

The paradox of trust for male couples: When risking is a part of loving

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Abstract

Among gay men, there is evidence to suggest that serious, committed male couples practice especially risky sex. To understand the reasons why male couples might take such risks, 92 participants (46 long-term couples) were asked to complete a survey in which they independently indicated their sexual practices, why they engaged in them, and their attitudes toward relationships. Three sets of findings suggest a paradoxical relationship between emotional intimacy and sexual risk: (1) love, trust, and commitment were used more often to explain riskier than safer sex; (2) those more dependent upon their relationships and who desired a stable and lasting relationship practiced riskier sex; and (3) requesting safer sex had negative connotations (e.g., suspicion of extrarelationship sexual contacts). Of those who practiced safer sex (i.e., *protected anal sex*), 94% indicated that they did so because of their “fear of AIDS.” Implications of these findings for developing HIV interventions for male couples are discussed.

Despite the enormous risks, there is evidence that many gay men fail to consistently practice safer sex (Stall, Ekstrand, Pollack, McKusick, & Coates, 1990). One especially risk-prone subgroup is the rarely studied 40% to 60% of gay men in long-term relationships (Blumenfeld & Raymond, 1988; Peplau, 1991). Ironically, although many gay men may seek committed relationships as a strategy to lower their risk of HIV (King, 1993), members of male couples may actually be at higher risk for HIV (McKirnan et al., 1991; Reiss & Leik, 1989) than single gay men if their partner is *actually* HIV positive. Certainly, those couples who practice unprotected anal sex who are either unaware

of their HIV status (Pinkerton & Abramson, 1993) or couples who are aware of their HIV sero-discordant (i.e., where one partner is HIV positive and one partner is HIV negative) status are at considerable risk.

However, even couples who *believe* that they are HIV negative and sero-concordant are often still at risk for the following reasons. First, a partner may believe that he is HIV negative when he is actually HIV positive. For example, there is an “HIV window period” where antibodies to the virus may not be detected (Lackritz et al., 1995). In addition, an individual’s status may change from his last HIV test because he engaged in risky behavior outside of the primary relationship. In fact, the prevalence of extrarelationship sexual contacts is high among male couples. Peplau and Cochran (1988) found that 73% of gay men in relationships had sex with someone other than their primary partner at least once during the course of the relationship. Unfortunately, it is unclear how many of these encounters involved unsafe sexual practices. Even if only a small percentage

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of these encounters outside of the primary relationship involved unprotected sex, given the high base rate of HIV among gay men, estimated at between 21% and 51% in urban areas (Valdiserri et al., 1988), the risks could be substantial. Therefore, some couples who have tested negative may halt safer sexual practices even though it is unsafe to do so, creating a risk of HIV transmission.

Once one partner contracts HIV, the risks of transmitting the virus to the uninfected primary partner are especially high for at least two reasons. First, gay men in relationships are among the most likely to engage in unprotected anal sex (Coxon et al., 1993; Hays, Kegeles, & Coates, 1990; Kalichman, Kelly, & St. Lawrence, 1990; King, 1993). Second, those in relationships have sex more frequently and therefore potentially have a greater cumulative risk of HIV infection than do those not in relationships (Michael, Gagnon, Laumann, & Kolata, 1994). Thus, simply being part of a couple—even an apparently HIV negative one—does not negate the risks of unprotected anal sex. In fact, consistent condom use may be more effective in reducing one's HIV risk than limiting one's partners (Reiss, & Leik, 1989). Given the fact that male couples are more likely to engage in unprotected anal sex, we know surprisingly little about why male couples take such risks.

Some might argue that gay men do not really care about their partners and are therefore willing to put them at risk. There is no evidence to support this possibility. Peplau (1981) found no difference between gay men and heterosexuals in likelihood of being in love with one's partner. Similarly, Keller and Rosen (1988) found that gay men in relationships value the same qualities as do those in heterosexual relationships (e.g., love, commitment, companionship, and sex). Thus, paradoxically, those gay men who have developed loving, trusting, and committed relationships may be putting themselves and their partners at risk for HIV.

Trust, Risk, and Commitment: Interwoven Themes

Trust and risk may be surprisingly interwoven themes in intimate relationships. On the one hand, one prevalent message in current safer sex interventions is the following: "Using a condom shows that you care about your partner." This message assumes that caring and love are associated with *not* taking chances and "playing it safe." However, as Rempel, Holmes, and Zanna (1985) point out, taking risks is part of building trust and a closer, deeper relationship. The risks they were describing were "intimate disclosure, reliance on another's promises, sacrificing present rewards for future gains, and so on" (p. 96); they did not entail the possibility of contracting a fatal disease.

Clearly, one of the greatest health risks in a gay male relationship today is having risky sex (e.g., unprotected anal sex). Although a number of additional factors—over which one may not have knowledge or control—also contribute to the riskiness of sex within a relationship (e.g., the likelihood that one's partner is HIV positive), it is the *sexual behavior*, not the number of partners, or the relationship status of the individual per se, that seems to provide the most "clear-cut" operationalization of knowingly taking risks (Valdiserri et al., 1988). After all, it is only when one's own sexual behaviors are low risk (e.g., correct and consistent condom use) that a man in a gay couple can be sure that the risk is truly minimized. Behavior is also relevant to HIV-positive couples; here the risk is one of contracting a new strain of the virus (Larder, 1995) or exposure to other STDs (Mazzoli et al., 1993) that might accelerate the disease's progression.

Although Rempel et al. (1985) did not conceptualize risky sex as one of the risks that might be taken to build trust and subsequent closeness in a relationship, risky sexual behaviors may very well symbolize evidence of trust, love, and commitment in couples. This connection has most extensively been examined in heterosexual populations (e.g., Pilkington, Kern, & In-

dest, 1994), but there is no reason to believe that male couples are any different in this regard. In fact, a few studies suggest that a similar meaning of risky sex (e.g., as symbolic of trust, love, and commitment) might be found among male couples. For example, Burns (1993) discovered, in a sample of gay men, that love for partner was cited as an explanation for risky sexual behaviors but not as an explanation for nonrisky sexual behaviors. Kelly et al. (1991) found, among single gay men, that feeling that one's partner was special was an important contributor to high-risk sexual behavior. Conversely, safer sex might be viewed negatively or as a barrier to a close relationship (Binson, 1996). In light of these arguments, we derived four hypotheses.

Risky versus safer sex

As suggested above, risky sexual behavior may be viewed by couples as a symbol of love, trust, and, commitment. That is, couples may offer "relationship reasons" as explanations for risky sex, therefore:

H1: *In comparison to safer sex, riskier sex will be more frequently associated with love, trust, and commitment.*

Relationship interdependency

Past research has shown that risky sexual behavior and feelings of love are associated (Burns, 1993; Kelly et al., 1991; Pollack, Ekstrand, Stall, & Coates, 1990). Therefore, it seems likely that those individuals who are most dependent upon their relationship and who desire a stable and lasting relationship might be especially likely to take sexual risks in the relationship—to demonstrate their love and commitment, therefore:

H2: *Those who desire a stable and lasting relationship and who are dependent upon their partners (as measured by a closed-ended relationship attitudes measure) will take greater sexual risks in the relationship.*

Hypothetical change to risky versus safer sex

If having risky sex is viewed as a symbol of trust, a partner's request to have safer sex should be viewed as a sign of a lack of trust. In heterosexual relationships, for example, a request to use condoms is often viewed as a sign of extrarelationship sexual contact (Hammer, Fisher, Fitzgerald, & Fisher, 1996), therefore:

H3: *A proposed change from riskier to safer sex (i.e., a suggestion to use condoms) is apt to arouse suspicion of extrarelationship sexual contact.*

What motivates safer sex behavior in couples? Certainly, fear of AIDS may promote safer sex (Rhodes & Wolitski, 1990), and many of those who engage in safer sex do so because they fear contracting HIV (Gielen, Faden, O'Campo, Kass, & Anderson, 1994). Therefore:

H4: *Fear of AIDS will be the most frequently cited explanation for engaging in safer sex.*

Other possible reasons for risky sex

Although there is little existing literature looking at male couples' reasons for risky sexual practices, potential reasons may be gleaned from related research. First, there are apt to be pleasure-based or hedonic-based reasons. For example, men may be reluctant to use condoms because they believe condoms will lower their sexual enjoyment (Choi, Rickman, & Catania, 1994) or because they desire spontaneity, or because condoms are unavailable or they want to be "swept away" in the heat of the moment (Kelly et al., 1991). Second, some reasons may relate to unwarranted optimism regarding the estimated risk of contracting HIV. For example, some men may rely on discussions of sexual history or their belief in their practice of monogamy (McCamish & Dunne, 1993) to justify unprotected sex. Unfortunately, the exact nature of gay

men's reasons for unprotected sex and the reasons gay men give for using condoms are unclear. Therefore, one additional question posed by the current research was the following: What are the prevalent reasons for risky and safer sex for gay men in couples? We expected that hedonic reasons and reasons related to risk estimates, as suggested by prior research, would generally surface as reasons for risky sex for gay men. However, for *gay couples*, an additional set of reasons—previously unexamined—were apt to be critical: issues of love, trust, and commitment. Because relationship reasons for couples are apt to be as or more frequently mentioned than any other reason, examining this relatively understudied motivational pull—for male couples—was the focus of this research

Method

Participants

Participants were 92 gay men (46 couples) from Los Angeles County who met the following criteria: (1) both members of a couple participated, (2) members were in their current, "committed" relationship a minimum of 6 months, and (3) both members of the couple were over 18. Ages ranged from 18 to 68 years old (mean and median = 32 years). The majority of the sample was Caucasian (74%), and, on the whole, the sample was well educated; over 54% of the men surveyed completed at least 2 years of college, and all but one of the participants completed high school or its equivalent. It is also recognized that volunteer participants tend to be more educated, of higher social class, more intelligent, more approval motivated, and more sociable than nonvolunteers (Rosenthal & Rosnow, 1991).

Procedure

Each member of eligible couples, recruited via advertisements in gay print media and fliers distributed in the gay community, individually and privately completed separate surveys at the same time and location.

Upon placing their completed, anonymous surveys in envelopes to ensure confidentiality, participants were thanked and paid \$20 per couple.

Materials

In addition to general demographics (e.g., age; HIV status; income; education; ethnicity) participants responded to questions about the following areas described below.

Sexual behaviors and couple characteristics.

Men were asked to indicate the length of the current relationship; whether or not they had sex with someone other than their partner during the current relationship (and whether condoms were used if they did so); whether their partner knew that they had sex outside of the relationship; and their own and their partner's HIV status. Men were also asked to indicate the types of sexual behaviors that they engaged in with their partners (e.g., protected anal sex; unprotected anal sex; unprotected oral sex; protected oral sex; mutual masturbation).

Open-ended questions. First, the participant specified the sexual behavior(s) he was *currently* engaging in with his partner (see above). The survey then directed the participant to a page of open-ended questions that were appropriate given these sexual practices. This section assessed each participant's explanations for and beliefs about his sexual behavior within the relationship. For example, if a couple was engaging in protected sex, they would answer the following questions: (1) "Think back to the first time you had protected sex with your partner. Please take us through the sequence of events that led you to have protected sex. Please describe what happened." (2) "Please specify the reasons why you and your partner decided to have protected sex." (3) "Why have you and your partner continued to have protected sex?" (4) "What does having protected sex mean to you? What thoughts and feelings come to mind?" (5) "What do you think having protected sex says about your

relationship?" Finally, each participant was asked to explain what it would mean to him if his partner wanted to change sexual behavior (i.e., change from protected to unprotected sex): (6) "Imagine that your partner now wants to start having unprotected sex. What would this mean to you?" A couple engaging in unprotected sex would answer the identical questions except that the word "unprotected" was substituted for the word "protected" (and vice versa) in order to be consistent with the couple's sexual behavior. Because some couples engaged in both protected sex (e.g., anal sex) and unprotected sex (e.g., oral sex), they answered two sets of the above series of questions (i.e., one set of questions about their protected sexual behavior and one set of questions about their unprotected sexual behavior). Note that couples were asked to explain both protected and unprotected sexual behaviors. "Demand characteristics" were thereby minimized because couples were required to explain both "good" behavior (i.e., protected sex) as well as "bad" behavior (i.e., unprotected sex). Of course, couples may still have underreported their risky sexual behavior owing to social desirability. This is a general problem in this line of research.

Coding of open-ended responses.

Open-ended responses were coded in the following way. First, two graduate students went through the responses in search of recurrent themes or types of responses. A preliminary list of categories was compiled. During the first few weeks of coding, codes were added and surveys already coded were recoded to account for the new categories. During data analysis some of these categories with similar meanings were collapsed. (See Table 1 for a list and descriptions of the categories analyzed in the present work.) Six undergraduate research assistants were recruited as raters to assess interrater reliability for the coding of open-ended responses. In addition, there was one "master coder," a gay male graduate student. Cohen's kappas (Cohen, 1960) were run to assess interrater reliability, and the mean kappa comparing all of the raters (in-

cluding the master coder) was .92. In those cases where the codes assigned by the raters varied for a particular statement, the code of the master coder was used; this was justified in that the average interrater kappa between any given rater and all others was highest for the master coder (.94).

For later analyses, the reasons and meanings of sexual behavior given by participants in response to the open-ended questions were collapsed within couples. This was done in light of the fact that members of a couple often did not discuss the same behaviors. For example, if a couple had unprotected oral sex and protected anal sex, sometimes one partner would discuss the reasons for having protected anal sex while the other partner would discuss the reasons for having unprotected oral sex. Partners did not give inconsistent reports; rather, partners sometimes simply chose to report on different aspects of their joint behaviors. To get a more complete description of a couple's behavior and to avoid the problem of dependency of couple member's responses, the couple (e.g., the responses of both partners combined) was treated as the unit of analysis. Assumptions of parametric statistics, specifically normal distributions of variables and equal variances between groups, were not met unless otherwise specified; nonparametric statistics were therefore used.

Relationship Interdependency Scale. The questionnaire included several attitude items. Respondents rated their degree of agreement with relationship attitude statements on a scale of from (1) *strongly disagree* to (7) *strongly agree*. Five items tapped one's feelings of interdependency with one's relationship partner. This "Relationship Interdependency Scale" had adequate reliability ($\alpha = .75$). The five items comprising this scale were the following: (1) I'd be very upset if my relationship ended; (2) I get a lot of things I need from my relationship; (3) My partner provides me with a great deal of emotional support; (4) In general, I depend a lot on my partner; and (5) I want a relationship that will last for a lifetime.

Table 1. Reasons given for and meanings ascribed to sexual behavior

General Description of Reason or Meaning Given for Sexual Behavior	Examples of Reason or Meaning Statements
Relationship reasons	"Shows love/trust/commitment."
Fear of AIDS	"I'm afraid of getting AIDS." "I'm afraid my risky behavior will give me AIDS."
Hedonic reasons	"(Un)protected sex more pleasurable, feels better." "We got carried away in the heat of passion." "We had sex despite the risk" "We had too much to drink and had (un)protected sex." "Condoms are inconvenient."
Reasons related to risk estimates	"We discussed our sexual histories and decided it was best to use protection." "Neither one of us slept around much so we did not use protection." "We had been dating for over a month, so we felt that the time had come to do away with condoms." "We had known each other for a while but still felt we should use condoms." "We tested negative so we have (un)protected sex." "Monogamy is our safer sex." "We have unprotected oral or anal sex, but my partner does not ejaculate inside of me [pulls out]." "We had unprotected sex once [or for a period of time], so once the damage is done, it is done." "I just felt safe with my partner so we did not use protection." "I felt safer using protection."
Part of sexual script or schema	"Using [or not using] condoms is automatic."
Maximizing mutual outcomes	"Using condoms shows that we look out for each other's health." "Not using condoms satisfies <i>our mutual</i> desire <i>not</i> to use condoms."
Communication about sex	"We talked about sex." "We set our boundaries in advance."
Oral sex is safe	"Oral sex without a condom is not risky."
One or both HIV+	"My partner is HIV+, and I am not so we use protection." "We are both HIV+ so we do not use protection."
<i>Reasons and Meanings Used Only for Responses to Hypothetical Questions</i>	
Suspicion of extrarelationship sexual contact	"I would think that my partner had sex outside of the relationship or thought I did." "I would think that maybe something was wrong."

Results and Discussion

Relationship characteristics, HIV status, and sexual practices

The average length of the relationships was 43 months. However, the majority of the men did not maintain an exclusive sexual relationship with their partner; 62% of the

sample reported having had sexual relations with someone other than their current partner during their relationship. Only 30% of those who had sex outside of the relationship consistently used condoms when having sex outside of their primary relationship. Ten of the couples (21%) were completely monogamous—both partners reported no extrarelationship sexual con-

tacts. Sixteen of the couples (35%) had one partner who had sex outside of the relationship. For the remaining 20 couples (43%) both partners had sex outside of the relationship at one time or another. Eighty-four percent of the participants whose partners had sex with someone else during the course of the relationship knew about it. It is not clear, however, *when* partners found out about these extrarelationship sexual contacts and whether in the interim they were placed at risk. No differences were found in riskiness of sexual behavior or reasons given for engaging in different sexual behaviors as a function of extrarelationship sexual contact status of the couple.

Twenty-two participants were HIV positive (twenty-four percent); 64 were negative (seventy percent), and the remaining six (seven percent) were unsure or did not respond to the question. Six couples were therefore classified as "sero-unknown." Of the 40 couples where both members revealed their HIV status, 26 (sixty-five percent) of the couples were HIV negative, 7 (eighteen percent) of the couples were sero-different, and 7 of the couples (eighteen percent) were HIV positive.

One couple (2%) did not engage in oral or anal sex, only mutual masturbation. All of the remaining couples engaged in unprotected oral sex; all of these couples believed that unprotected oral sex is safe or of negligible risk. Seven couples (15%) engaged in unprotected oral sex only, and did not engage in anal sex at all (Risk Group 0). Sixteen couples (35%) engaged in unprotected oral sex but protected anal sex (Risk Group 1). The remaining 22 couples (48%) engaged in both unprotected oral and unprotected anal sex (Risk Group 2).

Sero-discordant couples. Contrary to the finding by Kippax, Crawford, Davis, Rodden, and Dowsett (1993) that unprotected anal intercourse is more likely among sero-concordant couples, the seven sero-discordant couples in our sample did not differ significantly from sero-concordant (i.e., both partners have the same HIV status) couples in the riskiness of their sexual behavior.

Three (43%) engaged in unprotected oral and anal sex (Risk Group 2). Two (29%) engaged in protected anal sex but unprotected oral sex (Risk Group 1). One couple (14%) engaged in unprotected oral sex but did not engage in anal sex at all (Risk Group 0). The remaining sero-discordant couple was the one couple from our entire sample that only engaged in mutual masturbation. Thus, the couple that engaged in the safest sex in our sample was sero-discordant. However, taken as a group, sero-discordant couples were just as risky in their sexual behavior as were sero-concordant couples.

Reasons for riskier versus safer sex

A series of chi-square tests were performed comparing the reasons couples gave for engaging in risky sex (unprotected anal sex) versus reasons couples gave for engaging in safer sex (protected anal sex). Therefore, only couples who engaged in anal sex were retained for these analyses. Sixteen couples were currently using condoms for anal sex and therefore only answered questions about protected sex behavior; 20 couples were not currently using condoms for anal sex and therefore only answered questions about unprotected sex behavior. These 36 couples were retained for analyses; and comparisons of reasons given for protected sex and reasons given for unprotected sex were strictly between-couples (see Table 2). To keep the comparisons strictly between-couples, two couples that were inconsistent in their current use of condoms for anal sex (i.e., they answered questions about both protected and unprotected anal sex) were excluded from the analysis.

No differences were found in reasons given for protected versus unprotected anal sex as a function of sero-status of the couple. However, to be certain that sero-discordant couples were not influencing the results of the comparisons of reasons given for protected versus unprotected anal sex, comparisons were also made excluding the four sero-discordant couples who were included in the reported comparisons and also excluding the five couples who were

Table 2. Percentage of couples using various reasons to explain less risky versus risky sex

Reason or Meaning	Protected Anal Sex (Less Risky)	Unprotected Anal Sex (Risky)	Likelihood Ratio
<i>Reasons Relating to Main Hypotheses</i>			
Relationship reasons	38%	95%	15.21**
Fear of AIDS	94%	15%	25.52**
<i>Other Reasons</i>			
Hedonic reasons	38%	95%	15.21**
Reasons related to risk estimates	56%	90%	5.55*
Part of sexual script	44%	10%	5.55*
Maximizing mutual outcomes	38%	5%	6.36*

Note: $N = 36$ for each chi-square comparison.

* $p < .05$. ** $p < .01$.

unsure of their sero status. All significant differences remained significant ($p < .05$) and in the same direction. Thus, even after looking only at sero-concordant couples, the differences we found in our comparisons were identical.

In Table 2, we have organized these reasons into two general groups paralleling the focus of the report. The first category includes reasons that relate to the main hypotheses of the current work. Briefly, as hypothesized, relationship reasons were more frequently associated with unprotected anal sex while fear of AIDS was more associated with protected anal sex. The second category includes reasons not directly related to our main hypotheses. We will discuss this latter set of findings first before returning to the reasons related to relationships and fear.

Two categories of reasons were used more frequently for unprotected anal sex than protected anal sex (see Table 2); they included issues pertaining to immediate pleasure—*hedonic reasons* (e.g., sensation concerns, got carried away etc.) and *reasons related to risk estimates* (e.g., “My partner pulls out,” “Once the damage is done, it is done,” and “I felt safe with my partner”). With respect to *hedonic reasons*, consistent with earlier work (Choi et al., 1994), concern about sensation was a prevalent reason for foregoing condom use. These findings justify the argument that men may be

more willing to use condoms if health-care messages eroticize condom use.

Reasons related to risk estimates illustrate areas where couples inaccurately estimate the level of risk involved with certain behaviors, thus creating “safer sex myths.” “Pulling out” before ejaculation is one example of a “safer sex myth”; such “safer” unprotected behaviors need to be addressed in future research and in HIV education. Note that “pulling out” is not unique to gay men; it is also an ineffective strategy some heterosexuals use to prevent pregnancy. Another frequently mentioned myth, used to explain unprotected anal sex, is that “we had unprotected sex before and once the damage is done, it is done.” This explanation indicates a lack of understanding of “cumulative risk” (Kingsley et al., 1987). The notions of cumulative risk and repeated exposure must be clarified in current safer sex interventions as the message is apparently not understood by many.

Testing HIV negative was also a frequently mentioned reason related to risk estimates. Given “window periods” and extrarelationship sexual contacts, HIV interventions must ensure that couples who test HIV negative do not harbor a false sense of security based upon test results alone. Another reason relevant to risk perception was the presumption of monogamy in the relationship. Monogamy was offered as an explanation for engaging in risky sex, but the reality is that most couples will have sex

with someone other than their current partner during the course of the relationship (Peplau & Cochran, 1988). Therefore, intentions of monogamy alone are not a fool-proof method of safer sex.

Other overly optimistic perceptions about the role of knowledge about one's partner can also lead to inaccurate risk assessment: "Discussing sexual histories" and "knowing each other for a while," both relevant reasons for unprotected anal sex, illustrate the common misperception that "knowing one's partners can minimize (HIV) risk" (Valdiserri et al., 1988, p. 804). Most HIV education emphasizes, correctly, that one can never know everything about another person, and that the safest approach to take (if not abstinence) is to use condoms.

Two other categories were used more frequently for protected anal sex than for unprotected anal sex: *part of sexual script* and *maximizing mutual outcomes*. Forty-four percent of the couples who engaged in protected anal sex implied that "this is just what we do" (*part of sexual script*). This finding suggests the value of counseling couples simply to initiate condom use; the more condoms are used, the more likely they may be to become integrated into one's typical sexual script. In this way, safer sexual behaviors may become automatic and normative parts of sex. In fact, Kelly et al. (1991) suggested that experience with safer sex may contribute to a pattern of safer sex maintenance.

Maximizing mutual outcomes was also cited frequently as a reason for protected anal sex. "I want to protect myself and my partner from HIV" is an example of this category. The use of this reasoning by couples currently engaging in *protected sex* suggests that a successful safer sex message for couples may be one that focuses less on individual outcomes (protecting self) and more on joint outcomes (protecting each other).

Reasons and relationships:

Main hypotheses

Trust, risk, and commitment: Interwoven themes. Our first hypothesis was that in comparison to safer sex, riskier sex will be

more frequently associated with love, trust, and commitment. In support of this, feelings of love, trust, and commitment were associated with risky sexual behaviors more often than with safer sexual behaviors (see Table 2). To gather converging evidence for the link between relationship variables and sexual risk-taking, scores on the Relationship Interdependency Scale were correlated with level of sexual risk taking (unprotected anal sex = high and protected anal sex = low). There was a significant correlation between sexual risk taking and relationship interdependency ($r = .35, p < .01$) for all participants engaging in anal sex.

Because participants belonged to couples, independence of responses could not be assumed. Therefore, we could not simply correlate the responses on these two variables across the 72 men included in the analysis. Instead, the responses of partners needed to be separated, to avoid the dependence of response problem. To do so, one member of each couple was randomly assigned to Group 1 and the correlation between riskiness of sexual behavior and relationship interdependency was assessed for these 36 men. The same set of analyses was performed for the other 36 men not assigned to Group 1 (i.e., the Group 2 men). The separate correlations between riskiness of sexual behavior and relationship interdependency were thus as follows: group 1 ($r = .48, p < .01$) and group 2 ($r = .23, p = .19$). These correlations supported Hypothesis 2: *Those who desire a stable and lasting relationship and who are dependent upon their partners (as measured by a closed-ended relationship attitudes measure) will take greater sexual risks in the relationship.*

These findings are ironic in that the positive ingredients of a successful relationship (i.e., love, trust, commitment, and relationship interdependency) are also predictive of behaviors that could lead to HIV infection. What might explain this apparent paradox? One possibility, as Rempel et al. (1985) point out, is that taking risks within a relationship is part of building trust and a closer, deeper relationship. A second possibility, as articulated by Pilkington et al.

(1994), is that as trust develops, concern about AIDS diminishes, and sex becomes riskier. This might occur because trust in one's partner "may be overgeneralized such that the individual trusts the partner not to give him . . . AIDS" (Pilkington et al., 1994, p. 209). A third possibility also suggested by Pilkington and her colleagues is the notion of a halo effect. Those who feel positively (i.e., loving and trusting) about their partners may assume that their partners are "good" in general and in turn free of disease.

There is one additional reason why risk may be associated with loving. Risk-taking itself may be arousing. In a romantic context, that arousal may enhance romantic feelings and the desire for sexual intimacy. Supporting this possibility, Dutton and Aron (1974) found that men who interacted with an attractive female researcher on a scary suspension bridge—compared to those on a safe bridge—were more likely to have fantasies about love, kissing, and sexual intercourse as well as more likely to telephone the researcher later to "talk about the study." The causal connections between sexual risk-taking, arousal, and romantic feelings should be investigated in future research.

Looking at safer sex, it was not just viewed less positively than risky sex; it had specific negative associations. For example, a hypothetical request from one's partner to switch to safer sex practices ("Imagine that your partner now wants to start having protected sex. What would this mean to you?") raised the possibility of extrarelationship sexual contacts. This supported Hypothesis 3: *A proposed change from riskier to safer sex (i.e., a suggestion to use condoms) is apt to arouse suspicion of extrarelationship sexual contact.* Put another way, a move by one's partner to initiate safer sex may undermine one's trust in one's partner. Suspicion of extrarelationship sexual contacts was more frequently mentioned in response to a hypothetical change to protected sex (less risky), 53%, than in response to a hypothetical change to unprotected sex (risky), 13%, $\chi^2(1, N = 30) =$

5.68, $p < .05$. The same result was found when excluding sero-discordants ($p < .05$) and when excluding sero-discordants and sero-unknowns ($p < .01$).

This presents a problem for HIV prevention efforts. If love and trust for one's partner are associated with riskier sex and negative connotations surround safer sex, the prevalent safer sex message of "using a condom shows that you care about your partner" is likely to ring hollow with many gay men. The message assumes that caring and love are associated with not taking chances and "playing it safe," but this was not the meaning that most couples in the present study ascribed to safer sex.

Fear of AIDS

Hypothesis 4 stated that: *Fear of AIDS will be the most frequently cited explanation for engaging in safer sex.* Hypothesis 4 was supported, for in the current work, fear of AIDS was cited 94% of the time in reference to protected anal sex. Even after excluding both the sero-unknown couples and the sero-discordants, 91% of the couples having protected anal sex cited fear of AIDS as a reason for using condoms. After excluding sero-positive couples as well, 89% of the sero-negative couples cited fear of AIDS as a reason for using condoms. Most researchers have put sero-concordant negative couples in a low risk category for HIV infection. However, these couples are still afraid of contracting HIV from their primary relationship partner—even though both partners have tested negative for HIV. They are therefore likely to share our perceptions regarding the risks of gay men in couples we alluded to earlier. This finding is consistent with past research that has linked fear of AIDS to safer sexual practices (Gielen et al., 1994; Rhodes & Wolitski, 1990). Thus, fear appears cannot be discounted as an important tool for increasing safer sex behavior.

However, one must be careful when using fear to affect behavior change. If too much fear is aroused it may cause anxiety and a subsequent denial of the message that

triggered the discomfort (Chu, 1966). To be most effective, fear appeals should be paired with messages that promote feelings of self-efficacy (Maddux & Rogers, 1983). More specifically, individuals must believe that they are capable of responding in a way to avoid the feared consequence (Tanner, Day, & Crask, 1989). To be effective, HIV interventions for couples should provide individuals with a clearer set of strategies, skills, and plans for coping with the real sexual risks of commitment (e.g., probability of extraregulation sexual contacts and window periods). An approach known as "negotiated safety," which addresses these concerns, therefore holds promise.

Negotiated safety

Negotiated safety, an approach to HIV intervention widely used in Australia (Sadownick, 1995), encourages individuals with the same sero-status to form couples. Couples use condoms during the first several months of the relationship, and repeated HIV testing is administered during this time. If both partners are negative after this repeated testing, they can start having unprotected sex if they promise each other they will avoid anal sex outside of the relationship. If unsafe sex occurs outside of the relationship, it is permitted as long as one's partner is told immediately and the two resume condom use. Repeated testing can allow them to do away with condoms once again later on.

The first advantage of this approach is that it may increase couples' feelings of self-efficacy because it gives them a plan and a set of strategies for responding to extraregulation sexual contacts that minimizes each partner's exposure to HIV. The second advantage to "negotiated safety" is that it simultaneously *acknowledges* the desire of male couples to engage in unprotected sex to express love, trust, and commitment, and *provides* a lower-risk model for doing so. The third advantage of "negotiated safety" is that by keeping the topic of HIV salient, fear of AIDS should also remain salient in the minds of couple mem-

bers. Because this fear is paired with strategies to lower risk of HIV infection (i.e., boosting feelings of self-efficacy), it should be effective in reducing high-risk sexual behavior. The fourth advantage of this approach is that it addresses a problem with the restrictiveness of safer sex guidelines. There is evidence to suggest that safer sex guidelines may have failed some men because the task of maintaining the use of condoms indefinitely is too difficult, and they engage in "slipups," or random acts of unprotected sex (Sadownick, 1995).

Negotiated safety allows for the possibility of having unprotected sex within the context of a relationship that has a negotiated safety agreement; this may discourage some men from engaging in random acts of unprotected sex outside of the relationship that may be more risky than unprotected sex acts practiced within their primary relationship. One pitfall with negotiated safety, however, is the presumption of honesty. However, given the greater candidness of the negotiated-safety approach, honesty might not only be the "best policy" but might be less associated with conflict and relationship cost.

Conclusion

This study provides insight into how risky and safer sex practices are viewed by men in male couples. Safer sex is motivated primarily by fear of AIDS. Risky sex is viewed as a sign of love, trust, and commitment, while moves to initiate safer sex are viewed with suspicion.

Risky and safer sex are therefore not merely isolated behaviors. They are actions imbued with meaning, especially when performed within an enduring relationship. Unfortunately, HIV interventions have largely focused on the mechanics of sex (i.e., how to use condoms) and neglected the relationship context within which sex occurs. A failure to acknowledge that risky sexual behaviors are closely tied to loving may have led to ineffective HIV interventions in the past. Interventions targeted at couples and singles (straight or gay) that

discuss relationship issues must be developed so as to foster lower risk behavior in the future.

The possibility that risk-taking may increase romantic feelings and sexual desire (Dutton & Aron, 1974) suggests that the

association among love, trust, commitment, and sexual risk may not be such a paradox after all. Risk-taking, arousal, and romantic feelings may simply be intertwined parts of the complex experience of love.

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