Male Homosexual Behavior and the Effects of AIDS Education

A Study of Behavior and Safer Sex in New Zealand and South Australia

B. R. SIMON ROSSER

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Foreword by Eli Coleman

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Foreword

The Human Immunodeficiency Virus (HIV) is a menace threatening lives, economies, and cultures throughout the world. Many lives have already been lost. Billions of dollars have been spent to treat this illness, understand its mysteries, develop treatments, and prevent its spread. Certain cultures are in danger of becoming extinct. Minority and the culturally disenfranchised populations are most vulnerable. The dramatic proportion of this pandemic cannot be told in numbers, but rather in the stories of those affected.

Upon reading Dr. Rosser's extensive study of male homosexual behavior and the effects of HIV education, one is horrified by the injustice and ineptitude of many societies in effectively addressing this pandemic. Lives are lost because we will not talk about sex, understand human sexual behavior, appreciate sexual diversity, invest money in prevention programs, and foster research in psychosocial aspects of HIV. On the other hand, Dr. Rosser's research points the way out of this shameful situation. Instead of reacting to this pandemic with fear, prejudice, ignorance, and ineptitude, societies can use the tools they have for scientifically understanding human sexual behavior and preventing the further spread of HIV. If we applied our resources for the psychosocial understanding of HIV transmission to understanding the virus itself we could stop this pandemic. It's as simple as that.

Several perplexing questions arise. If we have the capacity of stopping this pandemic, why haven't we done so? The answer is found in social factors rather than in scientific ones. If the disease

affected the economically and socially advantaged populations of the world, limitless resources would be available. However, early in the pandemic the HIV was rapidly transmitted among gay and bisexual men. Since this has been a traditionally disenfranchised group in contemporary western culture, it could easily be ignored or scapegoated. However, the efforts to ignore or scapegoat have been thwarted to some degree because of the western gay liberation movement.

Western men who were having sex with other men were able to actively involve themselves in the fight against the pandemic because they had achieved a certain degree of social legitimacy. They had a personal investment in the fight and could urge its priority. In countries or cultures where homosexuality is more severely stigmatized, efforts to prevent the spread of HIV among men who are having sex with other men are facing a losing battle. As Dr. Rosser points out in this book, the ability to halt the spread of HIV among homosexually active men is greatly dependent upon the degree of social tolerance for homosexuality in a culture.

This is why this study comparing two countries with differing cultural heritages is so valuable to us. We can better understand the importance of social and cultural attitudes regarding men having sex with other men. In most theories of identity development of gay men, the importance of social factors is paramount — based upon social-interactionist theories.

In my model of the coming-out process, I have identified a series of developmental stages. Progression through these stages is dependent upon an interplay of individual and social factors. The social climate can foster identity development, intimacy skills, and relationships or erect barriers. One result of the HIV pandemic is a call for social recognition of same-sex relationships through "domestic partners" ordinances and church-sanctioned marriages. These social factors can assist individuals desiring intimacy in their same-sex relationships to achieve these goals. The final stage of my coming-out model is called integration, during which the individual has positively integrated their sexuality into their overall identity and has integrated themselves into society. Only in societies that permit an avenue of integration can individuals achieve this stage of identity development.

Cultural stigmatization precludes easy and positive identity development. Individuals who are attracted to the same sex realize they violate societal norms and expectations, causing them to question their own self-worth. They internalize the homophobic and heterosexist attitudes of the culture. A struggle for positive identity integration is a difficult one. For gay, lesbian, and bisexual individuals this experience is made more difficult. In western culture, it has been made easier through wider understanding and acceptance

of homosexual behavior. However, we still have a long way to go. And as this study points out, there are significant differences within western and Australasian cultures. Different countries and even different localities within countries may make identity integration a more challenging task. We will be able to stop the spread of this virus if we spend more time changing the social climate and attitudes toward a positive view of same-sex sexual activity — part of our sexual diversity within our culture.

Besides changes on this macroscopic level, we need to continue to develop and foster the subcultures that will give more active support to individuals with same-sex sexual attractions. In western culture, this means the further development and support of gay, lesbian, and bisexual organizations and institutions. In particular, we need more health organizations to serve this population. Health and prevention programs must know and be sensitive to the particular needs of this sub-population.

As Dr. Rosser has documented, educational prevention programs can be effective in controlling this pandemic. Not all programs are effective. Some are poorly designed or administered. Programs that promote sexual abstinence, for example, fail to take into account basic knowledge of human sexual behavior. We must employ what we know, target behaviors we want to foster or change, and empirically evaluate the effectiveness of these prevention programs.

Education programs need to go beyond changing or fostering certain sexual behaviors or practices. We need to educate the public about sexuality and human relationships, including same-sex sexuality and relationships. Society needs to learn how to understand its cultural diversity. We must fight ignorance and bigotry.

Until we have an enlightened society, laws must be enacted to protect sexual minorities. Discrimination, harassment, and hate crimes must not be tolerated. Some people only learn through punishment.

Leaders of religious denominations must come to terms with homosexuality. Condemnation of homosexual behavior is no longer tolerable. In their moral self-righteousness they fail to see the negative consequences of their actions.

Essentially, we need to create a climate in which gay, lesbian, and bisexual individuals respect themselves and others enough to want to engage in safer sex practices.

Even then, there will be some individuals who need additional support and help. One of the most perplexing problems experienced by those involved in HIV prevention programs is the question of why their efforts are not more successful. Dr. Rosser's study suggests a number of answers. The vast majority at risk for HIV will be helped by changing the social climate and promoting efficacious education

programs. However, I have always been concerned about the group that is not reached through these methods. This group of individuals is suffering from psychopathology that prevents them from learning or engaging in safer sex practices. These individuals may be suffering from psychopathology because of the negative social climate. But they are usually more affected by growing up in pathological families, where parents are usually suffering from psychological problems as well. Individuals with same-sex attractions receive a double dose of abuse when they also come from a dysfunctional family environment. This combination of cultural and familial abuse creates an array of psychological problems that are not resolved through education or even gay-affirmative psychotherapies. Mood, anxiety, thought, and personality disorders interfere with the adoption of healthy behavior patterns.

Therefore, there is a group of individuals who cannot learn or, in spite of knowing, never engage in safer sex activity. There are others who learn but relapse into unsafe sex activity. Two factors account for a large portion of the variance in individuals who engage in chronic unsafe sex: alcohol and drug abuse and compulsive sexual behavior. Both behaviors are often used to anesthetize psychological distress to attempt to alleviate pain. Attempts to reach these individuals must involve sophisticated psychological and psychiatric treatment. One must treat the underlying psychological disorder before the individual can begin to benefit from prevention programs. Dr. Rosser has identified this group in his study as the "relapse group" and the "stable unsafe sex group." He found that higher drug use during sex was associated with these groups. He suggested that we need to know much more about these groups and target specific prevention strategies accordingly.

It is extremely important that we do so. These are individuals who are highly likely to contract or continue to spread the HIV virus. This raises a broader perspective for public health officials and sociologists who are trying to contain this epidemic. It is a question that has perplexed many psychotherapists who have utilized developmental and social-interactionist approaches. Why, exposed to seemingly like environments, have some individuals successfully coped with their homosexuality, while others have labored, suffered, and found a positive identity utterly elusive? It has not been "politically correct" to say so, but some individuals have had difficulty because of psychological problems that are to some degree independent from their sexual orientation. Some develop psychological problems because of a variety of social factors such as: (1) the lack of an accepting and nurturing environment for homosexual expression; (2) myths and misinformation regarding homosexuality; (3) lack of information regarding methods for developing a positive self-identity and improvement of interpersonal functioning; (4) lack

of survival techniques for living in a predominantly heterosexual and heterosexually biased society; and (5) lack of healthy role models. Individuals suffering from these problems will benefit from the so-called gay-affirmative psychotherapies.

However, there are those who suffer psychological problems that are based on other factors that contribute to general psychopathology. These problems are best attended to with psychotherapies that have been found to be effective for these problems. For example, some anxiety, mood, and thought disorders are best treated with a combination of psychotropic medication and psychotherapy. Substance abuse disorders are often best treated with group psychotherapies and involvement with Alcoholics Anonymous, Narcotics Anonymous, or some other type of ongoing self-help group. The fear of many gay activists is that proposing these types of treatments represents a retreat from efforts to depathologize homosexuality. However, one cannot feel "gay" if one is clinically depressed or chemically dependent.

Psychological treatment for those who engage in chronic unsafe sexual behavior is time-consuming and costly. However, when available resources to combat this pandemic are limited, this group suffers.

Fighting and ending this pandemic will take enormous resources and efforts to change behavior and attitudes at all levels of society. We can accomplish this task better when we have a fuller understanding of human sexual behavior and the recognition that sexual health is as important as other factors in the general health of a society. We will be able to better utilize the resources we have if we base our prevention programs on scientific research rather than moral opinion. Dr. Rosser's landmark study has demonstrated the type of research we need. It is my hope that readers will encourage or develop prevention programs based upon his findings. We are indebted to him for his work.

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1

Introduction

We live in amazing times. This book is about one aspect of those times, one aspect of our culture. It has three aims: (1) to document homosexual behavior and life in the age of the Acquired Immune Deficiency Syndrome (AIDS); (2) to empirically investigate the psychology of safer sex; and (3) to evaluate the effects of AIDS education on sexual behavior. The book has been written to provide educationalists, researchers and other experts in the fields of AIDS prevention, sexuality, sexual behavior, psychology, psychovenereology, education, and more generally, health and its related disciplines with the findings from an extensive research study conducted in New Zealand and South Australia.[1]

I have also attempted to modify the text of this book so it can be read by the general public, and in particular, gay men, wishing to know more about men who have sex with other men.[2] The body of each chapter is introduced by a review of the research applicable to that chapter, followed by a presentation of what the study found and a summary of the major conclusions. For ease of reading, references, statistical material, and points regarding research, which may be of interest to fellow researchers and psychovenereologists but of limited interest beyond this group, as well as parenthetical comments and notes, have been appended in note form at the end of each chapter, rather than included within the text itself.[3]

The book is divided into four parts.[4] Part I explores what the lifestyle of homosexually active men[5] in New Zealand (NZ) and South Australia (SA) is like, and Part II investigates what aspects of this

lifestyle appear associated with safer sex, while Part III reports on some of the effects of AIDS education on homosexually active men's perceptions and behavior. Part IV provides a summary of the study's findings, with the final chapter outlining a vision of the future, for it is only by looking to the future that we can shape how to respond in the present.

Prior to this study, no studies investigating sexual behavior in the male homosexually active NZ population[6] had ever been published. Consequently, Part I is included, both to document this population in its own right as well as to provide the reader with a description of the population under study.

One of the difficulties of AIDS education is that so little is known about why some homosexually active men stick to safer sex while others engage in unsafe sex. While much has been published on behavioral co-factors of unsafe sex, almost nothing is known about the psychological[7] factors accompanying sexual behavior. For this reason, Part II has concentrated on providing an in-depth prospective investigation of variables that distinguish those who engage solely in safer sex from those who have unsafe sex.

The investigation of the psychological concomitants of safer sex has a number of difficulties; above all, that correlation cannot be taken to imply causality. Nevertheless, if it is accepted that sexual behavior is but one complex and integral aspect of an even more complex psychology of the whole person, then such investigations are warranted. Part III of this book explores the comparative efficacy of various education programs to modify perceptions of risk and to modify unsafe sexual behavior.

It is an assumption of this study that by achieving a wider understanding of the psychology of homosexual behavior more effective education programs may be designed. As one author notes,

> Even in those early times, the pivotal role to be played by social factors in handling the epidemic became evident; the fact that over 90% of those involved in the epidemic were in socially outcast groups — i.e., gay men and i.v. drug abusers — led to a great concern among the afflicted that the epidemic burgeoning among them was being ignored by the governmental establishment. It is difficult to assess the validity of that claim, except to note that less than five years later, biomedical science has made dramatic inroads on the problem, and that the areas of our ignorance that are going to do us harm are in the behavioral and social sciences, not in biomedical science.[8]

Like many other books on AIDS, this book covers a number of controversial areas. Unlike many other books, which approach the

area theoretically, this one utilizes an empirical approach examining the reality of NZ and SA men responding to AIDS. The book tests theories to find if they stand up and tells the story of one community's experience of sex in the AIDS crisis. Those, of whatever political belief, hoping to find in these pages a justification for their pre-conceived notions are unlikely to find them fulfilled, as the book addresses new areas and breaks new ground. Those earnestly seeking to understand something of the complexity of an area that has previously been much misunderstood will, I hope, be as fascinated as I have been by the responses of the men in this study.

Two philosophical questions remain to be addressed. First, is this study merely another attempt to "medicalize" or "psychologize" homosexuals? Clearly, the answer is no. While psychovenereology covers all sectors of the sexually active population, because anti-HIV positivity and AIDS in the western world are disproportionately high among homosexually active men and because education programs have been designed specifically to target this population, it is appropriate to limit this investigation to homosexually active men. Further research, beyond the scope of this study, is required to investigate whether the findings in this thesis may be generalized to include women and exclusively heterosexually active men. Having stated this, it is my earnest hope that those responsible for AIDS education targeting ethnic and other minorities as well as that targeting the general public will take the opportunity to examine the findings presented here. For in many ways the sexuality of the study population may be taken as incidental, as the wider focus of the study concerns the effects of education on human behavior.

The second philosophical question of interest is whether HIV transmission and AIDS is a medical problem or a behavioral/psychosocial one. If one accepts the former possibility, then traditional responses to infectious epidemics (such as isolation and compulsory testing or relying on the eventual development of vaccines and cures) are perhaps warranted and the nature of this research is therefore somewhat irrelevant. If the latter possibility is accepted, then, clearly, education, counseling, and other strategies are indicated. While the behavioral medicine or biopsychosocial assumptions upon which this study is based accept that disease and its management may be investigated from both perspectives, the focus of the thesis is clearly psychosocial as distinct from biomedical, a focus appropriate to the subject matter under investigation.

> Ultimately, we have to recognize that any area of medicine so intimately connected with sexuality will contain a complex interrelationship of highly cathected forces that demonstrate the accuracy of the comment by Darrow [1981] that venereal disease is not so much a medical problem with some

behavioral aspects as it is a social problem with some medical aspects.[9]

Philosophically, scientific research is often best viewed as being like a photograph.[10] Over time, while parts of the picture will no doubt vary, other aspects will remain intransient. Similarly, should another photographer take a picture from another angle, the insights gained might be different. To complete the analogy, it is only by several photographers taking pictures from several different angles that a reliable overall picture emerges from the differing impressions.

These, then, are my impressions of homosexual behavior, the psychology of safer sex, and the efficacy of AIDS education techniques, which I offer for your reflection. As a psychologist, I believe that health education has tremendous potential to change people's behavior and lives. As we shall see in AIDS education, this study suggests the effects of health education may be both positive and negative. As an empiricist, I strongly believe that health education must be based on hard data and be empirically evaluated. Otherwise we must, by necessity, go on not learning from our mistakes. If this study assists people to replace ignorance with fact, base their actions on empirical data rather than solely on impression or stereotype, and encourage other empirical research in this field, then the study shall have been immensely worthwhile.

NOTES

1. This book is based on the first doctoral research into safer sex behavior to be completed in the Southern Hemisphere (awarded in 1990). As such it is a groundbreaking work with much of the findings remaining speculative or requiring substantiation before being uncritically accepted as fact.

2. Maintaining the academic integrity of this research while trying to make it accessible to those without a statistical or psychosexual background has not been an easy exercise. Readers familiar with the usual form of scientific presentations will note that results and discussion have been combined to assist readability.

3. Other modifications to the original thesis are as follows. The literature review in the original thesis has been removed and a chapter inserted presenting data on discrimination and violence experienced by the sample. Similarly, Chapter 18 of this book has been included to summarize the major findings of this study and Chapter 19 included to note the implications of these results for the future.

4. See Chapter 2.

5. Throughout this study, the term *homosexually active men* has been used in preference to other choices such as *gay* or *homosexual*. In current usage, *gay* generally describes homosexually active men who identify themselves as such or the culture and social groupings of these men. The label *homosexual* (as a noun) historically referred to those with a clinical diagnosis of pathology that is no longer recognized, and so the term is inappropriate. (It is also a term heavily attacked by gay activists as stereotyping people by identifying one single aspect of their lives as sufficient to describe them and reinforces a dichotic conceptualization of sexuality

that is no longer held to be valid.) Consequently, the term *homosexual* in this book is generally used as an adjective, preferably to describe behavior or one aspect of a person's behavioral repertoire.

6. See Rosser [1988].

7. The term *psychological* is employed here to loosely subsume investigation of variables from behavioral medicine, epidemiology, and behavioral psychology.

8. Osborn [1986], p. 287.

9. Ross [1986], pp. 5-6.

10. In this case four photographs, two each taken at different times, of life in NZ and SA.

2

Research Purpose, Background, and Methods

AIMS, RATIONALE, AND HYPOTHESES

The aims of this study are threefold:

1. to describe the psychological, sexual, and demographic aspects of homosexual behavior in two Australasian cities of low HIV prevalence;
2. to investigate psychosocial and psychosexual factors that distinguish homosexually active males who practice exclusively safer sex from those who do not; and
3. to assess the efficacy of various AIDS education interventions on sexual behavior and perception of risk of HIV.

Little has been published on homosexual behavior in Australasia or in areas of low HIV prevalence. The first aim is important for three reasons. First, an adequate description of key variables is needed to assist in the achievement of the second and third aims of the study. Second, as the protostudy, it provides baseline data against which future studies can assess changes in sexual behavior. Third, by investigating the experience of homosexually active men in NZ, key factors affecting how AIDS education will be received can be identified.

While many studies worldwide have been published investigating sexual behavior in homosexual men, few have investigated, in

any depth, the psychological correlates of safer sex behavior. For this reason, the second aim of the study is to investigate and document the psychosocial correlates of safer sexual behavior.

At the time of the study, no research had been published investigating the comparative efficacy of various AIDS education and counseling interventions. Because education and counseling remain the major interventions against the spread of HIV, the importance of establishing, and I hope improving, the efficacy of such approaches is paramount.

Hypotheses

Consistent with the second and third aims of the study are two major hypotheses under investigation in this study. First, that psychological concomitants of unsafe sexual behavior exist that can be empirically investigated, and, second, that AIDS educational interventions differ in their efficacy and that these differences can be demonstrated empirically.

Together with these primary hypotheses are a number of secondary hypotheses. These are explicitly stated at the end of the introduction of the relevant chapter.

Limitations

The sample employed in this study, like all others in the field, is best regarded as a sample of convenience.[1] It is also a very small (< 1%) percentage of the estimated total population of homosexually active men. Thus it is important that any generalization from these findings to the wider population of "men who have sex with other men" be made cautiously.

The primary aim of the study is to investigate the possible existence of concomitants of safer sex. It is beyond the scope and methodology of this study to investigate the precise nature of any such relationships, that is, to identify whether variables are causally related to the primary variable of interest, safer sex, or in fact represent correlations contingent on some other variable or variables.

The focus of the study is a psychosocial investigation of homosexual behavior in areas of low prevalence for HIV. The degree to which findings from the study generalize to areas of high prevalence for HIV is a matter of conjecture. Consequently, both the nature of the relationships investigated and the generalizability of findings from the study remain areas for future research.

To test the second hypothesis, the relationship between safer sex (and its component behaviors) and several hundred psychosocial

variables was investigated. Such a methodology is especially vulnerable to significant results being found by chance.[2]

SETTINGS

With approximately 0.83 and 1.01 million inhabitants, respectively, Auckland and Adelaide are cities of comparable size. Other similarities between South Australia (SA) and New Zealand (NZ) include a predominantly European ethnicity of 85 percent[3] and 81 percent,[4] respectively, a similar standard of living (as evidenced by birthrate, death rate, and life expectancy), and a similar British colonial heritage, although SA, at federation, became part of the Australian Commonwealth, while NZ is an independent country. Both are the largest cities in their region, Adelaide being the state capital of SA and Auckland the commercial center of NZ. With English being the dominant language in both countries,[5] Adelaide and Auckland appeared well suited for comparative investigation. Regarding the prevalence of HIV and AIDS, relative to parts of Europe, Africa, and North America, both cities have low levels of reported HIV infection. At the time of the pilot study, SA (population 1.3 million) had 2 reported cases of fully developed AIDS and 138 persons confirmed HIV antibody positive. At the time of the Auckland study, NZ (population 3.3 million) had 50 cases of fully developed AIDS and some 263 confirmed cases of HIV antibody positivity. Of the anti-HIV conversions, in Auckland 77 percent and in Adelaide 75 percent were attributed to possible transmission via homosexual behavior.[6]

THE GAY COMMUNITIES OF AUCKLAND AND ADELAIDE

In common with other large cities, both Auckland and Adelaide have sizable gay communities[7] serviced by a number of entertainment venues. In Auckland, these included a hotel, three nightclubs, two saunas, and a number of small informal support organizations. At the time of the study, Adelaide had two hotels, two nightclubs, one sauna, a community center, and a number of sports, religious, social, and support organizations catering to the male homosexual population.[8] While any exact estimate of the number of men having sex with other men remains a matter of some conjecture, based on previous population studies, the male homosexually active populations for Auckland and Adelaide range between 19,900 and 33,700 and 24,000 and 44,075, respectively.[9]

While similar demographically, one marked difference between SA and NZ is the acceptance of homosexual behavior, as evidenced by