Determinants of High Risk Sexual Behavior: The Advocate Study of Gay Men

by

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DETERMINANTS OF HIGH RISK SEXUAL BEHAVIOR
THE ADVOCATE STUDY OF GAY MEN

Dissertation
Presented to the Faculty of the
California Graduate Institute

In Partial Fulfillment
of the Requirements of the Degree
Psy.D.

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by
Harry Drasin, M.D. Psy.D.
September 2000

The dissertation of Harry Drasin, M.D. Psy.D. is approved.

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California Graduate Institute
West Los Angeles, California
2000

To Alan, the love of my life.

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DISSERTATION ABSTRACT

DETERMINANTS OF HIGH RISK SEXUAL BEHAVIOR THE ADVOCATE STUDY OF GAY MEN

Harry Drasin, M.D. Psy.D.

California Graduate Institute
September 2000

Russell Hunter, Ph.D. Chair
Alexander Taylor, Ph.D., C. G. I. Reader
Janet Lever, Ph.D., External Reader

AIDS has become a ubiquitous disease of catastrophic proportions, which directly or indirectly affects all humans. In this 'sex study' included as part of the Advocate magazine in 1994, attitudes and sexual activities of 13,000 gay men nationwide were surveyed.

The literature suggests that younger age, engaging in prostitution, negative attitudes towards condoms, non-White race, fewer years of education, being in a "relationship," living in a small town, and the use of drugs or alcohol are risk factors for unsafe sex in United States. Disclosure of being gay to others, level of income, occupation, and having been abused or coerced into sex may also be risk factors for unsafe sex, but the data are either inconclusive or conflicting If anything, those who are HIV-seropositive appear to practice safe sex more often than those who are not. Religion or spirituality does not

appear to relate to high-risk behavior based on the available literature. There is too little data on masturbation to determine if it is an ameliorating factor regarding high-risk sexual activity, nor are there data which look at issues concerning healthcare in relation to high-risk sexual activity.

The research design here is correlational, and includes a representative sample of 2,500 of the approximately 13,000 responses received to the survey. Statistical methods used include both Student t-test and chi-square analyses of cross-tabulated data, factor analysis, and logistic regression.

Some of the research hypotheses were found to be correct, while others were rejected. Other than size of metropolitan area and certain religious subsets, sociodemographic variables did not predict high-risk sexual behavior in this study, findings somewhat contrary to the first research hypothesis.

The second research hypothesis, that there will be a significant relationship between various interpersonal traits and high-risk sexual behavior, was borne out by the many relationship and dating questions and variables found to be significant by multivariate analysis.

Hypothesis 3, that they will be a significant relationship between aspects of one's sexuality and high-risk behavior, also generally proved correct

The fourth research hypothesis, that there will be a significant difference between various life and sexual experiences and high-risk sexual behavior, was not found to be correct in this study group.

Hypothesis No. 5, a relationship between the use of drugs and alcohol and high-risk behavior, was partly correct. The use of many types of drugs was correlated with high-risk sexual behavior, but the use of alcohol was not.

Finally, hypothesis 6, a relation between aspects of health care and sexually transmitted diseases and high-risk sexual behavior, was not found to be correct.

The particular value of this study is that it was truly nationwide, contained large numbers of participants and large numbers of variables studied, included all sizes of metropolitan areas, and specifically defines high-risk sexual activity as anal sex to the point of ejaculation inside the rectum without the use of a condom.

While many of the results confirm previous studies, the constellation and clustering of results perhaps points to issues larger than HIV and high-risk sexual behaviors alone, issues that are fundamentally societal. These issues have to do with individuation, development of ego strength, feelings of self-esteem and self-worth, and the safety of youth to self identify both privately and publicly as gay. It is hoped that basic societal changes in attitudes towards gay men and women will reduce the isolation, loneliness, and feelings of being different that may well underlie the high rates of drug use and the meaning of the nature of sexual activity that is often present in gay community. It is at this fundamental societal level that progress against AIDS will need to proceed.

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INTRODUCTION

For many of us, the AIDS crisis has changed the way we go about our daily lives. Most of us who are gay have suffered personal losses, have lost friends, relatives, or acquaintances. Our country has suffered a loss of many thousands of talented young people who had their best productive years of life ahead of them. AIDS is a disease for which there is no cure, though substantial medical progress has permitted those who are seropositive to enjoy longer and better quality life than was the case even a few years ago.

As a shunned minority, gay men had been little researched prior to the AIDS epidemic, with the notable exceptions of Bell (Bell, Weinberg, & Institute for Sex Research, 1978), Kinsey (Kinsey, Pomeroy, & Martin, 1948), and Saghir (Saghir & Robins, 1973). Very little sexual research, in general, had been performed prior to Kinsey (Kinsey et al., 1948). That has changed. Many studies now document the most intimate details of the lives of gay men, especially with regard to sexual practices.

The Advocate, a leading gay periodical, commissioned a survey in 1994, the results to be published in its pages. A survey of magazine readers is not a new phenomenon, Psychology Today, Red Book, Playboy, and other magazines had received hundreds of thousands of responses to sex surveys that they had published.

The questionnaire was far more than just a sex survey, however. To date, it represents the only nationwide sample of gay men responding to questions regarding their sexual behaviors, their psychosocial, demographic and experiential attributes as well. Permission to use the study data was granted by its authors, Dr. Janet Lever and Dr. Mark Schuster (please see appendix B and C). Due to constraints of time and finances, the study has never been statistically analyzed by multivariate analysis before. The results of the Advocate survey form the basis of this dissertation.

CHAPTER 1

NATURE OF THE STUDY

Background of the Problem

AIDS is a familiar term to all of us. AIDS has been around for a long time, possibly as early as the 1950's and 1960's (Garry et al., 1988; Huminer, Rosenfeld, & Pitlik, 1987). Recent work suggests that the virus may have crossed over to humans in the 1930's (Altman, 2000). Since the first cases of unusual illnesses appeared in the early 1980's, and the blood test for the antibody to HIV was developed and marketed in 1985, hundreds of studies of gay men have been performed in order to elucidate risk factors, sexual habits, psychosocial, and psychosexual variables involved in their sexuality. The more information professionals have about sexual activities, behaviors, and motivations, the more directed educational projects can be in order to teach the principles of safer sex, and to be effective in maintaining an attitude of concern regarding health behaviors over the long-term. Since HIV is currently incurable, prevention is the major effort here -- the only cure is not to get the disease. Prevention is completely successful, as long as certain health behaviors are strictly maintained. Considerable education of the public is required, and to a large degree, has been carried out in order to help people understand the problem and be aware of what safe sex means. Since this is a totally preventable disease, and widespread educational efforts have been made, one must wonder about the thoughts and feelings of a person who either ignores or downplays the need for initiating and maintaining possible lifesaving behavior modification. Likewise, even when matters of

sexuality are discussed with sexual partners, there is "dishonesty in dating" (Cochran, 1990).

While there is, in general, agreement of the very high-risk nature of unprotected receptive and perhaps insertive anal intercourse when accompanied by ejaculation, and perhaps even when the withdrawal technique is used (Goedert et al., 1984), the level of risk has been debated for unprotected oral receptive intercourse with ejaculation. There seems to be little question that transmission of HIV has occurred by orogenital contact (Goldberg, 1988; Rozenbaum, 1988; Spitzer & Weiner, 1989), but the frequency may be relatively low (Maugh, 2000) when compared to other activities. When any chance exists of transmission of this disease, however, this form of sexual activity, while very commonly practiced in an unprotected manner, still represents risky activity.

Condoms are generally effective in preventing HIV transmission (Pinkerton & Abramson, 1997; Silverman & Gross, 1997) although lubricant types (Smith, Jolley, Hocking, Benton, & Gerofi, 1998a), and penis size (Smith, Jolley, Hocking, Benton, & Gerofi, 1998b) may influence condom slippage and breakage.

Practically every research thus far on risk factors for HIV transmission has examined relatively localized groups of volunteer subjects, and has collected data regarding a number of sociodemographic and other risk factors. None of these studies was truly nationwide. None of these published studies appear to have examined as many different sociodemographic, psychosocial, and experiential variables as were examined in this study. None of these studies had as many subjects. Rarely was the specific nature of high-risk sex so precisely defined.

Problem Statement

What sociodemographic and other variables, including age, ethnic group, education, occupation, income, religion, location, HIV serostatus, size of metropolitan area; attitudes, and behaviors predict the likelihood of engaging in high-risk sexual behavior?

Research Questions

1. What is the relationship between various sociodemographic variables and high-risk sexual behavior?
2. What is the relationship between various interpersonal traits and high-risk sexual behavior?
3. What is the relationship between aspects of one's sexuality and high-risk sexual behavior?
4. What is the relationship between various life and sexual experiences and high-risk sexual behavior?
5. What is the relationship between the use of drugs and alcohol and high-risk sexual behavior?
6. What is the relationship between aspects of healthcare and sexually transmitted diseases and high-risk sexual behavior?

Application of Results

The main and only focus of current efforts to reduce HIV infection is education. While much is known regarding sociodemographic and other variables, almost all studies focus on limited areas and populations and do not present as broad a geographical and numerical base as the present study. The more knowledge we have regarding behaviors, the better we can tailor educational efforts and direct scarce resources to areas which will provide the most benefit. The results from this study therefore will be helpful to provide additional information to help craft goals for HIV prevention education.

Theoretical Framework

On the surface, it would seem quite simple. HIV infection is preventable. Only a couple of behaviors are high-risk. Only a few behaviors need to be changed in order to substantially reduce or even eliminate the risk of infection. Why then is it so difficult?

Anna Freud has written (1966):

> Even in the normal state of being in love a man's intellectual capacities tend to diminish and his reason is less reliable than usual. The more passionate his desire to fulfill his instinctual impulses, the less inclination has he as a rule to bring his intellect to bear on them and to examine their basis in reason. (p 158)

Kelly (1995) reviewed this matter. He points out that the only means to prevent HIV is by behavior change. He goes on to say that this behavior is very hard for many people to change.

> Sexuality is among the most powerful and least understood of human motives and produces not only pleasure but is also intimately associated with love and affection, as well as our dating habits, relationships, self-concept, and self-esteem. Sex is strongly reinforced at levels ranging from physiology to fantasy to social pressure, and introducing changes in sexual relationships and patterns can be very difficult. (p.ix).

He goes on to discuss that most smokers know that tobacco is dangerous and most overweight people know that they should lose weight. Obviously, the same is true with HIV -- there is a gap between our knowledge and our behavior. He lists elements he considers critical to HIV risk-behavior change. These elements are: risk education, threat personalization, perceived efficacy of change, intention to act, risk reduction behavioral skills acquisition, cognitive problem-solving skills for change implementation and maintenance, and reinforcement of behavior change efforts.

There are a number of theories of human behavior, which have been employed to predict or explain high-risk sexual behavior. Before going into specific theories, a discussion of the place of anal sex in the sexual repertoire of gay men is needed. Upwards of 70 percent of gay men (Doll, Judson, Ostrow, & O'Malley, 1990) report engaging in insertive or receptive anal intercourse, or both. Saghir (Saghir & Robins, 1973) recorded that 85 percent of gay men he studied had been an insertor, and 93 percent an insertee. This does not appear to be a new phenomenon. Professionals probably might not have heard much more about this particular sexual activity if HIV had not come along. The issue of the place of anal sex in the sexuality of gay men is reviewed by Dowsett (1996). He has worked in the HIV/AIDS prevention area for many years.

> From the start, gay men working on the ground in HIV/AIDS prevention believed that gay sexual behavior could be changed to prevent the spread of the virus. This belief has proved generally accurate, and the documented changes in gay men's sexual behavior showed that there is a profound difference in the structuration of sex practices and sexual preference. If sex practices can be changed, then sexual experience is adaptive. And so, sexual feelings and meanings are also malleable. Once it is agreed that actual sexual sensation, experience, feeling, and meaning are changeable, it must also be recognized that homosexuality is profoundly social, influenced by history, culture, and experience: it is something we ourselves make.

> Beyond that, it must be remembered that gay sex is perverse; gay sex is different. The physical sensation of male-to-male sex is different from sex between women or between women and men . . . almost all gay men consider anal sex the symbolic center of gay identity. It is central to the social definition of male homosexuality and, therefore, claims its erotic core. Beyond its unique physical pleasures, it is perhaps this symbolic stature of anal sex, which acts as a crystallizing force on male homosexual desire. (p.37)

The centrality of anal sex for gay men relates to several factors, some of which may well be preprogrammed or instinctual. The tactile sensation and the bodily movements and activities are the closest gay men have to the sensations of vaginal intercourse. After all, the penis is an organ designed for penetration. Perhaps, these characteristics are preprogrammed in the human psyche, regardless of sexual orientation, to provide a high level of psychological and emotional satisfaction. This might well explain why many gay men are quite resistant to behavior modification or condom use. A further discussion of the importance of anal sex for gay men appears in Chapter 4 in the discussion section.

Cleary (1987) reviewed the subject of behavior change, and discussed why people take health precautions. He states, "it is necessary to be aware of the broad matrix of factors influencing health behavior if we are to understand variations in preventive actions." (p.120) Numerous models have been developed in this regard. According to Cleary, the most frequently used paradigms are the health belief model and the theory of reasoned action. The self-efficacy theory of Bandura also deserves consideration.

The health belief model, as discussed in Cleary (1987) (quoted below); Janz (Janz & Becker, 1984), Kirscht (Kirscht & Joseph, 1989), and Rosenstock (Rosenstock, Strecher, & Becker, 1994):

> . . .is a synthesis of so-called social psychological theories of value expectancy and decision making . . . As such, it focuses on behaviors that are under individual control and is concerned primarily with conscious decisions about the utility of specific actions. Variables used to predict individual behavior are (a) perceived susceptibility to a health threat, (b) perceived severity of the

> consequences of a disease or health threat, (c) the individuals evaluation of the efficaciousness of possible protective actions, (d) the perceived costs of or barriers to possible protective actions, (e) clues to action such as symptoms or mass media communications, and (f) demographic, structural, and social psychological factors that act as "enabling" factors. (p.121)

Kirscht (Kirscht & Joseph, 1989) defined four components which constitute the essential components of the health belief model: "personal susceptibility to a negative health condition, the perceived severity of the condition, the value of a behavior or line of action (variously labeled "benefits," "efficacy," or effectiveness"), and barriers to the action." (p.111) From his previous discussion, Kirscht summarized that "it can be seen that the health belief model presents a mixed picture as an explanatory framework for health-related behavior. Rarely has there been a confirmation of the full model; more often, different elements are predictive of behavior." (p.116) In relating to AIDS behavior, Kirscht (Kirscht & Joseph, 1989) stated that:

> The health belief model does call attention to personal vulnerability and to expectancies held by people as to what actions are implicated in the threat *(of AIDS)*. Furthermore, it points to the value imputed to behavior change of various sorts and, ideally at least, recognizes that there are personal, social, and environmental costs to behavior change. (p.118)

In reviewing the use of the health belief model Kirscht (Kirscht & Joseph, 1989) discussed the coping and change study conducted in Chicago (Joseph, Montgomery, Emmons, & Kirscht, 1987). This study involved 637 gay men from Chicago who participated in a psychosocial study and had completed two waves of data collection.

> This exercise in predicting behavior change via the health belief measures presents a very mixed picture. From the perspective of a model for understanding change, however, there was no real instance in which the set of elements together give a coherent picture of what is happening . . . From the data we have examined thus far, we are impressed with the dynamic and complex nature of the processes involved in behavior change. In this situation, the health belief model has useful features, but it requires synthesis with other frameworks for change. (p.122-3)