interview schedule but as a guide more than a rigid list of questions. This proved advantageous since many provided me with useful information I did not ask for. I asked some questions, however, to all members of the sample since they were vital to the research.

Lastly, in keeping with the guidelines of the Committee for Protection of Human Participants in Reasearch and the Committee on Gay Concerns [1986], I debriefed each person after the interview. Here, I had three concerns: a.] To explain my research. b.] To ensure that the person feels he has contributed positively by relating his experiences. c.] To correct any erroneous safe-sex beliefs as much as possible. Although most people's knowledge was in keeping with the biomedical guidelines, a few lacked proper information. One, for example, firmly believed that insertive anal intercourse was biomedically safe while receptive anal intercourse was not. Discussing this therefore, reduced the chances of later contagion for this person or his partners.

5.] FIELD OBSERVATIONS.

Since homosexuality is stigmatized, gay men are obliged to meet each other within specific settings. Not only do they provide safety but, more importantly, render a homosexual orientation academic. While meeting a gay man in a general

setting is the exception, it is the norm in a gay meeting place. Consequently, such places have existed in North America for four centuries. [Katz, 1976]

Although there are many ways of "getting sex" [for an excellent description, see Lee's book (1978) with this title], sex partners are commonly found is established gay meeting places. For additional data, therefore, I visited the following settings in three major cities: a.] Bars [N=18]. b.] Bathhouses [N=3]. c.] Cruising parks [N=2]. For the bathhouses, I was able to take notes immediately since I had a private roomette. This was not possible in the other places so I did so either later the same night or the following morning. I made these observations to augment the interview data. They are not necessarily the focus of analysis. Since many places I visited were mentioned by the respondents, however, they helped to provide a greater understanding.

I present the analysis in PART THREE. Although I maintain that my findings are typical of the ways in which people examine, interpret, assess, and act in sexual situations, I make no statistical inferences for the gay population. My research explores these ways; it does not quantify them. Any general statements, therefore, are meant to be theoretical.

* * * * * * *

PART THREE

CHAPTER EIGHT

THE POLARIZATION OF SEX ACTS AND THE SAFE-SEX LIMIT

If a gay man is quite unattached, then there's no harm in his having as much sexual experience as he wants.

[The Joy of Gay Sex, 1977]

CHAPTER EIGHT

Sociologists are often accused of flogging the obvious, and this chapter could be a prime example. Everyone knows sex acts are polarized since we hear about safe and unsafe sex everyday. So why bother discussing it? There are at least two reasons, both closely related. First, things become obvious when they are commonly agreed upon as such. The more readily people agree with each other about what they see, the more obvious something is. This puts the burden of truth upon the degree of consensus, not the thing itself. Something is so not because of any quality it might have, but because people see it as such. If consensus never changed, this would not be a problem. Inevitably, however, it does. So many things obvious at one time or another are now seen differently. The sun revolved around the earth, woman had no sexual desire, Europeans were intellectually superior, and so on. Ironically, we do not now see these things differently because they have changed; what has changed is the consensus about what is obvious. Second, "obvious" is often synonymous with "should be so." This, more than anything, blinds us to hidder mechanisms that lead things down not so obvious paths. Gay men molest children in spite of statistical evidence to the contrary. All Jews are rich in spite of those who are poor. A person who knows the dangers of AIDS will have safe sex inspite of the many that do know and don't.

Inquiry ending with consensus or what "should be" places

the cart before the horse. Rather, it must bypass such views and begin at the thing itself. If something is obvious, then it must be considered such because of things apparent about it, not people's agreements or ideologies. Agreement as proof is the nature of ignorance; agreement from proof is the nature of science.

In this chapter I place myself in good company and spend time flogging the obvious. The model states first that sex acts are polarized; some are regarded as safe and others not. It also states that the very consideration of acts as safe or unsafe is to regard their performance in the same way. Those polarizing sex acts, therefore, have formed a safe-sex limit. I explore all this in the responses of those interviewed.

I also devote time to a subject many would consider exploitive or unnecessary - the sex acts themselves. These are further considered obvious. Whether out of discomfort, distaste, or disinterest, however, homosexual sex is still a mystery to many and, consequently, many misconceptions and myths prevail. These must be dispelled. Sex acts are the very units of HIV transmission. A discussion of what gay men actually do, therefore, is not only necessary but essential.

I divide this chapter into two sections: a.] Sex acts. b.] Sex-act polarization and the safe-sex limit. The first relies primarily upon the literature and, to a lessor extent, past conversations I have had with gay men. The second looks at the responses of the interview sample.

1.] SEX ACTS.

What do you two guys do with each other anyway? Although this question can arise from righteous indignation, it is more often asked out of genuine ignorance. Sex, to many, must not only have both a penis and vagina, but includes roles rigidly defined by these organs. When no vagina is present, or no penis in the case of lesbians, sex is a mystery.

One way of demystifying it is to assume that roles are somehow imported. When psychiatrists were custodians of homosexuality, they maintained that gay men were either active or passive, feminine or masculine, "husbands" or "wives," etc. The first, manly, well-built, and "normal" in appearance is the insertor during anal intercourse and the recipient of fellatio. The second is slight, effeminate, coy, and takes the opposite roles. Consequently, literature long forgotten is filled with such dichotomies [Wortis, 1940; Fenichel, 1945; Bergler, 1957; Miller, 1958; Beiber et al., 1962; Holemon & Winokur, 1965; Socarides, 1968] that have since been adopted by popular culture. Thus, they are part of what is "obvious." As one woman asked me years ago, "Are you a pitcher or a catcher?"

A belief in the predominace of active and passive types strongly indicates a confusion of sex roles, <u>sexual</u> roles, and sexual orientations. Since men and women are regarded differently, it is thought that they should act differently during sex. What is done sexually is not determined by likes and dislikes, but by sex. Sex difference is what makes sexual

activity possible. It is no wonder many see sex between men as impossible. No difference exists and, thus, no roles to enable it. They must import these roles by adapting to them.

If this were true, not only would there indeed be a predominance of the two types, but all relationships would have one of each. Harry [1976/77] dispelled the first belief. He distributed a questionnaire in a variety of gay settings [community centres, bars, etc.]. For each of the four sex acts [active and passive anal intercourse and fellatio], he asked gay men to choose one of three responses: :"don't like it," "it's okay," and "prefer it." Two hundred and forty-three returned questionnaires were usable. As it happened, both preference sets were in the minority and most reported liking all acts.

Since there has been much research on gay couples over the last decade, much exists to refute the second belief. [Tuller, 1978; Harry & DeVall, 1978; Peplau & Cochran, 1981; Peplau & Gorden, 1982; Larson, 1982] Rather than importing heterosexual roles, gay men tend to form "best-friend" relationships to which they add sexual intimacy. Rather than being dismayed over the loss of sexual roles, many revel in the freedom. A lack of roles does not limit sexual expression, in other words, it diversifies it.

To prevent the transmission of AIDS, knowledge of the frequency and nature of sexual behaviour is essential. Consequently, past studies of homosexual sex have gained new importance. Although their were earlier attempts [e.g. Krafft-Ebing, 1886/1965; Ellis, 1897/1975], the first

worthwhile one came from Kinsey and associates. [1948] In their sample, 37% had "at least some overt homosexual experience to the point of orgasm" during their lifetime and 10% were exclusively homosexual. [p.650-651] Although this latter proportion is difficult to confirm, it is generally accepted today as the size of the gay male population. [Gay politicos often make it higher while the religious right make it lower.] Although their research was exhaustive, they offered little insight into the nature of homosexual activity beyond youthful sex play. This may be partially due to their assertion [one quite correct] that homosexual behaviour is defined by the participants' sex rather than their activity. [p.616] They do say much about sex acts in general.

In the 1970s, Jay and Young distributed one of the most detailed questionnaires ever among gay men. [Mine, I recall, took several hours to fill out.] The results were published in The Gay Report [1977] and it is the most comprehensive survey to date. [I cited their findings on multiple partnering in chapter one.] I will mention only that relevant to the transmission of AIDS. For fellatio, 74% [N=4,329] performed it "always" or "very frequently" and 72% gave the same responses for receiving it. When ejaculation was involved, these proportions fell to 40% and 38% respectively. For anal intercourse, the proportions were lower still. Twenty-three per cent performed it always or very frequently while 26% received it. This is encouraging since the act most enabling of HIV transmission is not as common as expected. It is also encouraging that safe acts such as hugging and

kissing are most common and unsafe esoteric ones are rare.

About the same time, Bell and Weinberg [1978] carried out another survey. Of nearly 700 males, 54% performed fellatio and 55% received it once a week or more. These figures fell to 24% and 20% respectively for anal sex. For favourite act, the modal responses were receiving fellatio and performing anal sex. This seems to reflect the western construction of sexual expression as both genital and penetrative. Although both surveys found nonpenetrative sex common, it was more of a prelude to fellatio or intercourse. This may be changing. Since penetrative sex now carries a different meaning, many have placed higher value upon other forms. As one of my own respondents said:

> I've decided that there are things I just don't do anymore, and its frustrating.... [But I am] more aware of the total body and sex as an experience [aside] from just coming (ejaculating). That part of it I actually like. I'm finding that certain nongenital acts can become even more erotic than the standard bit, so that's really nice. I think that had it not been for the whole safe-sex thing, I would've been much slower to realize this.
>
> [Choreographer, age 31]

We still know little about homosexual sex. We do not know if this comment is representative. We do not know which acts tend to occur together, how acts are negotiated [although Tripp (1975) and Simon and Gagnon (1987) offer some insight], how they are learned and enjoyed, and so on. As Coimbra and Torabi [1986/87], Cassidy and Porter [1989], Corballo, Cleland et al. [1989], and Abramson and Herdt [1990] have all suggested, all of this ultimately arms us for the battle against AIDS. To change behaviour, we must **not**

rely on assumptions about what is obvious. Rather, we must go directly to this behaviour and study it on its own turf.

Sexual activity is in many ways universal. Much truth lies in the assertion that sex is sex wherever one goes. But it also varies. An abundance of historical [e.g. Licht, 1952; Eglington, 1964] and cross-cultural material [e.g. Churchill, 1967; Gregerson, 1983] attests to this. Its nature is at least partially determined by culture and nowhere is this more apparent than in the changing economic, political, and ideological outlook toward masturbation. While once a private act, it is now the quid pro quo of a growing erotic telephone business. Gay community newspapers such as RG [Montréal], Gaybeat [Ohio], and Gayly Oklahoman [Oklahoma] now devote several advertising pages to these "976" numbers. It is also encouraged in AIDS education media. The Gay Men's Health Crisis, for one, has a safe-sex comic book depicting an erotic telephone encounter between two men. An act once juvenile at best and sinful at worst is now a legitimate way to deal with sex urges and, ironically, a way of contributing to the economy.

Whether sexual energy is being drawn away from unsafe acts and toward masturbation is not known. This would seem a prime topic for research. What is apparent, however, is that the nature of sexual activity is not fixed but fluid. It is sensitive to emergent phenomena. The fact that even masturbation can fall into the "invisible hand" of a market economy gives new fuel to old cynics. ["Is nothing sacred

anymore?"] The fact that emergent phenomena can play a key role in changing sexual behaviour gives us encouragement and focus. We must be receptive to the ways in which culture affects sexual expression. But we cannot do this without knowing how people see their everyday lives. This is the central concern of this thesis and, I hope, its contribution.

2.] SAFE-SEX POLARIZATION AND THE SAFE-SEX LIMIT.

Before I explore the ways in which respondents saw sex acts, two points must be made. First, whether or not acts were polarized depends upon definition. Polarization suggests two extremes with a continuum in between. Dichotomization, on the other hand, suggests only the two extremes. Masculinity/femininity exemplifies the former while male/female exemplifies the latter. Many referred to sex acts as either safe or unsafe and, thus, may have only seen a dichotomy. Others mentioned gradations as in the following:

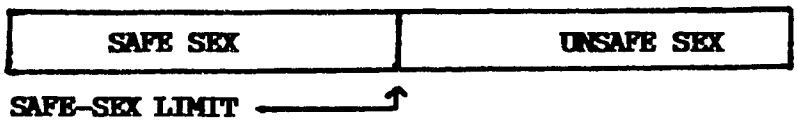
> There are three divisions. There's absolutely safe sex, moderately safe sex, and risky sex. In this category is anal sex without a condom and possibly also fellatio - swallowing semen. In moderately risky sex, I think people have listed fellation - not using a condom, even if you don't swallow.... Especially safe are things such as mutual masturbation, touching, rubbing, etc.
>
> [Student, age 25]

Others listed certain acts as "iffy," "supposedly [unsafe]," etc. Even though some may see only a dichotomy, I will use the term "polarization" since this does not affect the

original propositions. Even with only two categories, a safe-sex limit still exists. Instead of it being on a given point of a continuum, it is located at the midpoint as in **FIGURE TEN** below.

FIGURE TEN

THE SAFE-SEX LIMIT IN A DICHOTOMY



Thus, even though gradations may not exist, **all** respondents polarized sex acts; some are considered safe, others not. This has occurred as a direct result of encountering, examining, and interpreting AIDS-avoidance information and is fixed **prior** to entrance into any sexual situation.

The second point concerns the existence of the safe-sex limit. While some respondents mentioned only the risk of an act ["this is unsafe," "there's no risk in that"], others defined it in terms of **their** performance ["I would never..."]. Does only the latter indicate a safe-sex limit? As I stated, to see an act as safe or unsafe is, by definition, to see its performance in the same way. If one sees mutual masturbation as safe, he also sees **his** engaging in it as safe. In view of this, all statements of risk indicate a safe-sex limit.

To begin with, most respondents had accurate knowledge. [For a summary of biomedical guidelines, see **APPENDIX ONE.**] When I asked, what safe sex meant to them, the following answers were typical:

> Definitely the use of condoms if you're going to go for anal sex.
>
> [Student, age 22]

> Oral sex... if you really want to be safe, you should use a condom. Its not that you're going to get it if you swallow it [semen] or anything, but like if you have any cuts in your mouth like even if you brush our teeth, you're going to have open sores.... there's pre-cum. [pre-seminal fluid]
>
> [Student, age 18]

> Kissing and mutual masturbation and rolling around and hugging and so on [is safe].
>
> [Unemployed man, age 36]

While research conclusions about the risk of unprotected anal intercourse are definitive, other acts such as fellatio or kissing are said to be "low risk." Consequently, as Fineberg states [1988], many are uncertain about what to do. This is reflected in several responses as follows:

> There are conflicting opinions about kissing so I would not put that as safe.
>
> [Choreographer, age 31]

> I still don't know about oral sex. Some sources like pamphlets say that you should use a condom. Others... say that as long as you don't swallow, you're okay. Others say what the hell, do it.
>
> [Student, age 18]

> If you kiss a person, you can get the saliva... supposedly, you can get the AIDS virus.
>
> [Unemployed man, age 28]

This uncertainty is not the result of somehow missing the proper information; other knowledge shows they had come across a great deal. More likely, it is just as they say - sources ["opinions," "pamphlets"] either vary ["conflicting"] from place to place or they make ambiguous statements ["supposedly"]. Some tended to make up their own minds. Naturally, this varied:

> I believe that oral sex is safe as long as you aren't bleeding with open sores in your gums because I've read enough that I think unless you have that open sore or something, you're safe.
>
> [Office worker, age 28]

> Some people say that you should use a condom [for fellatio] but that's kind of ridiculous. As long as the other guy doesn't cum [ejaculate], you're okay.
>
> [Unemployed man, age 34]

> [A friend] asked me do you use a condom for a blow job and I said of course.... That's just common sense to me.
>
> [Student, age 21]

> Taking cum in your mouth I don't believe to be a safe activity. That's just my personal belief. No matter how safe you tell me it is, I just won't believe you.
>
> [Student, age 21]

All were aware of condoms as a measure of protection but quite a few had serious doubts about their effectiveness:

> I don't consider anal intercourse even with a condom safe. They break.
>
> [Choreographer, age 31]

> The condom, I hear, can break. Who knows when it will and when it won't. Some guys get into it really passionately.
>
> [Student, age 18]

> No anal sex period! A lot of people say that anal sex is safe when you're wearing a condom. However, even a condom is risky. I mean something might get through and it might break or whatever.
>
> [Pianist, age 40]

The condom issue is a difficult one. Although it is commonly thought that they break, evidence exists to reduce this to improper usage [Woods, Cleghorn et al., 1989; Smith, Pareja et al., 1989] or the use of oil-based rather than water-based lubricants [Pugh & Englert, 1989; Voeller, Coulson et al., 1989]. Still, laboratory testing yields a mean failure rate of 0.23% [Feldblum & Fortney, 1988] which, considering the fatality of AIDS, is high. Some respondents found ways to reduce this even further:

> Intercourse has to be with a condom. I have friends who use more than one.
>
> [Student, age 21]

> If you're going to fuck, use a condom. It even helps if you use two... I mean doubling it up, although it probably takes the pleasure out of it.
>
> [Student, age 18]

Mixed messages about condoms such as that by The Red Cross [see **FIGURE ONE**] are common in AIDS-education media. This leads a question: Should we de-emphasize their effectiveness or do our best to encourage them along with instructions for proper usage. The former may encourage caution. It may also discourage use entirely. ["The damned things are no good anyway. Why bother?"] The latter would minimize this. If we do de-emphasize their effectiveness, we must do so for disease prevention, not moral reasons. Such dishonesty may

actually hinder AIDS prevention, not help it.

During my visits to bathhouses, I was impressed with the visibility of condoms. They were dispensed freely at the door, posters and pamphlets encouraged them, and quite a few carried as they peered into roomettes looking for sex. For those in roomettes, lying on one's stomach is commonly an invitation to anal sex. [Styles, 1979] Many did take this position but, often, a condom was plainly visible on the table beside the cot. There was also unsafe sex. In one bathhouse, it was common to leave one's door open while having sex as an invitation to a third or fourth partner. I witnessed anal intercourse on a number of occasions and, occasionally, it was without protection. Without a proper survey, it is impossible to determine the frequency of safe of unsafe sex in any area. The fact that some continue risky behaviour while others do not, however, is sufficient to conclude that the meanings attributed to it are far from uniform.

Although sex-act polarization is thought unique to the 1980s, a few indicated this took place for them long before:

> I've always used a condom so it doesn't affect me one way or another. It was generally because of sexually transmitted disease other than AIDS but it turned out to my advantage.
>
> [M Jel, age 36]

> I've always been very safe anyway. Even in the seventies, I was always very worried about catching things like syphilis and gonorrhea so I've [good] reason. AIDS is just basically an extension of that for me.
>
> [Pianist, age 4?]

Gay men were certainly concerned about STD before AIDS and, in this sense, the greater the concern the greater the sex-act polarization. The fact that none were fatal, however, prevented this from fully developing. Often, they took the following view:

> I used to go to [a bathhouse] every once in a while before AIDS was around and go through a whole slew of guys one night. Then, a few days later... oh-oh, I caught something. But then its okay. You go to a doctor and [you get] a shot of medicine or whatever.... They could cure it.
>
> [Lab technician, age 31]

In **PROPOSITION FOUR**, I stated that all acts a person is aware of are polarized - not just those he happens to prefer. This is indicated in the following:

> I don't even like doing it [anal intercourse] when its safe. But it isn't safe.
>
> [Male prostitute, age 24]

Whether an act is distasteful, disgusting, or physically impossible, to conceive of it and place it on the safe-sex continuum is to consider its performance in the same way.

Respondents did not always refer to specific acts or their mechanics. Sometimes their definitions included other meanings:

> It means making intelligent decisions. All of your decisions... should be self-respecting. So why shouldn't that extend to the sexual aspects of your life as well?
>
> [Caterer, age 29]

Other times, they merely parroted media rhetoric ["Don't exchange bodily fluids."]. In total, however, all had definite ideas about what they would and would not do. Their

safe-sex limits were both present and fixed. The educational model would stop here. Well-informed people will not engage in unsafe sex. This must be kept in mind for the final two chapters of this thesis. Here, I show how fixed definitions of unsafe sex are altered - **how unsafe sex is made safe.**

* * * * * * *

CHAPTER NINE

ALTERNATIVE DEFINITIONS OF SAFE SEX:

SEX PARTNERS

Things and actions are what they are, and the consequences of them will be what they will be: why then should we desire to be deceived?

[Bishop Butler, 1692 -1752]

CHAPTER NINE

Life is a never-ending succession of categorization. We anticipate our experience, recognize it as familiar, organize it, and assign it to waiting categories. A thousand units of experience are sorted in an instant. If we see a man in a hospital dressed in white, preoccupied, stethoscope around his neck, he is "a doctor." A woman seated in a classroom taking notes is "a student." Someone walking a dog "lives nearby." People in movie theatres "have bought tickets." A boy red-faced and screaming "is angry." An old man sitting on a porch in mid-afternoon "is retired." We assign meanings to **all** whom we see based upon their appearance, actions, dress, traits, etc. All of these meanings are inferences for we never know absolutely - even if we ask.

We experience our sex partners no differently. We encounter them, examine them, select aspects potentially meaningful, interpret these aspects, and assign them meaning. If they fit into categories we have already built from past units of experience, we immediately slot the partner in. He may fit into thousands of categories simultaneously. He may be "tall," "polite," "a smoker," "sexy," "middle class," "well-built," "happy," "a Canadian," "employed," "likely to be seronegative," or "likely to be seropositive." This chapter is about the last two - safe sex partners and unsafe sex partners. In PROPOSITIONS SIX and SEVEN, I stated that people who perceive themselves as susceptible to AIDS,

and who are aware that not everyone is seropositive, will polarize sex partners. They do this because safe and unsafe partners have become meaningful categories to them. They may make the difference between life and death.

I divide this chapter into two sections. In the first, I discuss the strength of meaning safe and unsafe partners have. How important is it to have a seronegative partner? How important is it to avoid a seropositive one? In the second, I explore the meanings respondents assigned to partners. Since the data yielded literally hundreds, they were difficult to organize. Nevertheless, six themes were apparent as follows: a.] Age. b.] The body. c.] Race/ethnicity. d.] Education, intelligence, goals, career. e.] Promiscuity, sexuality, interest in sex, cruising ability. Whether or not partner-dependent meanings are used in risk assessment, they are, by nature, alternative definitions of safe sex. The danger is not in their formation, for this is how we understand an otherwise chaotic bombardment of experience. It is, rather, in their use. This is the subject of the last chapter; this one is about their formation.

1.] SEX WITH SEROPOSITIVE PEOPLE.

A person contracts AIDS by performing unsafe sex acts with a seropositive partner. If his acts are not unsafe [see **APPENDIX ONE**], he will not contract AIDS - regardless of his partner's serostatus. Although partner-dependent

definitions of safe sex are always present, they only become important when this simple fact is somehow missed, not fully believed, or relegated to the background. To determine this, I asked the following loaded question: If you knew in advance that a person was seropositive, would you still have sex with him? As expected, the negative responses far outweighed the positive ones. For those who would not, four reasons were given. First, they were hesitant to place complete faith in "safe sex" or measures of protection. The following reply illustrates this:

> I know that is you have absolutely safe sex, you're not going to get AIDS. But I also know that it takes only one small slip up of a split second and that's it.
> [Student, age 18]

Second, and similar, they did not have complete confidence in the biomedical guidelines:

> No, I wouldn't. I don't want to put myself at risk. Its not worth dying for... When AIDS was coming out in terms of how they were discussing it, every month they were finding something else that would be high risk. Perhaps in five years they'll say that saliva... can be a fluid that passes it.
> [Student, age 23]

The third reason was most interesting. They would avoid seropositive partners since they perceived them as symbols of contamination, fatality, and death. These are not so much reasons for possible transmission as they are for the reduction of pleasure. To perform intimate acts with people perceived in these ways is further perceived as too close to an unpleasant part of life. To be intimate with death is to acknowledge it, to flirt with it, to embrace it. There are

many parallels to this. People tend to be uncomfortable in funeral homes, intensive care wards, old-age homes and the like. They are alive and thus avoid any reminder that this is temporary. Seropositive partners may be seen similarly.

Some admitted their reservations were illogical. They know safe sex precludes transmission. Still, they adhered to them. This can be an indication that the proper selection of partners is important in avoiding AIDS. When this is the case, people are likely to assign highly significant risk meanings to particular aspects of their partners.

The fourth reason is an example of the supremacy of partner-dependent definitions. Sex with someone seropositive is synonymous with unsafe sex itself. This is shown in the next emotional refusal:

> Oh, no, no... never! Because we have an instinct of conservation and life is a gift. To go to bed with someone with AIDS, you have in mind always destruction. Not even all the people I know would go to bed with someone with AIDS. I know someone who said to me I don't give a damn if that person [has AIDS]. He was referring to a very handsome man.... It doesn't matter what he has. To die for love?... I said you are joking.
>
> [Teacher, age 38]

To avoid AIDS, the respondent does not look towards safe sex but safe partners. For the minority who gave positive replies, only two were unqualified. They had complete faith in the biomedical guidelines. Others gave the following types responses:

> I would if I were powerfully attracted to [him] but it would be sort of light safe sex.
>
> [Unemployed man, age 36]

> Yeah, I would. It would bother me because [of] fear of the unknown, fear of what I couldn't see. But I would qualify that by saying I would sleep with someone who [is] HIV-positive if I cared about [him] enough. But sleeping with [him] casually I would be very wary... Very wary!
>
> [Student, age 26]

Overall, there were two qualifications: a.] Only if I was highly attracted/in love with him. b.] I would be very careful. The first is more of an accolade to the theoretical possibilities of life. They saw such a situation as possible, but not one they would seek out or stay in if they could foresee it. Although I jump ahead, the second indicates dextral safe-sex limit motility. Acts generally considered safe are re-examined **for this situation**. They become unsafe by virtue of highly significant partner-dependent definitions of safe sex. Again, this does not enable transmission. Only when the safe-sex limit moves to the left [sinistral motility] is this possible.

2.] SAFE AND UNSAFE PARTNERS: WHO ARE THEY?

My intention for this section is to describe the **ways** in which the respondents constructed partner-dependent definitions of safe sex. Nothing more, nothing less. Although I discuss these ways in terms of themes and patterns, I make no assumptions about their representativeness among gay men. Some scholars [e.g. Jung, 1959] have argued for the persistence of certain symbolic archetypes among human beings. Symbolic interaction does not. It sees the individual

as without predisposition. [Blumer, 1969] Although it may well be that the themes and patterns are typified by impending cultural norms and values, I have no methodological basis to assert this. Nor do I see it as important. My purpose is to show typical construction, not typical constructs. They should therefore be taken as examples, not representations.

Since I organize the constructions into six principle themes, I am again guilty of reification. I do this first to make sense of the hundreds told to me, and second to show their dualities. Where one believed that a certain characteristic indicated a safer partner, another saw the same characteristic as indicating a less safe partner. This, more than anything, shows the dependence of meaning upon past experience - the individual's unique and often curious storehouse of knowledge.

A.] Age:

Youth and age have always been at odds with each other. Age is prized for its wisdom and discretion and feared as a harbinger of dependence and death. Youth is envied for its beauty and vigor and begrudged for its impulsiveness and naivety. Youth is a wonderful thing, it is said. What a shame it is wasted on the young. On the other hand, at forty, our life begins. We are not getting older, we are getting better.

What meanings did youth have for the respondents? Irrespective of age, some saw younger gays as less likely to be seropositive, others as more likely. For the former view,

two reasons were given. First, since they came out [*] recently, they probably have less sexual experience:

> They're fairly young so they haven't had much time to be exposed.
>
> [Doctor, age 50]

> I prefer people who are older but, if I were really being cautious, I would go with someone younger than myself and less experienced.
>
> [Student, age 23]

Second, since younger gays have come out in the era of AIDS, they are more likely to have **internalized** the necessity for safe sex:

> Somebody who is just coming out [would be] aware of AIDS probably at the same time [he is] aware of being gay.... [He would] either be too frightened to do anything that wasn't safe or just accept the fact that [he has] to have safe sex.
>
> [Choreographer, age 31]

> I've grown up in the AIDS generation where we have always known that if you fuck around, you're going to die. So we're more apt, maybe, to stay in the closet longer... which [gives] us more time to think.
>
> [Student, age 18]

> Guys my age are the ones who've grown up with AIDS. Having sex to us means being worried about AIDS and being worried about AIDS means having sex.
>
> [Another student, age 18]

Those seeing the young as less safe, did so because of their feeling of immortality, lack of responsibility, or both. The following is typical:

---

[*] "Coming out" is a multi-faceted process pertaining to political and personal identity, public declaration, sexual experience, etc. [For a good discussion of this, see Lee, 1977]. Unless I indicate otherwise, I define it as "becoming sexual as a gay person."

> The younger ones aren't as careful.... Its one of those things. We're young and its not going to happen to us. Overall, I think the younger ones [are] a little bit looser.
> [Lab technician, age 31]

In general, teenagers and young adults are a high-risk group. They often lack sufficient knowledge, are resistant to authority, and their sexual behaviour can be impulsive. [Diclemente, Zorn & Temoshok, 1986; Strunin & Hingston, 1986] This may be even more true when they are gay. Nevertheless, it is unrealistic to ignore the sobering effect AIDS can have upon sexual decision-making. In my own comings and goings, I have met many who are strong advocates of responsible sex. Their sexual identity has formed within an environment enshrouded by AIDS and the two have become inseparable. I do **not** say they are typical, only that they exist and are not difficult to find. In view of this, the internalization of AIDS among the new generation of gays is ripe for research. With the exception of a few journalistic efforts [e.g. Marks, 1988], this aspect of the epidemic has not been dealt with.

Older people, however defined, were no less meaningful to the respondents. A few found them safer because of their wisdom, emotional maturity, and caution. The majority, however, saw age as a sign of increased likelihood of seropositivity. First, older people had been actively gay during the notorious 1970s:

> It would be the people over 35 [having unsafe sex] who came out in the 70s when everything was going wild and crazy. You know, 10 or 15 partners a night. That was normal back then!
> [Unemployed man, age 36]

> The older crowd, like early 30s... I suspect them because they were in their hay-day when AIDS was not an issue... Some took part in what I've heard [were the] wild promiscuity years.
> [Student, age 23]

> They accepted being gay earlier and before AIDS when there was a lot of fucking going on.
> [Choreographer, age 31]

Second, old habits die hard:

> At [a bar] its an older crowd and I guess they would fall into the category of people whom I would think that they've been doing something certainly for so long and they won't change now. Or, that they've been having sex for so many years and nothing's happened yet and nothing's going to happen.
> [Student, age 25]

> Its like these old guys who are 60 [who] try to hit on me at [a bar]. I just blow them off [meaning reject them] and, two minutes later, they're trying to hit on some other guy. They're going to get AIDS because they're desperate. When they get [a sex partner], they'll do anything.
> [Student, age 21]

Interestingly, "older" meant in one's thirties for the first reason and middle aged and over for the second. The fact that AIDS did not exist in the 1970s did not deter them There are three channels of reasoning for this. First, promiscuity has become synomymous with AIDS. I say more about this shortly. Second, those who were promiscuous in the 1970s must also have been at the onset of AIDS. They may have been exposed before switching to safe sex. Third, while younger gays likely begin with safe sex, older ones **changed** to it. This

suggests difficulties and set backs which further enable exposure.

Those seeing older men as desperate tended to see unattractive ones the same way. Indeed, the two were often synonymous ["ugly old guys"]. Since they likely have less sex, they may act with abandon when they do. Thus, they are riskier partners. Popular beliefs about age, beauty, and sexuality no doubt play a large part here. Older and/or unattractive gay men seeking sex partners are typically seen as breaking tacit rules [Kimmel, 1977; Kelly, 1977], especially when these partners are significantly younger and more attractive. To find such beliefs among the younger respondents is therefore no surprise.

The idea that less sex leads to more unsafe sex is interesting when considering some of the more conservative AIDS-education campaigns' encouragements toward abstinence. Certainly Gochros [1988] has suggested this. However, the respondents' suggestion that built-up "horniness" facilitates unsafe sex is only one factor. As is suggested in Gold, Grant and Plummer's [1989] sample, long periods with no sex may also lead to justifications for unsafe sex ["I deserve it"]. With this in mind, what is needed is far more research on the effects of bargaining upon unsafe sex.

B.] The Body:

A body is something we all possess. As a result, it is taken for granted. It is, however, an object like any other and, thus, a part of the symbolic world of human beings.

Every part, every movement, and every difference has meaning to those who reflect upon them. Although a sociology of the body [Synnott, 1988] could well serve as a theoretical vehicle for partner-dependent definitions - which include body features such as age, race, beauty, and so on - I restrict this discussion to a few aspects and body parts. First, as an indicator of general health, build had significant meaning pointing to or away from seropositivity:

> A well-built person [is safer].. They're really into their body. They take care of their body.... From talking to people, I find that [those] who do weights [are] into vitamins and this and that and they eat really healthy foods. Their body's almost like a shrine. They treat it right.
>
> [Lab technician, age 31]

> I think the most important thing regardless is to find someone that's healthy. If somebody looks healthy, then he probably is healthy as well and this goes for venereal disease, AIDS, or what have you.
>
> [Office Manager, age 46]

> [An unsafe partner] would appear to be scruffy, maybe skinny.
>
> [Unemployed man, age 23]

When considering cultural metaphors, the association of the muscularity/thinness dichotomy with that of safe and unsafe partners comes as no surprise. Muscular men are "the picture of health." They have worked hard to achieve "the perfect male form." They are "powerful." Conversely skinny men do not eat well. They have no reserve energy. They are even untrustworthy. In the final stages of AIDS, people do lose weight rapidly. A muscular frame or a healthful appearance, however, in no way precludes HIV seropositivity. The majority of those infected show no symptoms whatsoever.

Hair has all sorts of meanings for us. On the head, its colour indicates beauty and temperament; its length masculinity or femininity; its absence; age; and its style conformity or rebellion. On the face it can denote trustworthiness and manhood, on the body virility, or not on the body youthful innocence. At least two respondents gave hair highly significant meanings:

> I look for receding hairlines to begin with.... One of the symptoms [of AIDS] is loss of hair.
>
> [Student, age 21]

> A mustache or a beard, to me, is a complete turn-off in the sense that it would make the person look older. A beard or a mustache is something sexually I really don't like which I associate [with] AIDS while long hair is something I do like which I also associate with AIDS. Long hair is something I feel looks very good on a lot of guys, especially younger guys. But its something I definitely associate with being HIV positive.
>
> [Student, age 26]

The first is clearly a case of misinformation. Certainly hair loss may result from chemotherapy, but it is not a symptom of AIDS per se. Furthermore, even if this were true, it still shows an error in syllogistic logic. Although AIDS leads to hair loss, hair loss does not necessarily indicate AIDS. Nevertheless, this belief well illustrates the often unique avenues interpretation may take.

The second comment also reveals much. First, as Synnott [1987] tells us, long hair is a sign of rebellion. Since the norm is to have it short, it denotes deviance, nonconformism, and unpredictability. If this is indeed how it is viewed, such meanings can easily be transported to the sexual sphere.

Second, beards and mustaches in the gay community usually typologize one as a "clone," a particular image made popular by gay men in New York and San Francisco in the 1970s associated with gay masculinity, assertiveness, and sexuality. Now, more than a decade later, it denotes age and promiscuity. Clones were certainly associated with high risk by other respondents.

The body area with probably the greatest potential for meaning assignation is the face. As Synnott [1989] once again tells us, we can see "age, gender and race of the self with varying degrees of accuracy, also our health and socio-economic status, our moods and emotions, even perhaps our character and personality." The respondents found the following aspects meaningful:

> Somehow I think of pimples and a greasy complexion. [Unsafe people] wouldn't really care too much about their appearance.
> [Student, age 18]

> What I generally do is look for the age of the person and compare that to the skin texture. Has it aged prematurely? Does he have a sickly pallor to him? Also the eyes, the youth of the eyes in relation to the age of the person.
> [Pianist, age 40]

> Its in their eyes. They look as though they're on the hunt.
> [Another student, age 18]

Each shows a distinct construction. The first is fairly direct. Physical qualities are associated with high-risk partners. Notwithstanding other associative indicators, what is meaningful is their presence or absence. The second is

comparative. An ideal relationship among age, skin texture, and eyes are predetermined and discordant ones are meaningful by default. The third is projective. A particular expression is seen to represent a particular motive which, in turn, points to a riskier partner. These examples only begin to show the great importance of facial features and expressions. Since the face is used constantly in interaction, it is no doubt a central determinant of risk. I say more about this in my discussion of assessment in chapter eleven.

C.] Race/Ethnicity:

Physical characteristics and cultural heritages naturally differ among human beings. They will therefore be given different meanings. Although much effort exists to promote racial and ethnic harmony, many stem from misinformation. As a result, they are prejudicial, mythical, and stereotypical. As Allport [1954] says, they can be positive or negative. Blacks are lazy, blacks are superior athletes. Italians are cheap, Italians are industrious. Jews are dishonest, Jews are more intelligent. The list goes on. How do race and ethnicity enter into partner-dependent definitions? First, to one respondent, blacks had very definite meanings:

> Well, I would definitely stay away from a black because of all the hype about them. I really mean any black because you can't tell if they're Haitian or not. I mean they all look the same. You can't tell them apart.
>
> [Student, age 23]

When considering past emphasis on high-risk groups, to give a higher risk meaning to Haitians is not surprising. However, his caution is not so much towards Haitians as it is towards black men in general. ["You can't tell them apart."] In addition to the Haitian controversy, there are several other reasons this could happen. The first and most obvious is our society's long history of prejudice and discrimination. When a specific group is disliked generally, people are far more likely to assign further negative traits to its members. [Allport, 1954] Fisher believes that part of this may stem from a cognitive link between the black/white and "good body/bad body" dichotomies. As he states [1973:66]:

> Black conjures up bad and negative meanings. It is obvious that both in the dictionary and in common usage the word black is considered to be a label for that which is evil, dirty and anti-God.

With such associations, an extension to the safe/unsafe dichotomy is easily enabled. Second, in the United States, blacks are over-represented among diagnosed AIDS cases. [Selik, Castro & Pappaioanou, 1988] This, however, has been reduced to a lack of culturally relevant prevention education and medical care towards minorities in general. [St. Lawrence & Betts, 1989; Mays & Cochran, 1987, 1988] Third, due to erotic exploitation, stereotyping, or otherwise, whites typically hold exaggerated beliefs about black male sexuality. [Davis & Cross, 1979; Hernton, 1965; Allport, 1954] Black men are hugely endowed, potent, mysterious, and powerful. Taking this a step further, they may be seen as

promiscuous, having little control over their sexual power and, thus, more likely infected.

The AIDS epidemic, barely a decade old, has given us new insight into the nature of prejudice. No **new** beliefs have been created because of it. Whether they pertain to black sexuality, gay promiscuity, or otherwise, **old** ones have only been given fresh fuel.

Since my interviews were conducted in a large city in the province of Quebec, language group was also named as an indicator of risk. The French and the English have been at odds with each other since the Hundred Years War [a.d. 1337-1453]. Their rivalry is nothing new. Nor is their foisting of sexual ills upon each other. While syphilis was once known as "the French disease," homosexuality, viewed with the same negativity, was "the English vice." The following, comments, therefore, come as no surprise:

> [The French] are more free with themselves and they're not as afraid to get going when they have sex. I don't know if its a matter of education of what but I think that almost everyone you'll speak to will tell you its true.
>
> [Office manager (English), age 46]

> I hope I don't sound racist, but there's a big difference between the anglophone and the francophone communities. The French people I've met have the idea that [AIDS] is not here. You have to be with a lot of people to get it. The [English people] I know tend to be more aware of it and tend to practice [safe sex] a lot more. But the French here would do anything, the ones I've met.
>
> [Choreographer (English), age 31]

> English are more dangerous because they are more into fucking... French people don't seem to want to do that much.
>
> [Unemployed man (French), age 19]

For those who did mention language group, the one indicating a higher risk was never their own. The French named the English and the English named the French. Although it is tempting to connect this with Quebec's current social and political struggles, it would be contentious with so few cases. What the comments do illustrate is the channels of meaning construction as well as their significance. The French are "more free" and **therefore** "not as afraid to get going when they have sex." There is **a big difference** between the two groups. English are "more dangerous" **because** they are "more into fucking." Whether these respondents will deliberately seek partners of their own group is not known. If they do, it is because they hold these meanings and **not** others.

D.] Education/Intelligence/Goals/Career:

A capitalist society thrives on industriousness. We have goals, we go to school, we learn, and we find our place. The loftier these goals, the more we go to school and learn, and the more important our position, the more we are respected. We are good credit risks, directed, stable, trustworthy, and **predictable**. On the other hand, with little education, no skills, low-status jobs, and no apparent goals, we are not as respected. Often, we are thought of as caring only for the moment, without convictions, lazy, and deadbeats. We are **unpredictable**. Predictability is vital in risk assessment. If a person is to be seen as low risk, others must be "reasonably sure" what he has done and what he will do. If his past and future are not immediately apparent, neither is

his present. The likelihood of seropositivity is left to pure chance. The following comments well illustrate this need for predictability:

> [A safe partner is] stable, has a lot to lose, secure, high on the social scale.
>
> [Unemployed man, age 28]

> If a person doesn't know where he wants to go, or I'm talking to someone and [he] says oh, I just live day by day. I've no general goals to attain. If I wake up in the morning, that's great... But if I feel that someone sets goals for [himself], long-range goals, the person has more to him.
>
> [Student, age 22]

> And then there [are] a few guys... I know [who] are real whores. But they're pretty stupid anyway. I mean they're not in school, they work as dishwashers, they probably never read a newspaper in their lives.... They're just not too safe about the whole thing.
>
> [Student, age 18]

Safe partners are "stable," "secure," and have "a lot to lose." They set "long-range goals" for themselves. Unsafe ones "live day by day" and have "no general goals to attain." All of these are significant meanings for the respondents. They not only enable them to predict risk, but other things ["has more to him," "stupid," etc.] as well.

Education and intelligence have a second important meaning. They indicate that the person **knows things**. He is either predisposed to or has devoted a considerable part of his life to acquiring knowledge. With all he possesses, he must "certainly be aware" of the proper ways to avoid AIDS. He could not possibly do **the wrong thing**. This was a common belief:

> People have actually wanted to go to bed with me because they think that someone so educated and intelligent would certainly be safe as a partner.
>
> [Doctor, age 50]

> You would assume that if someone was more educated generally, then he is automatically more aware about a lot of things, AIDS included. He would probably know that AIDS is out there and what to do and what not to do.
>
> [Pianist, age 40]

> I guess that's really important - being in school. I mean if a guy is exposed to all the awareness and stuff that's in school, he'll probably be more likely to have sex safe because he's into getting an education. All the gay guys I know [who] are in school tend to be super intelligent and super aware.
>
> [Student, age 18]

> If a guy is higher educated, he's going to be real paranoid about doing certain things.
>
> [Student, age 23]

Interestingly, this is no less the assumption of the education model explained in chapter two which assumes that people have unsafe sex because they **do not know things**. They are unaware of the dangers of AIDS. If they were educated, they would be aware. They would switch to safe sex.

As it happens, much evidence exists showing that more educated people are less likely to be seropositive. [Van Raden, Kaslow & Kingsley 1988; Gayle, Rogers et al., 1988] But to assume that they have a greater knowledge of AIDS, and that this automatically deters risky behaviour, is premature. Knowledge levels are high regardless of education. More likely, other factors are involved such as a higher level of satisfaction with life or a decreased willingness to take risks. This well serves to exemplify the need for in-depth

qualitative research to accompany the identification of variables. It is not enough to know that education, career choice, or any other variable is associated with a person's likelihood to have safe or unsafe sex. More importantly, we must know why.

E.] Promiscuity/Sexuality/Interest in Sex/Cruising Ability:

Although social research is borne out of the interests of the researcher, it must make every effort to shed any cumbersome moral baggage. For this reason, it is important to look at what is meant by the term "promiscuity." First, it denotes having many partners. Regardless of the actual number, this inevitably means "too many." Second, it refers to indiscriminate sex. Sex with one is as good as sex with another and partners can be chosen virtually at random. Even if only among physical qualities, however, there is always discrimination. Indiscriminate therefore means not using "proper" criteria. Third, as mentioned in chapter four, promiscuity is sex in an unacceptable context - a one-night stand, an extramarital affair, etc. Again this is measured by standard rules of propriety. Up to now, I have used the phrase "multiple partnering" instead. This has been my effort to circumvent the moral disapprobation or, for that matter, advocacy promiscuity carries. I look at it from the points of view of my respondents, not my own.

Chapter one showed how gay men of the 1970s cast off oppressive attitudes toward their sexuality and instead

celebrated it. Having many partners was an assertion of self. It was adventurous, normal, and healthy. Those who did were "liberated;" those who did not were sexually repressed. Indeed, "slut" and "whore" were not insults but jovial compliments among comrades. Now, with AIDS, high numbers of partners are no longer red badges of courage but scarlet letters. As one respondent said:

> I think that people [who] sleep with a lot of people have an emotional problem. If they have to do that, there's something wrong with them. They're lacking something. The fact that they can't be with someone even for two weeks. They have no sense of dignity.
>
> [Student, age 23]

As a rule, those seeing numbers of partners as indicating a riskier partner were careful not to make such judgments. They spoke only in terms of probabilities:

> Suppose the person has had four sexual partners in the past year and suppose each of those people [has] had four sexual partners. There [are] sixteen possibilities open to infection right there. The simple fact is, the more partners you have, the greater the chances you have of exposing yourself to infection.
>
> [Caterer, age 29]

> You have to look at safe sex for what it is in the first place. Condoms are not 100% safe, especially if you're going to be in a passive position ten times a week.There's still a much greater chance.
>
> [Student, age 22]

> When I get to know people, I find out how promiscuous they are, how many different men they've been with, how safe they are. If they've been with twenty men in the past five years, okay. No problem. If they've been with twenty men in the past two weeks, that's a little bit higher risk.
>
> [Student, age 21]

Each respondent shows a different perspective. To the first, a past encounter was fully equivalent to one or more chances of exposure **regardless** of its nature. All sex, therefore, was unsafe. The second acknowledged the protective power of safe sex but it had little meaning when compounded. The third saw risk in terms of definite numbers. Partner-dependent definitions of safe sex were therefore most significant to the first since safe sex acts were not an issue.

A second related group of meanings pointing to high risk pertain to sensuality and sexuality. The first involve visible clues such as dress indicating a person's potential to be "sexual." The second involves the type of sex these clues suggest. The following are examples of the first:

> The typical look, okay. He would be someone [who] looks a little sleazy, wears tight jeans, does a lot of cruising.
> [Office worker, age 28]

> I think there are very slutty outfits. I think it really depends upon how [they are] worn. When I go out to a club, people who look like they're dressing to show off their body rather than dressing to look good. For me, that's a very important distinction.
> [Student, age 26]

And these are examples of the second:

> I would avoid people who are into very out of the ordinary sex... Pierced nipples, not terribly mainstream.
> [Student, age 21]

> Probably someone who wears a lot of leather and talks about S&M [sadomasochism] all the time I would say is more likely to have AIDS.
> [Student, age 19]

S&M involves esoteric interests. As a rule, gay men have little exposure to it other than seeing the occasional "leather clone" across the bar. Popular conceptions of it, therefore, are often dependent upon rumour, imagination, and exploitative images. [Two respondent's mentioned the movie Criusing.] To many, S&M suggests pain, acts involving urine and feces, and a relinquishing of control. In general, this is exaggerated. [Lee, 1978; Greene & Greene, 1974; Fisher, 1973] Much of it draws the line at erotic role play [e.g. slave/master, soldier/prisoner] and is typically nongenital in nature. Nevertheless, the images persist. They not only point to unsafe acts but sexuality in general. Inherent in this is the notion that since AIDS transmission is associated with sex, the more "nonsexual" a sexual encounter appears, the safer it is. Hence, sex that becomes only incidental to a loving relationship has gained new attraction.

Third and closely related are meanings pointing to an interest in sex. If someone indicates this too soon, he is immediately thought unsafe:

> The kind who will just look over your body and not really care what you are inside. They're thinking of just the physical side, the sensation. They kind of just walk by and they have a sort of feverish look to them.
>
> [Unemployed man, age 28]

> I'm thinking of this one guy I met at [a bar]. He was about twenty. He came up to me and started talking and everything I said he turned into a sexual innuendo. He laughed all the time and he had this let's-go-and-fuck leer on his face.
>
> [Student, age 18]

> You can sense that they're not really talking to you and they don't want to either. There's a sexual undercurrent to everything.
>
> [Unemployed man, age 36]

In the 1960s and 1970s, gay bars were sexual market places. [Weinberg & Williams, 1974; Hooker, 1967; Achilles, 1964] To go to a bar, therefore, more often than not meant to search for sex. Although this is probably less common nowadays, bars, with dim lighting, frenetic music, and glib talk, still retain their sexual atmosphere. This has two effects. First, one may look at others sexually. Second, one may expect others to do the same. Indeed, many a man has been rejected sexually when he only wanted a light of his cigarette. Because of the sexual atmosphere, and because of AIDS, many are now caught in dialectic tension. They are sexually interested but they must not show it. Or, they know the other is sexually interested but, if he shows it, he will be considered high risk. One very observant respondent described this tension very well:

> If you want to meet people, you have to look as though this is the last thing on your mind. Its all supposed to be perfectly natural. One way is to be introduced by a mutual friend. Then its all legitimate and you can talk to the other person. But even then you have to look as though sex is the last thing on your mind even though its the first thing that occurs to you.... You have to look as though you're talking to this person just for the sake of talking and not cruising.
>
> [Student, age 18]

What this amounts to is a Goffmanesque presentation of self in everyday life [1959]. In the actor's front stage, he maintains the appearance of no interest in sex. The audience knows it is there but judge him on his ability to hide it. If he does not,

he has failed and allowed a view of his backstage.

For one to judge another on his ability not to show feelings both tacitly acknowledge as present almost satirizes risk assessment. [I know you know I know I'm not supposed to know what you know I know.] We do, however, have many parallels in everyday life. Although everyone eliminates body wastes, etiquette demands that we say we "go to the washroom" rather than anything more specific. We also do these acts in isolation. With these unspoken rules, we maintain the appearance that urination and defecation do not exist. If we say they do, we have broken a rule. Similarly, Anselm Strauss [1978] describes silent bargains between terminal patients and their care givers to maintain the appearance that they are not dying. Both are well aware of this but neither indicates that it is so. These are the rules agreed upon. Men who indicate sexual interest [at least too soon], therefore, have broken a rule. This may be interpreted as a preoccupation with the taboo topic and, thus, they are seen as less safe partners.

Interest in sex as a measure of risk extends also to "cruising." Cruising, in the gay world, generally means to look for sex. From my own experience, I see five stages. With a number of metaphors in mind, I name them as follows: 1.] Window shopping. 2.] Browsing. 3.] Moving in. 4.] Making contact. 5.] Maintaining contact. In the first stage, a person hunts for an acceptable partner. He may go from place to place or merely stand in a spot in a bar waiting for

someone to come by. Next he browses. He examines others for their acceptability or availability. Often, he may note the whereabouts of a particular man and return to him if none better are found. Third, after selecting someone, he moves to an advantageous position - beside him to converse, in front to make eye contact, etc. Next, he attempts to make contact. This involves any number of techniques such as eye contact, an opening line ["Come here often?"], or perhaps merely "being obvious." ["giving off vibes"]. Finally, he maintains contact through the purposeful ritual of conversation and gestures. [see Fast, 1970] He presents himself in a fashion he believes is attractive. This model is not meant as a set of hard and fast rules but a general picture. Many may not go through these stages, others leave meetings to chance, and others prefer sex in relationships.

Since gay men do cruise and are cruised, they typically notice the actions of others and interpret them in a variety of ways. Many, as it happens, pertain to risk assessments. In the first stage, they may be thought too obvious:

> If someone looks too available like the guys you see standing in the darkened areas of the bar watching the scene. They don't look as though they're interested in socializing. They just come night after night wanting to find someone and leave.
>
> [Student, age 18]

> Then there's the real cool type. You know, he's real cool. He just leans back on the bar with half a smile of his face, taking in the scene, sort of looking, and just knows that he doesn't have to cruise heavy 'cause some guy's going to come around eventually.
>
> [Another student, age 18]

At this stage, there is a dialectic tension between looking available and looking nonchalant. The first has the advantage of indicating availability, but the disadvantage of discouraging those also available but who do not want quick sex. The second has the advantage of attracting such types but discouraging those who may not see the person as available. One is damned if he does and damned if he doesn't. As these respondents indicate, a look of availability may be seen as over interest in sex. This may also happen while browsing:

> One guy came up to me.... [I had difficulty understanding him] because he only spoke french. He immediately went to another guy and started dancing in front of him.
>
> [Student, age 25]

> The kind of people for instance... When I go to places, there's always someone [who goes] three [or] four times to the bathroom. When he sees someone, he goes in there. He goes after him.
>
> [Teacher, age 38]

The first is the subject of a cruise, the second is an observer. Both see the cruisers as high risk because they are obviously browsing. Many believe that sex, in order to be safe, should be well planned. A partner should be carefully selected. When selections are made in the manners suggested, the impression is that planning is inadequate. ["Anyone will do."]

Moving in, involves placing oneself in a position of advantage. No respondents had observations here. This is likely because it is the most innocuous. However, cruisers become visible once again when they attempt to make contact:

> A person [who] makes quick advances [is less safe].
>
> [Computer technician, age 28]

> Their mannerisms... how slutty [like a slut] they are. If they're like that with somebody they've had eye contact with for four minutes, what are they like after a week. Its like forget the condom.
>
> [Office worker, age 23]

> I'd look at their mannerisms. I'd see if they were real friendly. You know, quick with their affections. Instantly touching someone. Because if a guy's like that, he's just out for a good time and he doesn't really give a shit.
>
> [Student, age 23]

During the fifth stage, a second dialectic tension exists in relation to the skill with which one attempts to attain the goal of sex. If a cruiser is inept, he will general not have success. If he is too efficient, he may be thought of as high risk:

> Usually, when you cruise, it means you've cruised before so that means that you're sexually active. People have this image of me that I'm really sexually active so I'm a high risk of having AIDS.
>
> [Student, age 19]

> Someone [is safe when] he almost looks as through [he is] uncomfortable cruising you. If they look as though its really easy and they've done it a hundred times, then chances are that they've done it a hundred times.
>
> [Student, age 18]

Many more partner-dependent definitions were given. Each is based upon the respondent's storehouse of knowledge. Even though we may disagree with them since we give their observations different meanings, what is apparent time and again is their logic. If we place ourselves in the position of the actor, they make sense. This verstehen understanding

is what I hope to accomplish. We must not judge the actors' interpretations from our point of view, but from theirs. They are the architects of their behaviour.

Lastly, I state once again that these particular interpretations are not meant to be representative. I have no methodological basis to assert that most think younger men are safer, unattractive ones less safe, or otherwise. What I show here is the existence of such constructions and typical architecture. I do not say which ones exist, only that they do exist.

* * * * * * *

CHAPTER TEN

ALTERNATIVE DEFINITIONS OF SAFE SEX:

SEXUAL CONTEXTS

We shall not cease from exploration. And the end of all our exploring will be to arrive where we started and know the place for the first time.

[T.S. Eliot, 1888 - 1965]

CHAPTER TEN

In this section, I examine the respondents' context-dependent definitions of safe and unsafe sex. Before I do this, however, some general theoretical principles about sexual contexts must be explained. First, in true tautological fashion, they define sex as sexual. No matter what the action, and no matter what the object of that action, if the context is sexual, so is the action to the actor. Conversely, if the context is not sexual, then, again to the actor, neither is the action **regardless** of its nature.

Next, all sexual contexts are simultaneously meaningful in their past, present, and future. They do not arise when sex begins but continue **into it** from what has happened, **through it** in what is happening, and **out of it** in what is expected to happen. An encounter may **come from** a "bar pick-up," **take place** as a "one-night stand," and **result** in "both going their separate ways." Another may come from "several weeks courting," take place as an "expression of love," and result in a "marriage." Sexual contexts, include not only the sex acts themselves, but the desire that initiates them, the search and negotiation that secures their occurrence, and their expectation and result.

Sexual contexts also locate action in time and space. They determine **how** and **when** action is sexual. They are indexical to the actions that give rise to them and not interchangeable. Nevertheless, at the theoretical level, they

do have common features and, thus, are easily sorted into typologies. In this chapter, I use the following one to present the respondents' comments: a.] Locations. b.] Situations. c.] Environments. Risk is defined by geographic location in the first, socio-cultural circumstance in the second, and physical surrounding in the third.

If these categories are seen as separate dimensions, then any sexual encounter will contain all three. It will simultaneously be in a definite location, a certain situation, and a specific environment. The reality of a sexual encounter to the actor is therefore multidimensional in the tradition of Goffman's Frame Analysis. [1974] Each dimension is a separate frame and, depending upon the actor's reflection, one, another, or all may be important at any moment.

In risk assessment, there are two possibilities. First, while one dimension seen as unsafe may be enough to consider the same for the total encounter, two or three will make this even more likely. The actor may, for example, see anonymous sex [a situation] as unsafe. If it is in a bathhouse [an environment], it may be more unsafe. If it is in a bathhouse in New York City [a location], it may be still more so. In such cases, the more multidimensional the safe or unsafe risk assessments are, or the more frames they have meaning within, the more safe or unsafe an encounter will be regarded. The following well illustrates this:

> I was in a park cruising which I rarely do anyway. Its kind of risky. It was late at night. This scruffy looking kid came up to me and said he wanted to make some money. I said I don't pay for it. He insisted. Like he was so desperate he would've gone with anybody. I ended up giving him a few bucks because I felt sorry for him. He probably went to buy drugs.
> [Teacher, age 38]

Each frame - a park, late at night, prostitution, would have sex with anybody, buying drugs - had an unsafe meaning for this respondent. As they built up, the potential encounter became progressively more unsafe.

The second possibility is that a low-risk assessment in one frame may override and cancel out a high-risk one in another. A person may see prostitution as a high-risk situation for example, but decide to have sex with a prostitute who is "just starting out" or who solicits in a low-incidence area In both cases, as Goffman would say, the actor "keys" up and down to gather the raw material for his assessment.

Contextual frames become even more multidimensional when broken down even further. In any sexual encounter, there may be several locations, several situations, and several environments. For the first, an encounter may take place in a small town, but one close to a large city with high HIV incidence. Or it may be in an isolated rural area, but with a partner visiting from a city of high incidence. In both cases, two discordant locational contexts are present simultaneously. They may also be concordant in which case one gives strength of meaning to the other. For the second, a person may have sex with a prostitute, but one he has known

for years and loves deeply. Here, two low-risk situational meanings override a high-risk one. For the third, an encounter may take place in a tea room [a public washroom where sex takes place], but one in a building where only respectable people are thought to go. The second meaning overrides the first. I say more about such processes later.

1.] LOCATIONS.

In the United States, as of April, 1989, there were 91,877 diagnosed cases of AIDS. Twenty-one per cent came from New York City and seven per cent from San Francisco. With the exception of Los Angeles, no other city had more than three per cent. [Centers for Disease Control, 1989] To a number of respondents, these high incidences automatically rendered sex in these cities unsafe:

> In San Francisco, you'd better not fuck or blow [perform receptive fellatio upon] anybody because there's a lot of it going around there.
>
> [Unemployed man, age 34]

> [Before], you might've read about these things in the newspaper every once in a while, but it was mostly down in the [United] States - New York, San Francisco. There was never really anything here which meant that you could go absolutely ape-shit [wild] and never have to worry about a thing.
>
> [Lab technician, age 31]

Since these are areas of high incidence, the probability of a partner being seropositive is seen as much higher. This further extended to people visiting from these cities:

> I would first of all avoid people from highly infected areas - New York, San Francisco and places like that.
>
> [Student, age 21]

> The type of guy who tells me he's from New York... I'll be very nice and say no thank you. There's a high concentration there.
>
> [Student, age 22]

> I would make sure that [a partner I choose] doesn't go to New York every week end.
>
> [Unemployed man, age 19]

In these cases, the high incidence and thus, higher likelihood of a seropositive partner, is seen as imported. Lastly, as a true measure of variety, one respondent saw this in an entirely different perspective:

> A lot of people say that they would avoid people from New York or San Francisco because of the high concentration in [those] areas. But I would choose a guy from San Francisco right away because I lived in that city and people from San Francisco are very very careful and they're very very aware of AIDS. Where as is someone came from some other area of the country where they had never learned about AIDS or they just can't seem to think that it would happen to them, they wouldn't be very safe at all.
>
> [Pianist, age 40]

Here, the high incidence did not increase the probability of seropositivity but decreased it. From his past experience, people in San Francisco were "very very careful" because they had to be.

All respondents lived in a large city in the province of Québec which I call "La Cité." [See footnote, next page] Some who were familiar with other Canadian cities, saw La Cité as less safe. A few reduced this to language:

> I would say that the typical gay male in [La Cité] is somewhat more promiscuous than... [in] Vancouver or Toronto. I think [this is so] probably because the English and French communities are separated... I think the language problem as a whole might just contribute to general promiscuity.
>
> [Student, age 26]

> They seem to be a lot better informed about it in Toronto. I haven't got a lot of hassles [there like] I've got here. What I found is that the whole network of information - AIDS crisis centres, helplines - they come out of the [United] States... All that was written in English, Toronto just pulled up... because I can remember getting pamphlets from New York in the gay bars in Toronto. None of it was in French until years later here.
>
> [Student, age 21]

Others thought so because of a different sexual atmosphere:

> The gay community here compared to the gay community in Toronto... When I'm walking in [the gay area of La Cité], I feel like I'm walking along the Castro [the gay area of San Francisco] twenty years ago.... I think its extremely tacky. The whole ambiance I find is just very very seedy, very sleazy.
>
> [Caterer, age 29]

> Here, everyone seems open about sex. Its hard to say, but they all seem more promiscuous here. In Vancouver, there are not as many gay men as there are here, not as many gay clubs. When I came here, I felt that I was cruised more. Men were open to saying that they were interested in me and it was more sort of free and sleazy.
>
> [Student, age 21]

The former examples are speculative. The respondents sought reasons for La Cité being a place of riskier sex, the latter ones are comparative. Sex is riskier in La Cité for the first

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To ensure anonymity, sociologists have typically kept the location of their study confidential. Lesnoff [1954] described the gay community of "Easton", Prus [1980] studied the social organization of the hotel community in "Eastville, and Lee [1978] looked at the gay ecosystem of "Metropolis." In my own study, I quote frequently from the interviews which not only contain personal information, but descriptions of specific commercial establishments. In order to further reduce the chance of identification, I follow suit and call my study location "La Cité."

because common traits with another risky place are seen, and for the second because meanings pointing to higher risk are more concentrated than in another location.

2.] SITUATIONS.

Society and culture define sex in numerous different ways. It may be "dirty," wrong, loving, defiant, or illegal. It may be within a marriage, an affair, a statutory rape, or a one-night stand. And it may be between relatives, friends, gay men, co-workers, or a prostitute and client. Although the partners and actions may not vary at all in these situations, perceptions of norms, values, morals, institutional patterns, religious doctrine, and roles do. These perceptions, in turn, define the sexual context and serve as determinants to how a sexual situation is regarded. How does this affect risk assessment? First, several respondents gave definite high-risk meanings to prostitution:

> [High-risk] people are found in the parks... If you pay them money, they go to bed with you and they do those [unsafe] things.
>
> [Teacher, age 38]

> Street hustlers [male prostitutes] don't eat right, don't sleep right, they often don't bathe properly. They also go with anybody [who] flashes a couple of twenties [dollars].... I'm sure a lot of them would do something unsafe with others.... Who know where they've been or who they've been with before.
>
> [Office manager, age 46]

Interestingly, this last respondent gave such meanings only

to street hustlers. Because of other beliefs about education and class, he saw another form of prostitution as safe:

> It [has] also been my experience that [escort-service prostitutes] are a cut above the ordinary street hustlers. They are usually better dressed and a lot of them are college students trying to get rent money and that sort of thing. I've met a number of them who are quite well-spoken and educated. They are usually not the sort who take drugs or come from the slums like the street boys do. Its just stands to reason that they wouldn't have AIDS.
>
> [Office manager, age 46]

This well serves as an example of context polarization. Although he did refer to partner-dependent traits such as education or drug-taking which may supercede the two prostitution contexts, they were definitively associated with one or the other. To him, therefore, street hustlers are unsafe while escort-service hustlers are safe.

When interaction becomes familiar, and it has meaning beyond its immediate purpose, two people are said to have a relationship. Although this includes kinship, friendship or business partnership, it is more often an account of what people mean to each other sexually. Among heterosexuals, where relationships are recognized, numerous terms exist to demarcate their stages and types. They date, go steady, get engaged, marry, have an affair, divorce, and remarry. While gays certainly have comparable stages and types, little terminology exists for such demarcation. Usually, they fall under the catch-all "lovers." Gay lovers may live together or not, may be sexually exclusive or not, or may have known each other for a week or several decades. They are still lovers

and, thus, still "in a relationship."

In past chapters, I showed how relationships are often portrayed by educational and news media as safe sexual contexts. We must not have one-night stands or sex with strangers, we must "get to know" our partner, and the like. In reality, only three conditions of relationships exist which preclude infection [Canadian AIDS Society, 1989:34]:

> **1.]** "Both parties have had no sexual interaction with anyone prior to their relationship with each other, neither of them has been exposed to HIV through blood transfusions or needle-sharing, and they have maintained complete sexual exclusivity with each other since the beginning of their relationship."

> **2.]** "Both parties have maintained sexual exclusivity with each other for at least six months, have practiced safer sex for six months, neither of them has been exposed to HIV during that time through blood transfusions or needle-sharing with third parties and after at least six months both of them have received negative results on their HIV antibody tests."

> **3.]** "Both parties have maintained sexual exclusivity with each other since 1977 and neither of them has been exposed to HIV through blood transfusions or needle-sharing."

Not surprisingly, many respondents saw a relationship in and of itself as safe and one-night stands or immediate sex as unsafe. The deciding factor was not any of the above conditions but, rather, familiarity with the other:

> You have to get to know a person.... Its important because its your life.
>
> [Student, age 23]

> When you feel comfortable with somebody - one hundred per cent - then those feelings of wondering disappear.
>
> [Computer technician, age 28]

In terms of probability, relationships may reduce risk if unsafe sex is the rule. With random selection, an unsafe encounter with one person is less risky than that with two or more. But a single exposure is all that is necessary and unsafe sex with one is much more dangerous than safe sex with a dozen. Furthermore, many unsafe encounters with a single infected person increase the chance of infection even more. When "knowing someone" and "having a relationship" are seen as safe sexual contexts, they may well be used as justifications for unsafe sex. As one example, when I once asked an acquaintance if he had safe sex, he told me he didn't have to since he was in a steady relationship. The relationship, as it happened, was barely a month old and both parties had prior unsafe sexual experience.

3.] ENVIRONMENTS.

If a person's goal is to have sex, he must first have a partner. If none are otherwise available, he gets one by going to a place where they will likely be found. If he is gay, a homosexual orientation must generally be understood by virtue of a person's presence in the place. In view of this, he has four choices. First, there are gay bars. He may find a partner, but only to have sex with elsewhere. ["Your place or mine?"] Some have back rooms for this purpose but, since AIDS became epidemic, they are now a rarity. Bars in La Cité, to my knowledge, have never had a formally recognized one.

Second, he may go to bathhouses. They are set up for immediate sex and several encounters may be had in one visit. Third are "tea rooms," or public rest rooms where sex takes place. Here, fear of discovery is everpresent and sex is generally furtive. Fourth are public cruising areas. They may be outside - parks, beaches, streets, alleys and parking lots. Or they may be inside - video arcades, erotic movie houses, shopping malls, or subways. Depending upon practicality, sex may take place in the area, or it may not. In this section, I discuss each separately with respect to the respondents' polarizations. First, I address a number of general issues pertaining to them.

Each type of setting has common features. Bars offer music and alcoholic beverages, and occasionally dancing and darkened corners. Bathhouses have showers, saunas and roomettes with locking doors and cots, and occasionally orgy rooms, videos, and bars. Tea rooms have urinals for cruising and stalls for privacy. Public cruising areas have any number of informally designated demarcations such as bushes, alleys, pathways, or isolated corners to facilitate cruising and sex. Each, therefore, offers a specific environment which, through repeated action and informal channels such as folkways and tacitly acknowledged rules, becomes known to the individual in specific ways. One bar may be regarded as sleazy, another respectable. One bathhouse may be known as friendly and full of "good-looking hunks," another as cold and full of "old trolls." A tea room may be "hot" at lunchtime or otherwise.

Since environments are contexts with specific meaning, they may become sexual contexts as soon as sex takes place or is perceived as directly attainable. When this happens, these specific meanings are **imported** and become part of the individual's sexual experience. They therefore have the potential to be regarded as safe or unsafe.

While sorting the respondents' comments, I became aware of two distinct levels of environmental polarization. First, there is that between different types. Bars may be considered safe, tea rooms not. I call this **interpolarization**. The following are examples:

> Outside sex doesn't turn me on.... I think its bad because its totally anonymous sex. I don't really like that idea. Like I don't necessarily have to call somebody ever again but at least I have that option if I pick [him] up in a bar.
>
> [Student, age 21]

> With the bathhouse, you have the institution with the profit motive. I think that gives a very different flavour than some place like [a park] or the washroom at [a shopping mall]. It [the former] is not as safe.
>
> [Student, age 26]

To the first, outside place are less safe since no follow-up contact is possible if desired. To the second, bathhouses are less safe since their profit motive somehow encourages unsafe sex. The other type of polarization is that between like environments. I call this **intrapolarization**. For example:

> I'd probably be more afraid that I would contract AIDS if I slept with somebody from [BAR A] than if I slept with somebody from [BAR B] or [BAR C] because its not the same kind of people. I think that people who are older are more dangerous and [BAR A] has a lot of older people while [BAR B] has a lot of younger people.
>
> [Unemployed man, age 19]

Although age for this respondent is the prime determinant of risk, it is nevertheless associated with the three bars he mentions.

As concepts, inter- and intrapolarization are useful in at least two respects. First, it is possible that those who interpolarize environments base the safe meanings of one extreme on direct experience and the unsafe ones of the other upon indirect experience such as rumour and negative imagery. A number of respondents who saw tea rooms and bathhouses as unsafe, for example, had never visited them. On the other hand, those who intrapolarize likely do so from direct experience with both extremes. The respondents who polarized bars had first-hand reasons for doing so. Intrapolarization, therefore, may indicate more experience with one type of environment while interpolarization less with another. Second, bars, being multi-purpose environments [cruising, entertainment, making new friends, etc.] with much competition among them, may be easily polarized since they attract different types of people. Other sex and cruising environments, in contrast, have a single purpose and may be distinguished only by their potential to facilitate it. One tea room may be better for sex, for example, because the stalls are in a more strategic location. Interpolarization between these environments therefore promises to reveal much about their ability to facilitate sex as well as the way they are regarded. All of this promises much for future research.

A.] Bars:

It has often been said that gay men are incessant bar goers. Many are in them several nights a week as well as week-end afternoons. This is thought especially true of young out-of-the-closet gays and has no doubt contributed to popular images of them as heavy drinkers, irresponsible, and living life "in the fast lane." Those who have these views may be guilty of measuring the habits of gays with a heterosexual yardstick. If a heterosexual man going to a bar often is a "lush," then so is a gay man. A number of differences are missed here. First, heterosexuals can be freely heterosexual anywhere. It is the society norm and the the presumed orientation until proven otherwise. [The 1970s lapel button "How dare you presume I'm heterosexual" is a measure of this.] Gay men can only be freely homosexual when amongst each other. They must therefore be in a place where a homosexual orientation is understood. This is the main function of a gay bar - for whatever reason, to render a homosexual orientation academic. Indeed, for this reason, Weinberg and Williams called the gay bar "the cornerstone of the gay community." [1974:45]

Since they are indeed places to be gay, gay bars have a number of secondary functions. They are places to meet friends, catch up on news, sit and relax, read, make romantic contacts and so on. [Bell & Weinberg, 1978; Hooker, 1967; Cavan, 1966; Achilles, 1964] They are, however, also sexual market places. Although a number of researchers have looked at this aspect - those just mentioned as well as Taub

[1982], Read [1980], Lee [1978], Noel [1978], Hoffman [1968], Lesnoff [1954] and Cory [1951] - such interest seems to have fallen off when it is most needed. Consequently, as Mulvey and Steriti [1988] and others have noted, our data come from times of oppression or gay assertiveness and may be outdated. The AIDS crisis has no doubt brought with it many changes affecting bar interaction pertaining to cruising and sex. Questions have arisen for which we have no answers. Has bar attendence dropped off? Has the frequency of bar pick-ups diminished? What are the new rules surrounding the search and securing of sex? Have bars reflected these new in policy, set up or otherwise? Do these changes, in their turn, perpetuate the new rules? These questions are important not merely for the sake of sociological research but, more so, because their answers can contribute much to educational intervention.

In this research, I find that bars as contexts are very important to the respondents in their definitions of safe sex. Four bars were mentioned most frequently. I will call them the Donatello, the Leonardo, the Raphael, and the Michaelangelo. I visited each several times. The Donatello is La Cité's main leather bar. It is a large converted warehouse, dimly lit, with a dance floor, pool tables, and empty oil drums serving as partitions between the different areas. At the entrance, there are erotic pictures of masculine men cupping their genitals. The patrons are between thirty and forty years old, masculine, many dressed in leather. All who mentioned the Donatello saw it as unsafe:

> The Donatello, when you walk in, you get black and white sketches of men with cocks [penises] that are six feet long and in various states of arousal. Its dark and its loud and it bases its whole publicity on being a leather bar and leather is associated with one aspect of the gay lifestyle.
>
> [Student, age 21]

> I saw the movie Cruising with Al Pacino [about] a leather bar and basically, I feel that that's what go on [at the Donatello].
>
> [Student, age 22]

> [At the Donatello], there are more drugs, its more promiscuous, its a mix of old and young. It a smaller, more closed group and things that are accepted at [the Donatello], they're just not accepted at other bars. I mean they still sell poppers [amyl nitrite: a stimulant used to heighten sexual arousal] at the counter!
>
> [Student, age 26]

All indicators mentioned - "cocks that are six feet long," the movie Cruising, poppers, and so on - are symbols of sexuality. Just as with partner-dependent indicators, those pointing most directly to sex and, thus, the medium of AIDS transmission, are considered unsafe. Some compared the Donatello to the Leonardo. They also referred to symbols of sexuality but saw them as less blatent. As a result, they regarded it as a safer bar.

The Michaelangelo, now closed, was one of the more "trendy" bars in La Cité. It had a large dance floor, played the latest dance music, and had a younger college-aged crowd. Many dressed in the latest fashions. This crowd has since gone to the Raphael with a comparable atmosphere. If the Donatello and Leonardo are considered overly sexual, the Michaelangelo and Raphael are their antitheses. Many patrons I spoke to found them cold and the people unapproachable. In

gay vernacular, they are known as "S&M [stand and model] bars" or "twinky bars" and the crowd "gives attitude." All respondents who mentioned them found them safe:

> At [the Raphael], they're all pretty boys. I'm not approached there as much as I'm approached in [the Leonardo]. It not like everybody is into sex. They just go there to dance, laugh and maybe show off their new outfits.
> [Student, age 21]

> If I were looking for sex, which I'm not, I'd probably go to [the Michaelangelo]. They're younger and they're not as promiscuous there as in, say, [the Donatello].
> [Student, age 21]

Again, sexual symbols [or the lack of them] are the principle determinants of risk. Patrons "just go there to dance," they're "not as promiscuous," and so on. Even though characteristic of the person are described rather than the bars themselves, the two are associated. Someone may be seen as less safe because he is older, but **also** because he is found in the Donatello. Another may be safer because he is young, but **also** because he goes regularly to the Raphael. The first meanings may stand on their own merits. So may the second ones. Together, however, they give strength to each other.

B.] Bathhouses:

Unlike bars, bathhouses have a single purpose - to facilitate impersonal sex. They may be equipped with an exercise area, a swimming pool, or a television room, but to go to them solely for these reasons is virtually unheard of. Serious studies of bathhouses are rare. The first effort came

from Weinberg and Williams [1975/76] who assessed them in terms of how efficient they are in accomplishing their purpose. Ideally, those wanting impersonal sex should have a private and comfortable place for the acts, safeguards against harm, a variety of partners to choose from, and an understood and shared purpose with others. As the authors conclude, bathhouses fulfill these needs very well. Rooms four feet by seven feet with locking doors and a cot provide the private place. Thin walls allowing others to hear every sound ensure against attack. Places to check valuables preclude robbery. A variety of men in there for the same reason provide both choice and shared reality.

Descriptions of actual activity may be found in studies by Armstrong [1980], Styles [1979], Lee [1980], and Hoffman [1968]. Since I visited three bathhouses in three different cities [including La Cité], I offer my own. All three offer a choice of lockers or roomettes. Those who choose lockers generally like to hunt for sex by roaming the dimly lit corridors looking into rooms. Those in rooms like to wait in them with the door open for prospective partners to happen by. Lee [1978] uses the terms "hunter" and "hunted" to distinguish them. The hunted may also leave their rooms and hunt themselves. Street clothes are not allowed on the premises and all wear a towel around their waist. Most fold it over to maximize exposure and attractiveness.

In most bathhouses, doors are left open as a sign of availability. The one in La Cité is the exception since, after a police raid in the mid 1970s, the doors have springs

and close automatically. Instead, they are left unlocked and the hunters open them. No one objects since this is the understood line of action. In the rooms, the hunted assume positions they believe will make them most appealing - lying down, sitting up, and so on. If the room does not have a dimmer, many will dim the lights by placing an article of clothing over them. Some leave their rooms completely dark and open the door only slightly. As Lee [1978] notes, this typically means the occupant is older and less attractive.

Generally, it is up the hunter to indicate that he wants sex. He will pass by a room and look, pass by again more slowly, and again slower still. During this stage the hunted may encourage him with direct eye contact or discourage him by averted his eyes or turning his head away. Although it is tempting to read in the rooms since long periods may pass until acceptable partners come by, this generally discourages hunters since they may take it as noninterest. Persistent hunters may stand directly at the room entrance and even fondle their genitals. Here, the rejection takes place by merely not acknowledging his presence or looking away completely.

Verbal initiatives are also common. Hunters will stand at the doors and say "Do you want some company." The hunted either say yes or "Not right now thanks" or "I'm resting." The last is used so commonly it has become cliché. Rejections are done quietly, simply, and politely. They do not generally hurt or discourage the hunter since they are understood to be be only on physical grounds. If he receives one rejection, he

will try others and generally be successful.

My observations are not dissimilar to those of the other ethnographies mentioned above done a decade or more ago. Little has changed. Much exists, however, to indicate that adjustments have been made since the advent of AIDS. Condoms were handed out at admission and sometimes they were placed visibly on the table beside the bed by the hunted. Not only does this indicate a willingness for safe sex but anal intercourse as well. Before AIDS, men could only lie on their stomachs to communicate this. Posters and pamphlets warning of the dangers of unsafe sex were everywhere and, in at least one bath, a representative from the city health department visited regularly to hold meetings or give information. As I mentioned earlier, it is difficult to know what type of sex takes place since most of it is behind closed doors. When they were open to invite a third participant, however, I observed both the use of condoms and no use of them.

The respondents perceived bathhouses as unsafe for two reasons. First, those who never went there or did so only once or twice connected the oserved or imagined activities with an "unclean" or "diseased" environment:

> I find them inherently depressing.... Something about the whole place makes me feel I should... its like I'm in a leper colony and I should be yelling unclean! Unclean!
>
> [Unemployed man, age 27]

> I picture a very dirty, sleazy, unsanitary type of environment and I would assume its a perfect breeding ground for any disease.
>
> [Student, age 23]

In reality, the clean/unclean dichotomy refers to the presence or absence of dirt or otherwise unwanted foreign particles. Nevertheless, it is linked by metaphor to other structures of experience having nothing to do with this. We are encouraged towards clean living and to have good clean fun. Cleanliness is a virtue, the result of hard honest work, and the result of religious purification. Indeed, it is next to Godliness. Cleanliness is good, right, conforming, pure, moral, innocent, sacred, and perfect. Dirt is bad, wrong, deviant, tainted, immoral, perverted, profane, and imperfect. It is not surprising that these metaphors also extend to sex, especially when it seen as a means of disease transmission. [For three good discussions on this, see Clatts and Mutchler (1989), Sontag (1988), and Gilman (1988).] The baths are environments stripping sex of all commitment and emotion, maintaining its practice with the highest degree of efficiency, and thus laying it bare. "Something about the whole place" makes the first respondent see them as "unclean" and the second pictures them as "sleazy." These metaphors are therefore fused inseparably with bathhouses, raw sex, and, ultimately, AIDS.

Second, bathhouses were seen as unsafe since a few significant observations are thought representative. When I asked some respondents to elaborate upon why they felt the baths were high-risk environments, they gave the following accounts:

> A couple of weeks ago, I was at the one over on [a street]. I was sitting in the sauna and it got heated up in there [meaning the atmosphere became sexual]. Two guys were in there and one of them started fucking the other. No condoms or whatever. He's just sitting there on the bench and he's got the other guy on top of him and he's going at it.
>
> [Lab technician, age 31]

> Occasionally, me and my boyfriend would go to the sauna [bathhouse] and there's sex going on in there from morning 'til night and none of it is safe. Its done right in front of you. There [are] no barriers. You see two people having sex right in front of you. You see four people having sex right in front of you. There [were] never any condoms. There was always oral [sex] and anal [sex].
>
> [Unemployed man, age 23]

> Group sex, multiple partners, you name it. Its behind closed doors but some aren't closed tightly and, if you care to join, you just go ahead... I guess there's a lot of anal intercourse without the use of condoms.
>
> [Model, age 36]

Obviously none saw all sex taking place during their visits. They did see some and either witnessed or imagined it as unsafe. These episodes, to them, were the tip of the iceberg. To see something as common with only a couple of examples is typical when what is observed is viewed negatively. One dishonest act, even a minor one, will make a person dishonest. Similarly, an ant in a salad in a restaurant will make the entire establishment unclean everywhere always. Since high risk negative, one or two high-risk acts can be enough to render the entire bathhouse the same.

C.] Tearooms:

A public rest room becomes a tearoom when homosexual activity takes place in it regularly. Virtually all our knowledge of them comes from a single source, Laud Humphrey's

Tearoom Trade. [1970] There a few other significant studies [e.g. Troiden, 1974] as well as some portrayals in film and literature [e.g. the 1987 movie Prick Up Your Ears] but Humphrey's work is the most comprehensive to date.

Humphreys sees tearooms as popular sex environments for several reasons. First, they are easily accessible. They exist everywhere and anyone can locate them. Second, they "locate the action." Once tearooms with frequent activity are learned of or discovered, they become known to the user as a place to go for the purpose. Third, they offer volume and variety. If one is popular, a steady flow of men of all ages and appearances will come in wanting sex. Fourth, they offer privacy within a public setting - both from without and within. From without, they are unknown to those not seeing them as tearooms. From within, they offer a public area to view those entering, and a private area within the stalls.

My own knowledge of tearooms comes from long-time acquaintances with several individuals who have used them. From this knowledge, I add a few other characteristics. Tearooms offer anonymity - not only within society in general but also the gay community. Humphreys notes that only a small proportion of tearoom users are gay-identified and those going to bars generally avoid tearooms. Although gay liberation since the time of his study may have changed this, it does reduce the chance of encountering those one associates with elsewhere in the gay community. Second, unlike baths or bars, a tearoom is not a gay place per se. Entering one does not necessarily mark one as homosexual.

This has great advantage for those who self-identify is heterosexual. While it may be difficult to avoid viewing a bathhouse visit as an admission of homosexual desires, a person may easily convince himself that he originally went to a tearoom for legitimate purposes. ["I went in to wash my hands and got this unexpected offer. So what the heck."] Third, tearooms are economically viable ways to get sex. While much money is spent at bars and bathhouses, tearooms are free. Finally, and most ironically, tearooms are seen by many as erotic, exciting, and adventurous.

Tearooms are also dangerous since their users risk arrest, exposure, and ruin. Certainly, as The Body Politic has frequently reported [Monk, 1986; Jackson, 1984, 1983], this has been the demise of many and has caused on-going debates upon public nuisance, privacy, entrapment, etc. AIDS has added even more controversy. Tearoom sex, it is said, perpetuates it. From what Humphreys tells us, however, this may be far from true. Among men, AIDS is transmitted most frequently through unprotected anal intercourse. [See APPENDIX ONE] In considering syphilis infection, this act, as he states [p.100], is rare:

> If anal intercourse is the sole source of syphilitic infections from homosexual contact, this disease constitutes a very minor threat to tearoom participants.... anal intercourse occurred in only one per cent of the tearoom encounters observed.

Troiden [1974] observes similar frequencies as do my long-time acquaintances. As they tell me, sex rarely occurs with two in a stall because of the danger of discovery.

Rather, it takes place via the eight-to-twelve inch space **beneath the partition**. Furthermore, also due to possible discovery, participants generally stop when they here someone walk in. Under these conditions, anal intercourse is possible but very difficult. Most sex, I am told, involves either mutual masturbation or fellatio. A couple of respondents came to the same conclusion. Although they did not use tearooms themselves, they received similar information from their friends and thought them safe environments. Others thought just the opposite:

> Oh, that's all unsafe. They're desperate and desperation leads to unsafe sex.... They are all a hell of a lot more desperate and desperation tells me somehow that they wouldn't be too careful.
>
> [Pianist, age 40]

> If somebody's hanging around in the washrooms, they, I suppose, tend to be a little more loose. My friend in [a city], on his lunch hour at work, he goes to the local mall and just runs his hour in the cans [washrooms]. He does this everyday just to see what he can get in there which is a little unsafe.
>
> [Lab Technician, age 31]

Both saw tearoom users as lacking the ability for rational judgment. One calls them "desperate," the other "loose." In this respect, their constructions are similar. The causes they impute to this this lack of judgment, however, are different. The first, in tautological fashion, sees tearoom use in and of itself an indication of the user's mind frame. Anyone who uses tearooms is desperate; tearooms are therefore have desperate people in them. The second sees tearoom users as freer sexually, but defines the sex as unsafe by a lack of

partner discrimination. His friend, as he says, uses tearooms "just to see what he can get" which is "a little unsafe."

It is interesting to speculate whether tearoom use has become less frequent since Humphrey's study. Some of my acquaintances tell me they are less busy than a decade ago; others say the opposite. Historically, tearooms were often the only outlet for homosexual males. Bars existed, but they were raided by police frequently and many were afraid to go to them. Merely being seen entering a bar could have led to ruin. Since then, much ground was gained by gay liberation. In general, gays may now go to bars without fear and there are many homophile organizations. On the other hand, tearooms continue to be efficient sex environments for the reasons mentioned above. They are available, accessible, free of charge, offer a variety, and are not necessarily incompatible with a heterosexual self definition. In any case, tearoom use is long overdue for a follow-up study.

4.] Public Cruising Environments:

This subsection includes all other areas where sex may be found - beaches, parks, alleys, cinémas, and so on - and, thus, "public cruising environments" is a catch-all category. Ethnographies of these sexual market places are few and far between. Pornographic movie theatres, arcades, and bookstores were studied by Donnelly [1981], Sundholm [1973], and Karp [1973], respectively; a highway rest area by Corzine and Kirby [1977]; a parking lot by Ponte [1974]; and beaches, streets, and parks by Lee [1978]. They may also be outdated.

Although many gambits may not have changed, AIDS may have given rise to a number of new tacit rules.

On several occasions, I visited one street area and one park in La Cité where cruising takes place. The first consists of two short parallel streets in a downtown residential area. I will call them Taylor Street and Tinker Street. In the evening, there were steady flows of lone male strollers and drivers. The strollers typically walked down one street, up the other, and back again. At times they would stop and stand or sit on a stoop. For variety of experience, I did both. The cruising ritual was virtually identical to that described by Lee [1978:59]. If two men are about to pass each other, their eyes meet, they lock for a second longer than usual, they look dead on as they pass, and one or both slow down and turn. If they talk, the conversation begins with "nice night isn't it" or some other opening line. Since most circle from Taylor to Tinker, a missed opportunity can be re-attempted the next time around. Drivers will also circle around. If they see someone appealing, they will slow down or stop. Sex may take place in the home of one if he lives nearby, but also in the back alleys between the streets. The majority of it, other gay men have told me, consists of fellatio and mutual masturbation.

To the uninformed, Tinker and Taylor seem just like any other street - some men sitting, a few others taking a stroll. To those going there for sex, their presence has highly significant meaning. I became most aware of this when one man passing by quickly told me and some others to leave

immediately since the police were "sweeping the area." He was a cruiser informing others of impending danger. Although the action can easily be interpreted otherwise, to those who understand its purpose, Tinker and Taylor are as much a shared and understood reality as that of bathhouses.

Only one respondent mentioned this area. To him, it was unsafe in spite of his conception of the action:

> I don't think too much unsafe sex goes on on [Taylor] street. You can't get into it that much because you're always afraid of getting caught. But the whole thing is unsafe. I've passed there on the way to [a subway stop] to go home and I see all these guys walking around looking for the first thing that's willing. Its dark and its sleazy and you don't know what you're getting. It just means trouble.
>
> [Student, age 26]

Even though he believed that the logistics would minimize the performance of unsafe acts, the Taylor/Tinker area was still unsafe. It is "dark" and "sleazy" and a person can't be sure of his partner. Unsafe sex, therefore, is defined not by acts but environmental conditions which "mean trouble."

City Park [pseudonym] is the centre of La Cité. Cruising takes place mostly at night in a half-acre forest area deep within. If nature set out to make a perfect environment for this purpose, it could not done better. Beaten footpaths enable traffic, there are glades for congregation, bushes for concealment, and natural landmarks to keep one's bearing. Two friends may go there to cruise separately and agree to meet at "the rock" an hour later. At least two gay men I know do this to guard against "gay bashing." If one does not return

to the landmark, the other searches for him.

In well lit areas, park cruising is similar that in streets - walk, make eye contact, stop, turn, etc. [For a good portrayal, see John Rechy's novel Numbers (1967)] This part of City Park has only dim moonlight further obscured by top foliage. Cruising gambits are thus different. Instead of eye contact, follow each other, turn their heads obviously when passing, or stop completely and stare. Once interest has been made known, one will walk slowly to a secluded area and stand. The other follows.

City Park's reputation was notorious in the 1970s. On a week-end night, a thousand men would venture to the area at one time or another from dawn to dusk. Some would wander around naked except for hiking boots and stories of orgies of up to thirty men with just as many watching were common. I saw none of this during my visits. In a typical two-hour period, there were no more than forty cruisers, most leaving within a half hour. I did see sex but it was rare and consisted mostly of mutual masturbation and fellatio. AIDS, no doubt, has lessened City Park's popularity. One respondent concluded the same when comparing it to a similar environment in another city:

> I think there are less people [in City Park]. Actually, last summer was the only time I went up there. My only other frame of reference would be the [beach area] in [a city]. I noticed then that the numbers radically and steadily declined. One summer, everybody was there and the next summer, nobody was there. It's very rare that you'll see someone engaged in a sexual act.
>
> [Unemployed man, age 27]

A few respondents who had never visited City Park also imagined the sex to be rare. For this reason they saw the activity as inconsequential to the spread of AIDS. Others believed the participants to be "sleazy," "irresponsible" or "just interested in the physical." Just like the tearooms, this makes City Park unsafe by tautology. [People who go to City Park are sleazy; City Park therefore has sleazy people.] Most, however, saw it as an unsafe environment purely for the image it suggests:

> Its sort of like a left over [activity] from the [19]70s, that whole scene [in City Park].
>
> [Unemployed man, age 36]

> It just seems very whore-like - get down on the grass and spread your legs and then get up and leave. And the question of unknown is so much greater because you don't know who you're sleeping with. You're not even asking the minimal types of questions or the minimal type of manipulation. Who knows what you're getting.
>
> [Student, age 21]

City Park cruising is an anachronism from the 1970s when sexual adventures were the norm, it is "whore-like," one can not ask "minimal types of questions," or otherwise. Although these meanings are discrete in themselves, they render all activity in City Park as unsafe. This makes it, **in and of itself**, an unsafe environment.

.In potential, there are probably trillions of sexual contexts. Although my typology may enable some understanding, it hardly does justice to the subject itself. Nevertheless, I

have shown that they are part and parcel of all sexual activity and very important in the ways in which it is regarded. As the respondents' comments show, they also have come to exist as definitions of safe sex. Again, this does not necessarily mean they are **used** in sexual activity. They may or may not be. If they are to be, however, they must be pre-existent and significant. And this chapter has shown that they **are** pre-existent and they **are** significant.

* * * * * * *

CHAPTER EVEVEN

RISK ASSESSMENT:

HOW GAY MEN SIZE UP A POTENTIAL SEXUAL ENCOUNTER

Though this be madness, yet there is method in't.

[William Shakespeare, 1564 - 1616]

CHAPTER ELEVEN

In the last three chapters, I showed how meanings pertaining to sex acts, sex partners, and sexual contexts can exist as definitions of safe and unsafe sex. Depending upon their character, any may be regarded as significant enough to determine action. Ideally, significant definitions should be based solely upon sex acts. This is, or should be, the goal of AIDS education. Providing a person's knowledge is biomedically accurate, he will likely perform only acts precluding transmission. However, alternative definitions, based upon the other two dimensions of sex, may also be strongly significant. When they are, they may override act-dependent ones and be used to determine action instead.

The question for this chapter is: do gay men take deliberate steps to determine the existence of alternative meanings of safe or unsafe sex? If so, it is a good sign that they are significant enough to be used. If not, there would be no reason to do so unless they are otherwise significant. If, for example, someone attempts to find out if a potential partner has "slept around," it is because the result of his inquiry is sufficiently meaningful as a determinant of immediate action. I therefore look first for the presence of such inquiry and, second, at its nature. I divide the discussion into three parts: a.] Theoretical and methodological limitations. b.] The nature of risk assessment. c.] Methods of determining risk.

1.] THEORETICAL AND METHODOLOGICAL LIMITATIONS.

To determine whether the respondents took deliberate steps to assess risk, I simply asked them: do you ever try to find out if a guy is safe enough to sleep with? I asked this question a number of times in various forms throughout each interview and, at times, I got different answers. The negative responses were mostly consistent. There were two types of denials, the following of which are typical forms:

> I really don't find it necessary. I mean I told you I have safe sex no matter how, no matter who, no matter what. If I do this, I sincerely believe that I won't get AIDS.
> [Student, age 21]

> No... In all honesty, I can't say that I ever have. I never even think about it when I'm cruising. The only thing I think about is do I like the guy and do I find him attractive.
> [Office worker, age 28]

The first is a clear indication that alternative definitions have no significance. The advance decision to perform safe acts regardless of circumstance overrides any the individual may have. The second is not so simple. It may mean he does not for the same reasons, but also that there has been no case where significant alternative definitions have **arisen.** This needs some explanation. As human beings, we come to possess an indefinite number of meanings from our experience. Indeed, the number of components of our storehouses of knowledge is immeasurable. In any situation, we do not check for the presence of them all, for this is impossible. we only check for what is immediately indicative through the presence

of other meanings, what we have come to associate with the situation, what is significantly absent, or perhaps what we are preoccupied with. Someone taking out a gun and pointing it at us is a highly significant meaning. It will likely petrify us. Still, unless we are in a highly dangerous profession or live in a lawless society, we do not think of this at all. It only "enters our minds" when other meanings indicate that it may happen. Thus, even though this meaning is **highly** significant, we do not normally take steps to determine its presence in our everyday dealings with others. For one to say that he does not take deliberate steps to determine risk, therefore, is no indication that no significant alternative risk meanings exist. It only means that he does not normally think of them. If they do arise, they are considered. If, while being cruised, a man says "I don't worry about safe sex. I depend on luck." this may indeed be significant enough to merit further inquiry. As a meaning, it has not been solicited, it has arisen by itself.

It is also possible that a person is not aware of how he determines risk. Here, ethnomethodology offers much insight. Again, as human beings, we must indicate the meaningful components of a situation to ourselves before he know how to act. If we enter a grocery store, we may expect food to be on sale inside. Still, once we are inside, we must indicate to ourselves that this is indeed the case before we shop. Similarly, if we only have sex with "safe people," we must indicate to ourselves that our partner is indeed safe before we do so. To some, this may take no more than a split-second

glance. Most of the time, "reality" is so taken-for-granted, we are unaware of the unique ways we use to indicate it to ourselves. [Garfinkel's breaching experiments [1967] well illustrate this.] We do, however, do this constantly. Even with a rigid predecision to perform safe acts only, we still assess risk. We indicate to ourselves each time that we have made this decision.

In view of these theoretical considerations, asking someone if they assess risk is a poor way to determine the significance of alternative definitions and an even poorer way to learn about risk assessment. Even though a "no" can not be trusted, however, a "yes" reveals much. It not only tells us about conscious risk assessment, but meanings significant enough to merit preoccupation. Thus, in the true spirit of half a loaf being better than none, these, in themselves, were the ends of my questions.

Since my interviews were loose and unstructured, the respondents related numerous anecdotes unrelated to my questions. As a result, I did indeed collect much data upon risk assessments they were not otherwise aware of. This, in turn, led to the revelation of significant alternative definitions not considered until they arose. I discuss these in the next chapter.

Again, it is not my purpose to take an inventory of all significant alternative definitions; nor is it to detect every way of risk assessment. My purpose is to show that alternative definitions **are** significant and that risk assessment **does** exist - no more, no less.

2.] THE NATURE OF RISK ASSESSMENT.

If people are to know how to act, they must first make sense of their experience. They do this by constantly assigning it meaning. As a result, they organize it. The task of sociology is not to understand experience itself, for without the experiencer, it does not exist. Rather, it must attempt to understand how people, as experiencers, experience their experience. It must not seek to organize experience; it must concentrate upon how experience is organized - how it is typified, classified and categorized on the basis of how it is **perceived**. Admittedly, any attempt to do this is a reification - a chopped up, deadened, and reassembled vivisection of a living continuous process. Since sociology must understand it for its given purposes, however, it can do no better - for to leave reality intact is to give it no consideration at all. In this subsection, therefore, I remove the experiences of gay men from their rightful places and reify them for my own purpose - to understand the nature of risk assessment. Although there are any number of workable vehicles to do this [e.g. Goffman's Frame Analysis, 1974], I choose the "documentary method of interpretation" which I have already explained. I use it as a theoretical base and then affix to it my own modifications and elaborations.

When I asked the respondents to give accounts of people they thought would most likely make safe or unsafe partners, I was given all sorts of characteristics. Some made sense to

me immediately ["thin and unhealthy," "visible purplish lesions"], others seemed strange and fanciful ["doesn't give a shit about clothes," "receding hairlines," "the real cool type"]. They made sense only to the respondent. Kuhn and McPartland [1954] found a similar division when looking at accounts of other phenomena. Some, drawing their meaning from popular conceptions, made sense immediately. Others, coming from personal or privileged knowledge, made sense only to the individual. In the first sense, an obnoxious person would be "someone who irritates you." In the second sense, he would be "people like John." Such latter indicators need explanation, as did many from the respondents.

When accounts do not make sense immediately, they do "need explanation." They need to be connected logically with consensual indicators. [People like John **drive me crazy** so they are obnoxious.] Not only is this the key to understanding the respondents' accounts, but it reveals much about risk assessment. I will explain. First, according to the framework of the documentary method indicators arise pointing to an underlying pattern. When they point **directly** to the underlying pattern, or when they need not pass through any other indicators before arriving at it deductively, they are consensual. "Purple lesions" point directly to "a person with AIDS." I call these **primary indicators**. Once removed, accounts point not to the underlying pattern but to primary indicators. A man wearing make-up to cover his face may be seen as doing so to hide purple lesions. The first appearance points not to a person with AIDS but to an indicator of such.

I call these **secondary indicators**. They are evident in the following account:

> [Men who are] very quick with their affection, instantly touching someone. Because if a guy's like that, he's out for a good time and he really doesn't give a shit.
>
> [Student, age 23]

"Very quick with their affection" is a secondary indicator. It points to the primary indicators of "out for a good time" and "doesn't really give a shit" which, together, can be taken as having a callous attitude towards safe sex. Once removed again are **tertiary indicators**. They are exemplified in the following:

> [A safe partner is] like me, right? I mean a guy who hangs around with straight [heterosexual] guys and is going to talk about gays and how they all like to go out and get AIDS and that they're all sex maniacs, right? And how you got to watch yourself about touching them and everything... Therefore, if a guy [as described] does like to go out and get a guy now and then, he's going to have all that kind of thinking in him still and he's going to watch himself. In him he's going to have that prejudice.
>
> [Student, age 23]

Here, "a guy who hangs around straight guys" is indicative of one who, when catering to his own homosexual desires, will have a negative attitude toward other gays. This, in turn, is indicative of someone who will "watch himself" which can be taken to mean having a conscientious attitude toward safe sex. The tertiary indicator points to the secondary one; this, in turn, points to the primary one which, finally, points to the underlying pattern of "a safe partner."

Although it is possible to extend this further, doing so would only render the interlinkage of indicators to

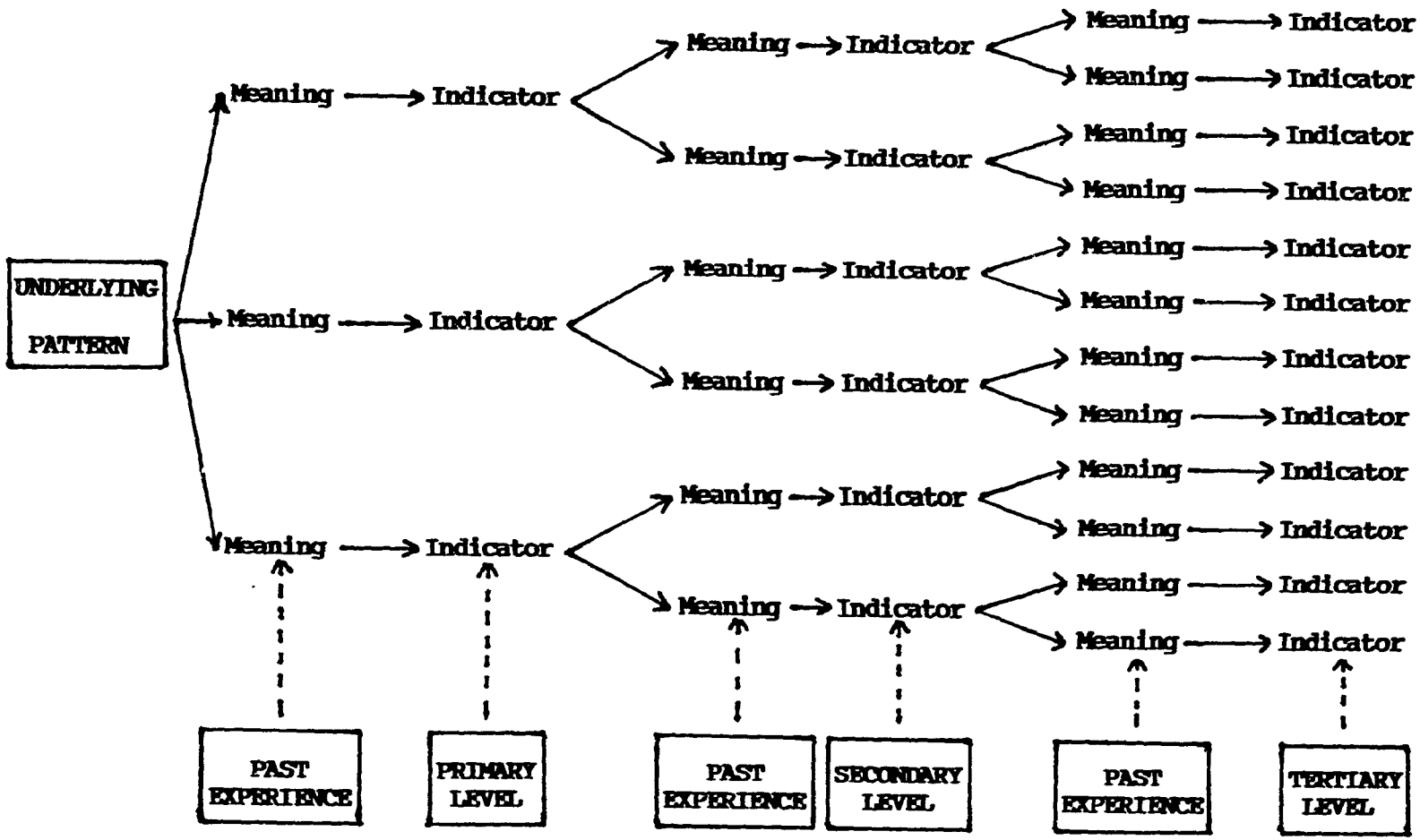
conjecture. The difference between a fourth, fifth, and even sixth removal would depend upon which root is chosen to the underlying pattern. A road passing through six towns may lead to Rome, but so may one passing through only two. Thus, I define tertiary indicators as all those not primary or secondary.

When this typology is seen in reverse, insight may be gained upon the development of meaning through the interpretive process. An underlying pattern gives rise to meanings pointing directly to it. These meanings, in their turn, give rise to further meanings which give rise to even further ones and so on. At every point, the formulation of meaning is based upon already possessed meanings gained from past experience. A complete picture of this process is shown in **FIGURE ELEVEN** on the next page.

As a reflection of reality, this typology has a number of serious limitations. First, it is a reification of a continuous process. It chops up the flow of experience and gives it a false character of discreteness. Second, the "removal level" of any given indicator depends upon who it has meaning for. To one, it may be primary, to another secondary, and to still another tertiary. Third, to use consensus as a measure of primary removal makes huge assumptions. Even though many may believe certain things, others may not at all. However, the typology **not** be regarded as an inflexible blue print of meaning development but as an **ideal type** or a **constant**. Given sequences of meaning should

TABLE ELEVEN

THE DEVELOPMENT OF MEANING FROM THE UNDERLYING PATTERN TO THE TERTIARY LEVEL



not have the typology imposed upon them; rather, they should be **compared** to it. If this is done, they will become less mhaotic and understandable from a stable theoretical perspective.

As I stated, a person may initiate and engage in sex without **conscious** risk assessment. In these cases, there is either a rigid predecision to engage in safe acts only or no significant alternative definitions arise. When they do, the machinery for risk assessment becomes operable. To explain, I first create a scenario and then refer back to it:

> Victor went to a bar on a Sunday afternoon. He met Julio, a man of about 30, and was attracted to him immediately. It would be nice, he thought, to maneuver him to his apartment for sex. The two talked for about an hour. When they turned to vacations, Julio told Victor he went to Cruisingtown, a gay singles resort, every month. This worried Victor. Cruisingtown was a place where lots of sex went on and maybe Julio had participated. To find out, he asked him what the town is like. Julio said "everyone was available" and, slightly embarrassed, he said that he "hadn't exactly been a saint." Victor was even more worried. Had Julio had safe sex? He changed the topic to condoms and complained about how expensive they were. He hoped Julio might agree which would mean he buys them but, instead, he only said "Really?" They talked a bit longer and, suddenly, Victor said he had to go.

The process, again an **ideal type**, takes place as follows. First, a significant tertiary indicator of "an unsafe partner" arises. A primary or secondary one may arise first but, to show the full process, I begin at this level of removal. [To Victor, the tertiary indicator was "goes to Cruisingtown every month."] The person then speculates that this **may** indicate that the partner he currently considers is unsafe. He "jumps ahead to the underlying pattern." To test

his hypothesis, he looks for secondary indicators. [Victor did this by asking Julio what Cruisingtown is like.] If he does, there will be two possible outcomes. First, the tertiary indicator will be found to "mean something else." In this case, no further speculation takes place **along this line**. Second, it will point to a secondary indicator. The original appearance is then confirmed and, since the distance to the underlying pattern is shorter, speculation will have greater importance. [Victor found that Julio "hadn't exactly been a saint."] The process then repeats itself. The person jumps ahead to the underlying pattern by formulating another hypothesis, he tests, the result will either belay or confirm his suspicions and, if the latter, a primary indicator will arise. [Victor tested this by talking about the high price of condoms.] At the final stage, a primary indicator will either point to the underlying pattern or not. Since it is primary, however, it generally will and its appearence will most likely be enough to reject the sexual encounter [as did Victor]. However, if the person wants to be even surer, he tests once again. This entire process is depicted in **FIGURE TWELVE** on the next two pages.

Goffman [1974] stated that human beings deal with multiple levels or "frames" of reality with little difficulty. They may either key up or down from one to the other, or they may deal with two or more simultaneously. Risk assessment may take place in the same way. If each "line of assessment" as describes is regarded as a frame of reality, then speculation and testing of different indicators may take

FIGURE TWELVE

THE PROCESS OF RISK ASSESSMENT FROM TERTIARY INDICATORS TO THE UNDERLYING PATTERN [1 of 2]

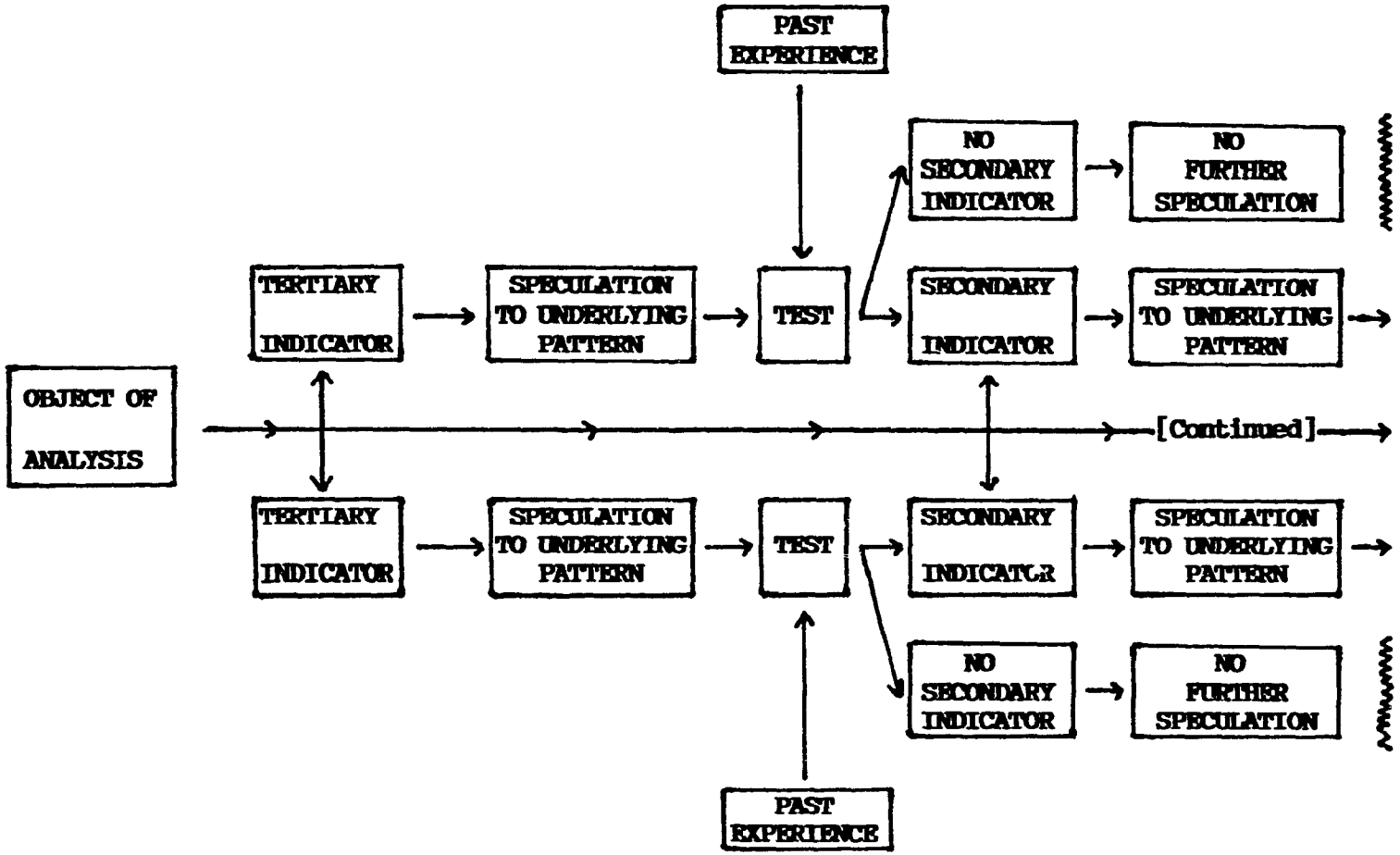
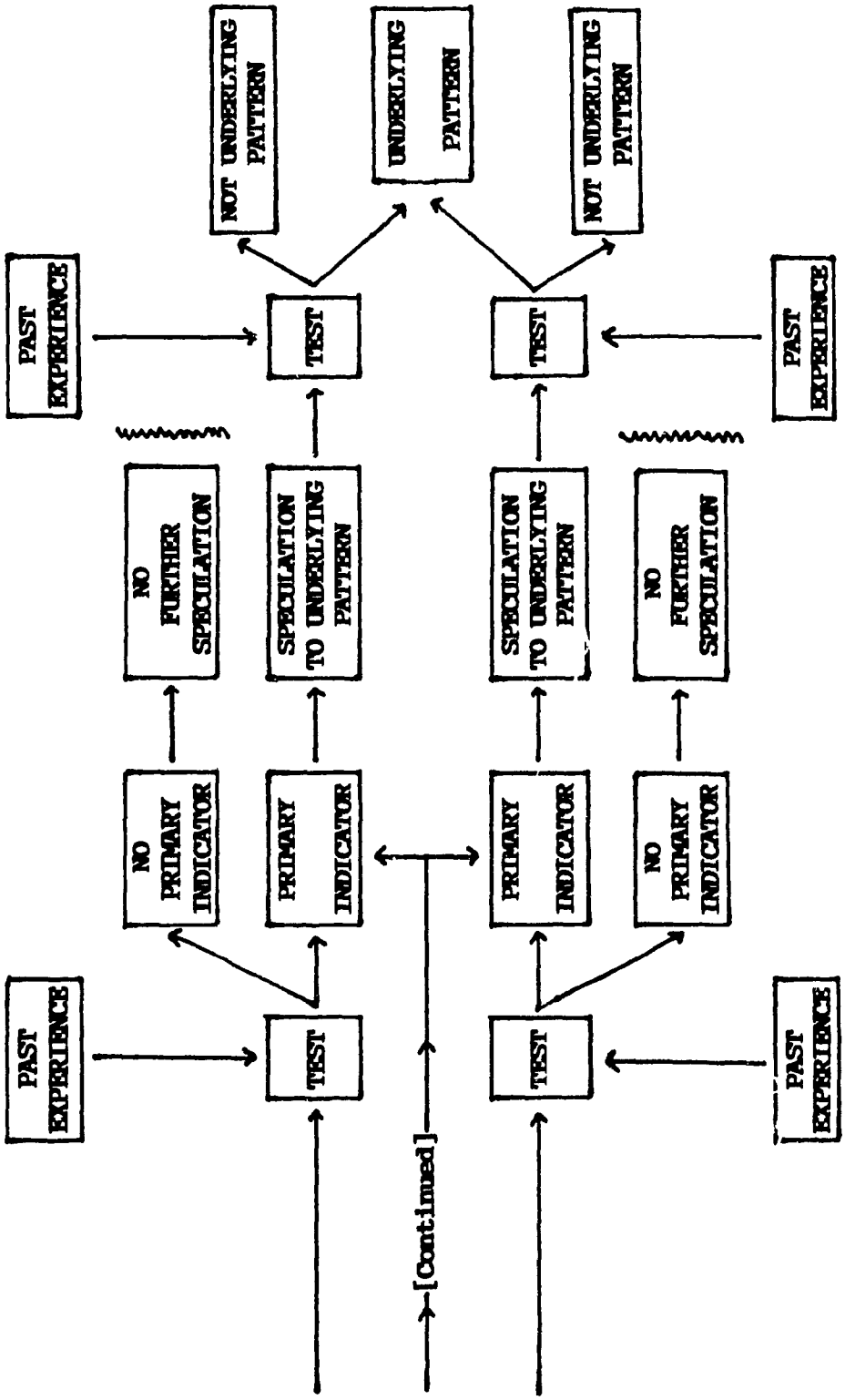


FIGURE TWELVE

THE PROCESS OF RISK ASSESSMENT [2 of 2]



place on several levels, sequentially or simultaneously. Risk assessment may therefore be a unilinear or multilinear process.

Some final points must be made. First, although I have chosen partners to illustrate risk analysis, the model applies equally to contexts. Whether a location, a situation, or an environment, contexts also have primary, secondary, and tertiary indicators. Any may be the object of analysis. Second, risk analysis need not necessarily begin with the hypothesis that partners or contexts, as underlying patterns, are unsafe. In more optimistic scenarios, significant indicators may arise pointing to safe partners and contexts. Third, risk analysis need not be carried to completion whenever indicators arise. Sometimes, the mere existence of them, even at the tertiary level, is enough to make a decision upon sexual action. ["He goes to Cruisingtown and that's good enough for me. He's not safe!"] Lastly, I again emphasize that my explanation is **not** to be taken as a blue print for all risk assessment. It is an **ideal type** meant to give perspective to the many variations, nothing more.

3.] METHODS OF DETERMINING RISK.

So far, I discussed risk assessment in two respects. First, it exists even though a person makes a rigid advance decision to perform safe acts only with everyone he has sex with. He merely points this out to himself each time a sexual

encounter becomes possible. Second, risk assessment occurs whenever significant indicators of safe or unsafe partners or contexts arise. The person may be aware he is doing this, or he may not. In this subsection, I discuss a third area of risk assessment where decisions are made in advance to systematically test for the presence of particular indicators. Whether primary, secondary, or tertiary, these indicators **are significant** enough to warrant methodological determination in all sexual encounters where they are thought to be found. In other words, people will use definite methods to determine risk prior to sexual activity. The respondents told me of many. Some were simple such as asking direct questions about sexual history, others were innovative such as inspecting the other's bathroom cabinet for antiviral drugs. Most fell into one of four categories: a.] Questioners. b.] Manipulators and experimenters. c.] Impressionists. d.] Inspectors. I present each first and then discuss the more uncommon ones.

Since we rely heavily upon verbal communication, it is no surprise that asking questions was the most common reported way of determining risk. The respondents are **questioners**. Typically, they ask their prospective partners about the number and contexts of past sexual encounters. [This is often recommended in AIDS education media.] If the number is small and the contexts within relationships, the partner is considered safer. The following reports are typical:

> I'd have a conversation.... I would talk to him. I would discuss things such as where do you live,... have you any major boyfriends, did you have a lover for a long period of time, do you have a lot of casual sex, and so on. [I would] find out more about the person to see if he does have casual sex often.
>
> [Unemployed man, age 23]

> People who pick you up get into a long conversation before. Like what are you up to? What do you like to do? They all like to know if you've been safe. When I go with somebody, in the conversation I work it around. I say what have you been doing, eh? And if I don't think its too safe [I decline].
>
> [Unemployed man, age 24]

> We usually talk. I get their history. I want to get an idea of their background and what kind of [people] they are. So I'll just sort of talk to them.
>
> [Student, age 22]

Unless in a bathhouse or tearoom, conversations virtually always take place among strangers before sex. However long, they are used to present oneself in an attractive manner, feel comfortable with the other, arrange the encounter, and so on. For these men, they are used additionally to determine risk.

In some cases, a respondent not only attempted to get information about sexual history but he was aware of being questioned himself for the same purpose:

> They go about it in a beat-around-the bush way. We're talking and they're asking me questions and then I wonder if I answered that one right.
>
> [Child care worker, age 22]

> In a round-about way, they say how you doing? Ever sleep with that guy? You know, stuff like that? They want to find out without offending you.
>
> [Unemployed man, age 24]

One might assume this would cause resentment. To many, it does not. Some saw it as a sign of caution which, in turn, indicates lower risk. Conversely, when no questions of sexual history are asked, it may indicate the opposite:

> He wanted to take me home right there and then after talking to me for ten minutes! I could've been anybody. I could've slept with every guy in town. He didn't even ask anything except what's my name and what's my favourite bar.
> [Student, age 18]

In general, diplomacy is the rule. Although questions had a specific purpose, they were designed to appear as though they had another. To ask "have you ever had a long-term relationship?" may be intended to determine periods of promiscuity or fidelity to partners, but deliberately appears as showing interest in the person, general barroom conversation, or otherwise. Some even asked "do you come here often?" to determine frequency of cruising. Even through some were aware of their **questioner's** real purpose, they did not let on. Instead, they either gave their best answers or qualified them with an explanation. ["I did go through a promiscuous period **but** that was a long time ago."]

Once again cruising ritual takes on mutual hidden purposes and mutual knowledge of the hidden purpose of the other. [I know you know why I ask these questions, you know I know this, and I know you know I know it!] Goffman might have used a job-interview metaphor to explain it. The interviewer questions the applicant, the applicant knows the intention of his questions, he knows the applicant knows this, and he credits him for doing so. But as long as neither "breaks the

rule" and reveals his awareness of the ritual, it will go on smoothly.

A variation of this method is "being direct." Questions are asked having no other purpose than to determine risk:

> I ask them straight out. Do you fuck around a lot? Especially if its an older man.
>
> [Unemployed man, age 24]

> I would ask. I'm not a person to pull punches.... I would ask them if they had ever been in a long-term relationship. I would ask them if it was monogamous. I would ask them... how sexually active they had been in the past.... If anybody feels that I'm being too direct and too invasive by asking [him] those questions then sorry. If that bothers [him], then [he's] not the type of person I want to be associated with!
>
> [Caterer, age 22]

Not only do the questions have a direct purpose, but they are entirely undisguised. Both examples show this well. The second respondent even gives his questions an additional purpose. Not only does he base his assessment upon the responses, but the other's reaction as well. Two birds, so to speak, are killed with one stone.

Most respondents preferred round-about questions instead of direct ones. As they stated, such candor is not only taboo but of limited value since the other may become defensive or lie. As one put it, "Everybody's a virgin these days, right?" The second method, involving verbal manipulation, is intended to "control" for lies. Questions or statements are made in such a way as to get the other to inadvertently reveal information about himself through words or actions. The following two comments exemplify this:

> [The respondent relates a past incident where he thought he had AIDS, went for a test, and found he did not.] I usually relate that story because it has two purposes. [First], they may open up and tell me something and [second], they may get totally turned off and just walk away. Then I don't want anything to do with the person anyways.
>
> [Student, age 21]

> The way I do it is I just don't ask a question, I'll give my answer to the question and then say how about you? I don't come here often. Are you here a lot? I don't get out that much. This is really new to me. Oh, I'm sorry, this is really weird. I don't meet people like this. Do you? I sort of manipulate them.
>
> [Another student, age 21]

In the first case, as the respondent states, there are two purposes to the story. First, it may lead to the other's revealing significant information. He is a **manipulator** since the story has only a hidden purpose. Second, he tells the story as stimulus, and then measures his subject's response. The story is the treatment and he is the **experimenter**.

The second respondent uses a method similar to the questioner's but with an added feature. While the questions are designed to get specific answers, the revealing premises beforhand are designed to disarm the other and ensure that the answers are truthful. He is a **questioner** but also a **manipulator**.

The third method is that of the **impressionist**. He has a conversation like any other before sexual activity, but he detects significant variables through impressions, feelings, "vibes," or what is "written" on the other's face. The following are typical examples:

> Some faces, you know. We are human and sometimes our eyes tell our attitudes. Our features. There's a sensuality. You can say these people are like this, like that.
>
> [Teacher, age 38]

> I'm a college professor and I'm around people that age [young] all the time and, when you're used to that, you just learn to read them very fast.
>
> [Pianist, age 40]

> [From young people in City Park] you can tell from the vibes you get whether they've had a lot of experience with men.
>
> [Office worker, age 28]

> [Regarding bathhouses] Its a vibrational thing. You just get the feeling that there are things going on there in spite of or in the face of AIDS.
>
> [Unemployed man, age 36]

Although each vibration, feeling, or impression has a subject [young people, a bathhouse, eyes], the **impressionist** does not base his assessment upon any empirical quality of it. Rather, he is attuned to his own feelings towards it. The first saw attitudes in eyes, the second "reads" young people, and the third and fourth get vibes or vibrations. The criteria for assessment therefore differs. Questioners, manipulators, and experimenters base their decisions upon the variable qualities of their subjects. Impressionists do the same but they are their own subjects. Their decisions are based upon how **they** react. In this way, the criteria for assessment is **built in.**

The fourth methodologist is the **inspector.** Here, physical characteristics are inspected for tell-tale sig' of risk:

> I'm going to look at how healthy the guy looks. Is he thin? Is he sick looking? I wouldn't even consider this kind of a guy.
>
> [Unemployed man, age 34]

> What I generally do is look at the age of the person and compare that to the skin tone, the skin texture. In other words, has it aged prematurely? Does he have a sickly pallor to him. Also the eyes - the youth of the eyes in relation to the age of the person.
>
> [Pianist, age 40]

> [In City Park] First of all, you get them in a place where there's a bit of light, then you can see.
>
> [Office worker, age 28]

> I sort of check the person out first. If somebody had Kaposi's sarcoma, there's the spots. Otherwise, I was told that there were a certain amount of bumps along the lips. I was told this from a gay... dentist [who] said that he would check that.... He said they were like white bumps.
>
> [Choreographer, age 31]

Everyone forms impressions of others on the basis of what he or she sees. In this sense, inspectors are no different. They distinguish themselves, however, not only by their advance decision ["I'm going to look..." "What I generally do..."] both to look for particular characteristics, and base a conclusion upon them. Inspection is a good method in so far as it can accomplish its goal unobtrusively.

AIDS education media have occasionally recommended that partners inspect each other's bodies before sex. This has some advantage in that certain visible characteristics such as Kaposi's sarcoma lesions do indicate an AIDS-related condition. However, when their absence leads to the belief that the other is safe to have sex with, inspection is misused. As a point of interest, one respondent said he had

diagnosed two people as having an AIDS-related condition while in bed with them. He, however, is a doctor.

Two other methodologists of note are **networkers** and **snoopers**. The following are respective examples of both:

> You know what happened to me?... I was introduced to someone by my friends. [I have a] particular friend who would never say anything bad about anybody... I asked [him] what do you know about this person. He says well, basically, he's nice person. After I got to know the person some more, I found out he was really promiscuous. Every [member of my race] he spotted, he went after. It could've been avoided because I asked my friend to tell me everything about this person. He didn't want to mess it up. I said well, I'd prefer you to do that rather than for me to do something and then regret it after. 1 said to him tell me the next time I ask you.
>
> [Child care worker, age 22]

> If I go to his place, that's good because I can find out a lot more about him from just what kind of stuff he has lying around his apartment.... Like if the guy has a lot of porn [pornography] lying on his coffee table, you know he's really into having it with a lot of guys.
>
> [Unemployed man, age 34]

The networker relies upon the network of social relationships within the gay community to gain access to important information. Since many who go to bars regularly tend to know or know of each other, this method can be possible. Its efficiency, however, depends upon the information others hold as well as their willingness to impart it. In the above instance, this led to the method's failure.

.Snoopers are similar to inspectors in that they base their assessments upon tangible phenomena. They differ, however in that their method depends upon access to private

areas of the other's world. In view of this, it is likely that snooping is a more opportunistic method.

To review, I have discussed three aspects of risk assessment. First, even though a decision is made in advance to perform safe acts only, the actor must still indicate this to himself each time he is faced with an encounter. Second, risk assessment may not be conscious until significant indicators of safe or unsafe partners or contexts arise. Third, many men systematically use particular methods to determine risk. If my intention in asking the respondents about their methods is to reveal them, then my own research method is poor. Many are not aware of their often taken-for-granted ways of making sense of their experience. The resulting typology of methods, however, was only serendipitous. My true intention [which I told the respondents in debriefing] was to determine **significant** indicators of risk. If a person uses methods regularly to determine particular indicators, then it is likely that they are significant enoug'. to determine his sexual behaviour.

* * * * * * *

CHAPTER TWELVE

SAFE-SEX-LIMIT MOTILITY:

HOW GAY MEN MAKE UNSAFE SEX SAFE

These Moors are changeable in their wills; - fill thy purse with money: - the food that to him now is as luscious as locusts, shall be to him shortly as bitter as coloquuintida.

[William Shakespeare, 1564 - 1616]

CHAPTER TWELVE

The ultimate goal of my research is to respond to the question: why do homosexually behaving males, fully aware of the dangers of AIDS, continue to have unsafe sex? Even though these dangers are well publicized, and even though knowledge levels are high, newly diagnosed cases continue to come in at an alarming rate. My answer is that this continues because, through social construction, these men **make unsafe sex safe.** They are aware of the act-dependent definitions of safe sex, but they neutralize them with overriding definitions pertaining to sex partners and sexual contexts.

To explain this, I develop the **safe-sex-limit motility model** as shown in **FIGURE SIX**. First, once a person gathers information upon sex acts, he polarizes them. He holds some as safe, others not. I represent this with a **safe-sex continuum**. By definition, to regard an act as safe or unsafe is to regard its performance in the same way. The continuum is not merely one of acts, therefore, but of act performance. Since this suggests a limit upon which acts the person is willing to carry out, I call the point dividing acts held as safe from those held unsafe the **safe-sex limit**. It exists for the person prior to any sexual encounter.

Even though he may not hold such meanings as significant enough to guide behaviour, he also polarizes sex partners and sexual contexts. This is a natural development from the knowledge that not everyone is seropositive. Again, some are

held as safe, others not. Together, I call these meanings **alternative definitions** of safe or unsafe sex. Depending upon the circumstances of a sexual encounter, these definitions may become significant enough to override act-dependent ones, or they may not. When they do, they are used to guide behaviour instead. Typically, the person thinks yes, this act is unsafe, but **not in this case**.

During risk assessment, alternative definitions interact with act-dependent ones in one of three ways. First, they will have no effect. None are significant enough to override the original act-dependent ones, the safe-sex limit stays as is, and there is **no motility**. Typically, this occurs when people have high degrees of self efficacy and strong commitments to act-dependent definitions. Second, alternative definitions override act-dependent ones in such a way as to render acts originally held as safe unsafe. On the continuum, the safe-sex limit moves to the right, a process I call **dextral motility**. Here, the person may believe his partner is is so unsafe that few or no acts performed with him preclude transmission. Third, and most important, alternative definitions override act-dependent ones causing those originally held as unsafe to be redefined as safe. Since the safe-sex limit moves leftward, I call this **sinistral motility**. Here, unsafe sex is made safe. Even though the person knows the acts he performs are "normally" unsafe, special circumstances - most typically, a strong belief that his partner is not infected - render them safe.

When no motility or dextral motility occurs, there is

essentially no danger of infection. In both cases, providing his knowledge is biomedically accurate, the person performs safe acts only and, in the latter, he may perform none at all. The danger of infection is imminent only with sinistral motility.

In this chapter, I use the respondents' comments to show how this takes place. I divide the discussion into three parts: a.] How alternative definitions affect each other. b.] Dextral motility. c.] Sinistral motility. Since "no motility" is self explanatory, I omit it.

1.] HOW ALTERNATIVE DEFINITIONS AFFECT EACH OTHER.

In the tridimensionality of sex, I stated that all three dimensions - sex acts, sex partners, and sexual contexts - are inseparably interlinked. Each gives substance and meaning to the others. Before discussing how sex acts are affected by alternative definitions, it is necessary to explain how these definitions affect each other. In the spirit of Goffman's Frame Analsis [1974], I mentioned that there are indefinite numbers of both partner-dependent and context-dependent definitions in one sexual situation. Not only will any one of the first affect any one of the second, but any will affect another **within** the same dimension. One partner-dependent definition will affect other partner-dependent definitions; one context-dependent definition will similarly affect other context-dependent definitions. The interlinkage is endless.

In view of this, I limit this discussion to a few examples where partner-dependent and context-dependent definitions affect each other.

Most commonly, the respondents' comments show that meanings given to environments directly affect those given to the partner:

> [Dating agencies] are the best because people are probably trying to stay away from the bars.... They are probably not on the town or in the bar scene trying to find someone. They're trying to take a smarter approach to it.
>
> [Computer technician, age 28]

> If the person's home or apartment looks untidy or run down, that can give you the indication that maybe [he does not] have the energy to do [clean] it. If [he does not] take care of [his] belongings, you get to question why.
>
> [Computer technician, age 28]

> [In La Cité], gay clubs, they don't allow women. If they do, its like once a year or once a month. Because they are all men, it seems like everyone there, or the majority of the people there, are looking for something. They're looking for a one-night stand.
>
> [Student, age 22]

When the first respondent saw people using dating agencies as "not on the town" or "taking a smarter approach," he did so because of the meanings such organizations have for him. These meanings, in their turn, transferred directly to the people involved. As the second comment indicates, he did this similarly with another environment. An untidy apartment reflects upon the occupant.

The second respondent notes that La Cité's gay bars do not admit women. This creates a special environment with meanings pointing to those within it. His perception that

they are looking for one-night stands arises directly out of their environment. Situational contexts had the same reflexive effects:

> I think that [going to bars] is playing Russian Roulette. You meet somebody and you go home with [him] and you don't know [him] at all.
>
> [Student, age 22]

> If you're in a relationship, then you're with someone you can trust.
>
> [Student, age 25]

Both are very obvious. In the first case, "meeting somone in a bar" and "going home with him" are are sequential situations. They define the context. As a result, they also define the partner. He is someone "you don't know" and sex with him becomes "sex with a stranger." In reverse, sex with a stranger is sex with someone you don't know and, thus, someone met in a bar. The second case also shows this reflexivity. Since someone "you can trust" is someone "in a relationship," then someone in a relationship is someone you can trust.

One of ethnomethodology's principles is that all documentary evidences are accounts. Accounts not only reflect upon themselves but, as these examples show, they also reflect upon each other. As this happens, we begin to see patterns and organize our experience. This is the very essence of what distinguishes humans from other animals. The danger comes in when one account is regarded in such a way that it overrides and neutralizes another. When this happens, we may ignore accounts that are otherwise significant.

2.] DEXTRAL MOTILITY.

In my scheme, the safe-sex continuum begins with those acts held as safest and continues leftward to those held as least safe. Safe acts are on the right, unsafe ones on the left. The safe-sex limit divides the two. When dextral motility takes place, this limit moves to the **right.** Alternative definitions have affected act-dependent ones in such a way that acts originally held as safe are redefined as unsafe. How does this happen? How do definitions of partners and contexts affect definitions of sex acts in this way?

To begin, I defined a sexual encounter as a situation that not only exists in action but in **potential.** When people consider having sex with someone, they reflect upon **their** sexual action with that person. This is a broad definition for, in this way, a sexual encounter may be no more than a passing fancy toward a magazine center fold. There comes a point, however, when the consideration of sex with a person [even a type of person] is seen as **possible.** When this happens, the individual acknowledges that an **achievable** sequence of actions on his part will lead to its actual occurrence. Depending upon his desires, he may carry out these actions, or he may not. Thus, as I define it, a sexual encounter has at least seven stages: 1.] Fantasy. 2.] A desire to actually achieve it. 3.] An acknowledgment that certain actions will make it acheivable. 4.] Consideration of carrying out those actions. 5.] Decision to carry them out. 6.] Carrying them out. 7.] Achieving sexual action.

Since this is the case, a sexual encounter may cease to be such at any stage.

Risk assessment takes place at the fourth stage - the consideration of carrying out actions to achieve the sexual encounter. Here, the respondents' comments show that partner-dependent definitions often prevent the sexual encounter from progressing to the fifth stage. In other words, the person considers having sex with someone, but certain meanings surrounding that person indicate that the risk is too high. Acts normally considered safe are considered unsafe **with that person**. The following are typical examples:

> The ones [who] are acting like sluts. They're just all over everybody. Somebody like that **I wouldn't** trust. The type [who is] acting like a real whore. **You just get the impression** that they're not really into anything safe. They want to get fucked or they want to fuck or whatever.
>
> [Lab technician, age 31

> First of all, drugs... if they come back to [my apartment] and they're going to do drugs regardless of whether or not I want to do them. That immediately **makes me feel** unsafe.
>
> [Student, age 26]

> **I tend to shy away** from people who make obvious attempts to look gay - clones [a "gay look" of the 1970s], queens [outrageously effeminate gay men], people who need to set themselves apart. Often a part of that defining oneself outside of normal society involves anonymous sex.
>
> [Unemployed man, age 27]

Sexual action is considered in each case. Because of certain partner-dependent meanings - acting like "sluts," using drugs, making obvious attempts to look gay - that action is considered unsafe. The first would not trust such a partner,

the second feels unsafe, and the third tends to shy away. Certainly, they may be averse for other reasons. They may respectively feel that sluts, drug users, and clones or queens make unstable lovers. Their statements, however, in direct response to my questions, refer specifically to the risk of their sexual action. Furthermore, though they may be theoretical statements, they are no less an indication of what the respondent would do under the given circumstances.

As John Alan Lee points out in his correspondence to me [1989], risk assessment is continuous. It takes place at any stage where meaningful indicators arise. If this is true, so may dextral motility as the following suggests:

> Number one for me is a person who's not circumcised. **I feel** there's more risk in that. When I'm confronted with that, **I normally hold back** and **don't get too much involved.**
>
> [Computer technician, age 28]

Sex acts [possibly involving receptive fellatio], generally held as safe, are redefined as unsafe as soon as a meaningful indicator arises - in this case, an uncircumcised penis. [Pun unintentional.]

Sexual contexts - whether environmental, situational, or locational - were no less prominent in making safe sex unsafe. First, the environments:

> [I've] never done the baths. **I would never** even consider it because it would be **impossible to make sure you protect yourself**.... Its just an unregulated situation where you have no control.
>
> [Student, age 21]

> The first time I was in [a particular bar], it was very meat market-ish. The last time I went in, it was [even more of] a meat market. I mean **I consider that unsafe even if you're having safe sex.**
>
> [Student, age 18]

In both cases, meanings given to an environment reflected back upon the sex acts potentially arising from them. For the former, since a bathhouse is an "unregulated situation," protection during sex is "impossible." For the latter, the meat-market atmosphere of the bar rendered any sexual action arising from it unsafe - "even if you're having safe sex." Situations also had this power. One respondent told the following story:

> It was someone I met in a bar and [he was] quite decent in my opinion. I didn't sleep with [him]. We went out for a coffee and [talked], then I went to his place and we talked again. The subject [of sex] came up and we said to each other: "I don't know you and you don't know me. How do you know I'm not lying?" and vice versa. We both felt that we should just get to know each other [before having sex]. Then he kind of came on to me [made a sexual advance] and I was just shocked because we had just discussed this. I left because he probably [just] said this to please me. Obviously, he was lying and couldn't even wait a week.
>
> [Student, age 22]

This story shows how both context-dependent and partner-dependent definitions override act-dependent ones. For the former, when the respondent refers to the fact that he and the other did not know each other, he is in effect saying that sex is unsafe under such circumstances. "Getting to know each other" is to relocate the sex to a safe context and, thus, make it safe. For the latter, when the other made an overture, the respondent perceived him as "lying." Sex would therefore have been unsafe since it would be with a

partner who lies and who "couldn't even wait a week."

Few locational contexts were mentioned other than the high-incidence areas of New York City and San Francisco. A number thought that any sex in these cities is less safe. As one said, "If I'm in New York, I'd be very careful about what I do sexually." The very fact that being in this city would make him "very careful" well illustrates dextral motility.

As a general rule, when dextral motility takes place, the chances of transmission are greatly reduced. Either the person will restrict himself to those acts he still holds as safe, or he will avoid sex entirely. He will not perform acts he holds as unsafe. This is a direct result of the safe-sex limit moving to the right. However, dextral motility does **not necessarily** preclude exposure to HIV. There are two reasons for this. First, the person's knowledge may be limited to such a degree that he may normally perceive biomedically unsafe acts as safe. His safe-sex continuum, in other words, is based upon incorrect information. Second, at some point, alternative definitions may merge with act-dependent ones in such a way as to render them inseparable. This needs some explanation. Ideally, act-dependent definitions should be the **only** criteria guiding people's behaviour. In other words, unsafe acts should be regarded as such with **any** partner and within **any** context. When alternative ones override them, circumstances are such that their meaning is neutralized. This suggests that they are more or less stable **until** such circumstances arise. However, alternative definitions may be

so significant that they become **attached** to the act-dependent ones as a prerequisite to their truths. Anal intercourse is unsafe **if** the partner is infected. A condom is necessary **only when** in an unsafe environment. Mutual masturbation is safe **unless** done with such and such a type of partner. This is quite different than seeing an act as unsafe in and of itself. The following comments indirectly illustrate such linkages:

> If I ever go with a hustler [in this case, a male prostitute he finds on the street], it would just be something quick in a care.... I would always do something safe with a hustler.
> [Office manager, age 46]

> If I didn't know the person, I would ask him to use a condom more than likely.
> [Student, age 23]

> Flings [casual sexual liasons] areokay, but only with safe sex.
> [Pianist, age 40]

The first would "always do something safe **with a hustler.**" What would he do with others? The second would use a condom **if** he did not know the person. What would he do when he does know someone? The third sees casual affairs as acceptable **only with** safe sex. What about under other contexts? In each case, safe sex is conditional. It is carried out not as a general rule but under specific circumstances. The safe-sex limit moves leftward, but not so that acts are greatly limited. Rather, it moves from a position which already permits much unsafe sex to one where it ideally should be in the first place. Without the conditions leading to **dextral**

motility, it sits in its regular spot already **too far to the right.**

3.] SINISTRAL MOTILITY.

With few exceptions, when the safe-sex limit moves to the left, alternative definitions have had positive effects. If the goal of AIDS education has been to get people to see some partners and contexts as less safe than others, it has accomplished it very well. As I have shown, the respondents typically avoid sexual contact for such reasons.

When people do come to regard some partners and contexts as less safe, they are **comparing** them to others. If some are less safe, then others must be safer **by definition.** No value can be given to anything without a frame of reference. If some people are more likely to be seropositive, others must be **less likely.** If some contexts involve higher risk, then others must involve **lower risk.** When people hold such meanings, they will certainly avoid high-risk situations. In doing so, however, they will be drawn toward low-risk situations. Sinistral motility, when the safe-sex limit moves to the **left,** is inevitable with some as a by-product. In this sense, education and news media rhetoric has **backfired.**

In the previous section, I concluded the discussion with examples of alternative definitions being so significant that they become **conditional** to act-dependent ones. An act is

unsafe **only** **when** done with an unsafe partner. Not only does this lead to dextral motility but, more importantly, the reverse. The following comments show how this happens:

> [Anal intercourse] is unsafe **if** the other person has AIDS. I mean if you're going to fuck another guy who has AIDS, then you're going to get it. But **if you're sure** the other guy doesn't have AIDS, the **go ahead**.
>
> [Unemployed man, age 34]

> I think everything is safe **as long as** the person you're doing it with is **okay**.
>
> [Student, age 23]

Both, rather than giving sex acts risk values of their own, make these values entirely dependent upon partners. Anal intercourse is unsafe **only** **when** done with an unsafe partner. Every act becomes safe **only** **when** done with someone who is "okay." These, however, are general statements. When other respondents said they would relax their standards, they would only do so if they saw their partners in very specific ways:

> The **size** of the individual. He'd **look very athletic**. [Because of this] **I would do things I normally wouldn't do**. Things like allowing ejaculation while performing oral sex. that's something I'm very fussy about. It would have to be [with] someone **who I think is safe**. I guess not using condoms [for anal sex] is alright **if I think** the person is safe.
>
> [Computer technician, age 28]

> I guess I would go **from** safe sex **to** low risk **if** the person was very responsible and I had known him for a long time. So, honestly, it does make a difference in that way.
>
> [Student, age 21]

The first mentions two acts he normally considers unsafe - a partner ejaculating while he performs fellatio, and

unprotected anal intercourse. With very athletic partners, the risk meanings for both are neutralized. "Looking very athletic" is a partner-dependent meaning significant enough to override the act-dependent definitions. The second comment well illustrates *sinistral motility*. The safe-sex limit moves from its point on the continuum just to the right of "safe sex" to one just to the right of acts considered "low risk." Alternative definitions causing this movement are "very responsible" and "known him for a long time."

Theoretical statements of "what I would do if" were not the only ones showing sinistral motility. Often, partner-dependent definitions actually did influence sexual behaviour. One overriding factor was nervousness:

> I did it [insertive anal intercourse with no condom] to a guy about a year and a half ago.... I knew the guy for a really long time. I was **pretty sure it was safe with him**. He was really nervous and paranoid about getting AIDS. He was really nervous about it.
>
> [Student, age 23]

> I'll tell you a story of a guy I met a while back named David [name purposely changes]. I saw David in a bar and started talking to him. He came from a **very good family** and they were **very well off**. When it came down to the part where we were going to have sex, he was **very very scared and nervous** about the whole thing. He was very nervous about what could happen and what he could catch. He was **even nervous about kissing. I figured out** that if he's going to be that nervous and uncomfortable about all this, **then he's safe**. It would be **very unlikely** that he would have a lot of experience and it would be very unlikely that he's ever done anything before that would be really unsafe.
>
> [Pianist, age 40]

Both show similar interpretations. The partner was overly concerned about the dangers of AIDS in sex. This made it likely that he had been conscientious about safe sex before.

Since this was the case, he "had to be" seronegative and, thus, safe. It is interesting that the respective partner's willingness to have unsafe sex with the respondent - whether easily or after much negotiation - had little effect.

Sinistral motility took place for the next two respondents since they perceived their partners as having little previous sexual experience:

> Of all the times I had sex in [City Park], maybe three times I have sucked [performed active fellatio] somebody else. In all three cases, they were young - students, possibly late teens, early twenties and **you can tell from the vibes** that you get whether they've had a lot of experience with men. Not only does this make me **less worried about the kind of sex I have** with them but it also excites me more.
>
> [Office worker, age 28]

> [There was] recently a time when I had anal sex with someone without a condom. I suppose, at the time, this person had only slept with two other people. He had just come out of the closet and it was sort of at his suggestion that I do it without a condom. Its a real double standard because I knew at the time that I didn't want to come [ejaculate] inside yet **it just didn't seem like as big a risk.**
>
> [Student, age 26]

The first, an **impressionist** [see previous chapter], believed that his partners were safer because of their youth. This, in turn, made him feel safer about performing fellatio. In other words, because he defined his partners in a specific way, this particular sex act was also redefined. The safe-sex limit moved from a point to the left of it to one on the right. The second respondent saw his partner as seronegative because of his lack of sexual experience. Once again, however, a partner's willingness to have unsafe sex is downplayed. Even though the respondent did see this as an

indicator of high risk, it was overshadowed by the one indicating low risk.

In this chapter's first subsection, I showed how partner-dependent and context-dependent definitions interact with each other. Often, as the following illustrates, they have an interactive effect on act-dependent ones:

> The unsafe sex I did have would generally be with one of the escorts... I will use escort services [call-boy agencies]. I know that it's expensive, but **I have a better chance** of finding a cleaner person - someone who doesn't have anything I can catch.... If they're going to charge all that money, they had better be [safe], hadn't they? Its also been my experience that they're a cut about the ordinary street hustler. They're generally cleaner looking. They are usually better dressed, and a lot of them are college students trying to get rent money and that sort of thing. I've met a number of them [who] are quite well-spoken and educated.... It just stands to reason that they wouldn't have AIDS.
>
> [Office manager, age 46]

First, the partner and context indicators reflect upon and give meaning to each other. Escort services give one "a better chance" of finding partners who are clean, educated, and well-spoken - all indicators of low risk. They are therefore safe contexts which, in turn, give low-risk meanings to the partners found within them. The fact that it is a more expensive form of prostitution makes it even safer. Once the respondent sorts these meanings out, their combined product influences his act-dependent definitions.

The contextual indicator causing sinistral motility most frequently was and amount of time the partner is "known." This varied considerably:

> Its usually me who wants to have unsafe sex with them and they say no. But, generally speaking, **I restrict that** to when I've know the person for **a long time**. If you know them for a long time, then you trust them more.... Safe sex **means** that you don't get involved with a person **if you don't know** him. As soon as you [do]... and you learn that he is safe, then you can have any sort of sex that you want.
>
> [Pianist, age 40]

> There seems to be a certain monotony that instills itself after a couple of hours [of having sex], especially with the safe [sex] thing, especially after a **couple of times when you really get to know the person and feel safe**. Subconsciously, you say to yourself, well, this person can't have AIDS. You really get to trust this person.
>
> [Student, age 19]

> This is a cop out [rationalization]. There's no excuse for it. But I'm only human. I tend to talk to people a lot before I have sex with them. If the person is sincere, which I can only hope that [he is] after hearing of [his] past sexual experiences, I feel oh, maybe [he's] safe because [he's] usually been with a lover.... I go by my guidance, by what [he's] done in the past. Then, occasionally, I'll be unsafe.
>
> [Student, age 23]

If all three are compared, "knowing the other person" decreases in standard. The first sees it as "a long time," the second after "a couple of times," and the third after a long conversation. Each time, the respondent reaches a level of "trust" which enables sinistral motility.

The third respondent well illustrates how the advice of AIDS education campaigns can be used. "Know your partner" and "ask direct questions about your partner's sexual history before having sex" are phrases so typical of their messages they have become rhetorical. If their intention is to get people to **"be sure"** their partner is not seropositive then,

presumably, answers indicating more stable relationships and less anonymous sex [and perhaps less sex in general], would be best. However, by giving such advice, it is implied that transmission is dependent upon such factors as opposed to the acts performed. Not only is "knowing one's partner" virtually never defined but, once many believe they do, they use such knowledge as a license for unsafe sex.

Educators **must** be aware that the gay community is not a makeshift replica of heterosexual society. It is a distinct cross section with its own history, its own culture, and its own values. Often, because of the pressures put upon it, it is difficult to sustain a long-term relationship. And, as has at least been the case in the 1970s, the anonymous sexual encounter may be regarded as way of growing, of asserting, and of forming identity. Although this is rapidly changing, the past sexual histories of gay men are measured by other gay men by different standards.

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C O N C L U S I O N

CONCLUSION

The Safe-Sex-Limit Motility Model was born out of an enigma. In a world where one is constantly reminded of the dangers of AIDS, many gay men [and no doubt others as well] continue to have unsafe sex. Why? It would be simple to say that they are uninformed. Somehow, all warnings have eluded them. This is the assumption of what I have called the "educational model" and the driving force behind its prevention efforts. The more the information given to the population, and the more its concentration and consistency, the more people will restrict themselves to safe sex.

Although this outlook has helped, it is clearly only part of the solution. It misses the fact that many, already well informed, continue risky practices. There are at least two reasons for this. First, people are not merely shapeless mediums through which fixed information passes through on the way to fixed action. Rather, they are the creators of that action. They gaze upon a world, meaningless in itself, give it meaning through the process of interpretation, and conduct their behaviour on the basis of what makes sense to them. The safe-sex message, then, is shapeless until it is shaped by those who come by it. Second, the potential for differential interpretation may be reduced by uniformity, repetition and concentration of the message but, ultimately, it is always present. It is easy to assume that all people think alike but, clearly, they do not. Whatever an individual comes by in

his lifeworld, he will interpret it on the basis of what he knows, not what others know and not some collective reservoir of knowledge floating motionless above him. Ultimately, he will act on the basis of what works for him, not others and not society in general.

To answer why gay men continue to have unsafe sex, I have deliberately avoided such assumptions. Rather, I have treated knowledge not as correct or incorrect but as something which the individual possesses. Regardless of whether it is in keeping with the biomedical guidelines, it is still the individual's tool kit for interpretation. It is still what guides his behaviour. This is a significant departure from the usual tendency to treat incorrect knowledge as no knowledge at all. In truth, no one who is aware of something has "no knowledge" of it. He can only have knowledge of it that varies from that of others. To believe that unprotected anal intercourse poses no threat, or that handsome men can not have AIDS, may be uninformed or misguided, but it is knowledge to the individual nonetheless until he believes otherwise.

By giving all knowledge equal footing, regardless of its nature, a particular view of AIDS and behaviour becomes accessible. Even though gay men may be in possession of similar information on the risks of unsafe sex, they do not base their behaviour on some predefined objective way of regarding it or using it. Rather, they do so on the basis of what makes sense to and what works for them. This, in turn, is reducable not to "knowledge" as if it, too, were

predefined. Rather, it is reducable to the nature of "their knowledge."

In putting these assumptions into practice, I interviewed thirty-five gay men. Instead of placing an objective yardstick beside the responses to measure their accuracy, I treated all as equally representative of the individuals' interpretations of their lifeworlds. There were no true or false interpretations - only interpretations.

What have I accomplished with such an outlook? First, I have shown that sex is not merely a series of actions but, rather, actions towards particular people within particular contexts. Sex acts can not be disembodied from these dimensions. To the individual, they give them form, meaning, definition, and direction. He does not regard sex as an abstraction. Rather, he regards it as something he does. To "do" sex is to do it with others and to do it with others is to do it within particular locations of time and space. Second, I have shown that people's interpretations of the same phenomena are indeed different. While some are inclined to think older people are less likely seropositive, others see younger ones in the same way. While some people see tearoom sex as most dangerous, others see it as the safest available. These interpretations come not from some perversion of absolute knowledge, for such a thing does not exist. Rather, they come from the individual's own knowledge - a product of his unique experience and the basis for his behaviour. Third, I have shown that variations in behaviour are not the products of different degrees of knowledge but,

rather, different knowledge itself. Once again, if we want to know why people act the way they do, we must not look towards "how much" they know. Rather, we must look at "what" they know.

In presenting the respondents' interpretations, I have deliberately avoided counting those in common. Instead of reporting frequencies and proportions, I have deliberately used phrases such as "some believe," "a few think," or "one or two have said." To look for how many think such and such is to misunderstand my intent. I do not present what the respondents most commonly think, nor do I assume that any thoughts are generalizable. In fact, I firmly believe that thirty-five other respondents would have yielded thirty-five other interpretations. I only present the thoughts themselves to illustrate first their existence, second, their construction, and third their use in behaviour. I do not say "these are typical interpretations." Rather, I say "interpretation is the basis of behaviour and these are some of the ways one leads to the other."

If anything should come of my research, it should be the realization that AIDS prevention messages must be stripped of all encouragement to see safe and unsafe sex in terms of partners and contexts. To say that one type of person is less safe is to say that another is safer. To say that sex is not safe within a particular context is to say that it is safer within another. As I have shown, with some, this leads to false senses of security and, ultimately, the performance of

unsafe acts. Foremost in this respect, we must cease all recommendations to "know" one's partner. Not only is this undefinable in terms of quality and quantity, but it enables unsafe sex probably more than anything else. Viruses recognize only opportunities for transmission. They do not recognize social relationships. Finally, and perhaps most sadly, partner-dependent definitions of safe and unsafe sex lead ultimately to prejudice and discrimination. If people with AIDS are "the new lepers," then partner-dependent and context-dependent definitions within AIDS-prevention messages have certainly contributed to such a view.

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A P P E N D I C E S

APPENDIX ONE

SAFER SEX GUIDELINES

In March, 1988, the Canadian AIDS Society completed a report entitled Safer Sex Guidelines intended as a resource guide for educators. It is both comprehensive and insightful. For these reasons, I synopsize that pertaining to gay men. Copies of the report are available from **CAS Distribution, Box 55, Station F, Toronto, On. M4Y 2L4**

The authors purposely use the phrase "safer sex" rather than "safe sex." They do this to avoid the impression that most sex acts are either entirely safe or entirely unsafe. Second, they do not discuss abstinence. As they correctly point out, it is not a sex act. Third, they recommend that risk be seen in terms of activities, not group membership. Although the concept of risk groups is useful epidemiologically, "it is a destructive and dangerous concept when used in media, education and counselling. [p.6]

A distinction is made between **theoretical** and **practical** risk. The first pertains to whether the conditions for HIV transmission may be present. The second refers to its probability based upon empirical evidence. With this in mind, the authors recommend a three-level model of risk: a.] **No possibility** of HIV transmission. b.] **Minimal to low**

possibility of HIV transmission. c.] **Very high** possibility of HIV transmission. The first has neither theoretical risk nor evidence of transmission. The second has theoretical risk but there is either no evidence of transmission or a very small amount. The third has theoretical risk and a great deal of evidence to substantiate it.

In **TABLE THREE**, I list sex acts possible between men, their synonyms, and the report's risk classification of them. I omit exclusively heterosexual acts and those of the first level where no body contact whatsoever takes place [e.g. telephone sex, erotic talk]. The appearence of any act in this table makes no statement about its frequency or popularity. Indeed, some are no doubt common, others esoteric. The report also lists six principle co-factors which may modify risk favourably or unfavourably:

Sexually transmitted diseases: May irritate mucosal linings or cause ulcers, chancres, or open lesions. This allows greater viral access to the blood.

Multiple partners, multiple exposures: In general, the greater the compliance with the guidelines, the less the significance of the number of partners. Frequent unsafe sex is riskier than infrequent unsafe sex, but a single exposure is all that is necessary for transmission. The rate of infection in the population must also be considered.

Alcohol and drugs: May reduce the ability to make sensible decisions. May suppress the immune system.

Open cuts, skin sores: Allows virus to gain access to blood.

Condoms, protective barriers: Although latex condoms are impermeable to HIV, they are subject to misuse and breakage. Lambskin condoms prevent pregnancy but not HIV transmission. Water-based lubricants [e.g. KY jelly] rather than oil based ones [e.g. Vaseline] should be used since the latter softens condoms making them porous and breakable.

Spermicides and viricides: Nonoxynol-9 kills HIV. Since its base is detergent, however, it should not be used during anal intercourse. No others are recommended yet.

* * * * * * *

TABLE THREE

SEX ACTS, SYNONYMS IF ANY, AND THEIR CANADIAN AIDS SOCIETY RISK CLASSIFICATIONS

SEX ACT	SYNONYMS	RISK
Mutual masturbation	Jerking off, J-O	None
Dry kissing	-----	None
Body-to-body rubbing	Frottage	None
Body licking and kissing [except mucosal linings]	-----	None
Massage, body caressing	-----	None
Erotic bathing, showering	-----	None
Unshared sex toys	Dildos, etc.	None
Nipple stimulation [without drawing blood]	-----	None
Nibbling, biting [without drawing blood	-----	None
External urination	Pissing, golden showers	None
External defecation	Shit, scat	None
Receptive analingus with barrier	Getting rimmed	None
Insertive analingus with a barrier	Rimming	None
Wet kissing	French kissing	Minimal
Ingesting urine	Drinking piss	Minimal
Ingesting feces	Eating shit	Minimal
Analingus without barrier	Rimming	Minimal
Insertive fellatio without condom	Getting sucked, getting blown	Minimal

TABLE THREE [cont'd]

SEX ACT	SYNONYMS	RISK
Insertive fellatio with condom	Getting sucked, getting blown	Minimal
Receptive fellatio with condom	Cocksucking, blow job	Minimal
Receptive fellatio without condom, no ejaculaion	Cocksucking, blow job	Minimal
Receptive fellatio without condom, ejaculation without swallowing	Cocksucking, blow job	Low
Receptive fellatio without condom, ejaculation, swallowing of ejaculate	Cocksucking, blow job	Low
Insertive penile-anal intercourse with condom	Fucking	Low
Receptive penile-anal intercourse with condom	Getting fucked	Low
Sadomasochistic activity, blood drawn, proper blood precautions followed	[depends on activity]	Low
Insertive penile-anal intercourse without condom	Fucking	Very high
Receptive penile-anal intercourse without condom	Getting fucked	Very high
Intercourse with withdrawal before ejaculation without condom	Fucking, getting fucked	Very high
Shared sex toys [mutually receptive]	Dildos, etc.	Very high

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APPENDIX TWO

CHARACTERISTICS OF INTERVIEW SAMPLE

Thirty-five homosexually behaving males were interviewed in all. As I mentioned in chapter seven, they are a convenience sample. Nevertheless, there is considerable variation. They ranged in age from 18 to 55 with a mean of 27.6 years. Aside from two who could not recall, their years of sexual experience ranged from none to 40 with a mean of 10. The calender year of their first homosexual experience is significant in that it indicates whether AIDS was an issue at the time. Here, there are three watershed years: a.] 1981: when AIDS was first announced in the New York Times. b.] 1983: when media attention to AIDS mushroomed. c.] 1985: when Rock Hudson's announcement that he had AIDS appeared on the covers of Time, Newsweek, People, and MaClean's magazines. Determining their individual years of awareness was difficult since many saw this as a gradual multifaceted process. These three years, therefore, are a crude substitute. Discounting one who had no sexual experience and two who could not recall their first time, 12 [37.5%] respondents had their first experience before 1981, 20 [62.5%] before 1983, and 25 [78.1%] before 1985, cumulatively. Most were in their teens at the time. Twenty-six [81.3%] were 12 to 19, five [15.6%] from 22 to 24, and one was 40. The mean age was 17.

The respondents also had considerable education. Measured in years of schooling, the range was from 10 to 22 and the mean was 14. Although I did not record such factors, there also seemed to be considerable variety in socio-economic level, city area of residence, degree of openness with own homosexuality, and frequency of bar-going. Very few went regularly to bathhouses and tea rooms [public washrooms where sex takes place]. The sample is over-represented by students [N=15; 42.8%] and unemployed men [N=7; 20.0%].

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