AIDS HEALTH PROJECT

June 2002 v17 n7

FOCUS
A Guide to AIDS Research and Counseling

Frustrated Desire, HIV Prevention, and Gay Culture

Terry Trussler, EdD

Since its beginnings, much of HIV prevention research has focused on individual attributes to account for the behavior of "risk takers." Even while rates of unprotected sex among gay men have steadily increased over the past five years, the focus on the characteristics of individuals has continued to dominate explanations of risk taking.[1] Now that rates of HIV transmission are also beginning to climb, new perspectives are urgently needed.

The Community-Based Research Centre in Vancouver has always been skeptical about the "flawed personality" theory that underlies the individual risk-taker model.[2] The term "barebacking," for example, caught fire in gay discourse, because talking about unprotected sex became as fashionable as tattoos and piercings. Talk may not equal action but it begs a question: is doing the "cool" thing a more potent inducement for unprotected sex than the traits of individual risk takers as favored by the prevailing wisdom?

In theorizing about HIV risk, the Community-Based Research Centre has long emphasized social over individual factors, noting that social environments play an important role in governing individual health.[3] This conception is founded on two theoretical models in the health literature. First, Jonathan Mann's vulnerability theory strongly suggests that individuals are at risk due to their status within their societal context.[4] Although his theory has rarely been applied to gay men, Mann observed that HIV found routes of least resistance through communities of those most discriminated against in society. Second, population health theory, a relatively new policy framework in Canada, suggests that social status is a stronger factor than individual behavior in determining disease.[5] This theory also has yet to see much application to research on gay men.

Anecdotally, it does seem that the way gay men approach sex is determined as much by what they believe is acceptable to others as by what they know about their risk of infection. For a period of time, that cultural phenomenon—the power of community norms to make unprotected sex unacceptable—may have actually been responsible for the achievement of HIV prevention goals among gay men. But not any more, it seems. Recent studies of gay men in Vancouver have tried to grasp the relationship between increasing rates of unprotected sex and cultural change in gay life. The most compelling interpretation of what has emerged so far is that social status, rank, or position—the place of gay men in the societal scheme of things—may play a significant role.

In a city like Vancouver, dubbed "lotus land" by people in other parts of Canada, the good life seems abundant, but ultimately, it is truly available only to a few. What impact does the "frustrated desire" that many gay men experience as they arrive in this city and try to live their dreams have on HIV prevention? Could the effect of exposure to social boundaries explain the slow disintegration of safer sex?

Alienation among Young Gay Men

In early attempts to understand what was happening, the Community-Based Research Centre first focused on young gay men whose attitudes about safe sex appeared increasingly cavalier. This attitude seemed to suggest that young men were in the process of reinventing a "post-AIDS" gay life for themselves.[6] Could unprotected sex be catching on like a youthfully defiant fashion statement? A series of focus groups with 72 self-identified gay men between the ages of 18 and 30 found the opposite to be true: safe sex appeared to remain a valued pro-

Editorial: Status Symbols

Robert Marks, Editor

It is easy to be seduced by the idea that the truth is an either/or proposition, that risky behavior is influenced by what goes on inside a person's head—or even within the DNA of his or her cells—rather than what goes on outside his or her body. It seems just as likely that internal and external forces work concurrently, sometimes amplifying each other's effects, other times minimizing them, always influencing them.

The nature of much scientific research today is to specialize, to not simply focus but to focus tightly on a theory or an approach. While this close study—a form of myopia—serves to clarify and test specific factors related to risk, it can sacrifice a broader view that may be particularly beneficial at a time when many are reevaluating fundamental HIV prevention approaches.

Personal actions are more easily influenced than societal forces, and HIV prevention has been effective over time by concentrating on the individual, or more broadly, the way individuals interact in social groups. But, as we face more intractable prevention challenges, neglecting broad societal forces may undermine much of this success.

Both of the articles in this issue of *FOCUS* attempt to synthesize findings about individual behavior within the larger context of society. Applying population health theory, the dominant model for health policy in Canada, Terry Trussler defines social factors as "first-order" determinants of health. Primary among these is social status. He suggests that the high cost of living in Vancouver, the presence of anti-gay violence, and the difficulty of sustaining long-term relationships converge in a "frustrated desire" that threatens social rank and the motivation to remain HIV-negative.

Rodrick Wallace also considers the importance of social status, in particular, the communication of status through behavior. He proposes that when a behavior that communicates status within a marginalized community becomes destructive, it may be difficult to change the behavior if the conditions that caused it to become an effective communicator do not also change. For example, if unprotected sex becomes central to a gay male identity formed in the crucible of discrimination, violence, and fear, protected sex may be an unachievable goal for some men—even in the face of HIV—unless the societal forces that marginalize gay men change.

Society is at best a compromise: the social forces that marginalize and impede some advance others. It is unrealistic to expect society to change so dramatically as to eliminate the oppressive conditions that incubate what might become destructive behaviors. Acknowledging the role of broad societal forces—beyond the current use of social marketing to influence group norms—is crucial both in prevention planning and in psychotherapy, if for no other reason than it paints a more vivid and comprehensive picture of the truth.

tective strategy in the culture of young gay men.[7] But these focus groups also uncovered a wide assortment of other frustrations young gay men encountered in Vancouver, frustrations that these men, themselves, suggested were linked to the rise of unprotected sex.

Chief among them was the experience of alienation. Focus group participants described Vancouver as a "passing fantasy" for many young men, who come for "the rest of their lives" but leave in a year or two still looking for a job. Many doubted the existence of "gay community." They complained about a lack of venues for contact with gay culture outside of bars. Many expressed a deep desire to have a lifelong relationship with another man, but the cold realities of Vancouver's sexual marketplace made fulfillment of this desire seem impossible. These narratives described an initial excitement about connecting with "out" gay culture in a big city that was quickly eroded by encounters with the local gay scene and an urban society that still has difficulty embracing its gay residents. Intrigued by these findings, the Community-Based Research Centre used the population health model—which now governs health policy in Canada—to design a questionnaire probing the relationships between society, gay culture, and HIV prevention.

Population Health

Population health theory proposes a set of determinants, over and above specific diseases, that influence peoples' health.[5] The term "determinant" holds an uneasy but crucial place in the theory, because it suggests that there are inevitable factors affecting health beyond individual volition or control. Listed here in order of what is thought to be their influence, population health determinants include: income and social status; social support networks; education; employment; social environment; physical environment; personal practices; child development; biological and genetic endowment; gender; and culture.[8]

In this scheme of health, social factors are first-order determinants, taking precedence over personal practices and even biological endowment. Theoretically, those people, communities, and nations that rank higher have better health. Social rank—defined by confidence, authority, and power, even more than wealth—is the most important social status variable. Given the uncertain place that gay men continue to occupy in North American society, what might the "social status" determinant mean for gay health?

The Vancouver survey recruited a sample of 620 men over three weeks. Participation was open to all, and recruitment drew from a wide variety of venues, events, and media. Ultimately, the sample in many ways resembled any gay gathering in Vancouver. While the sample included a wide range of ages—from 18 to 70—the mean age was 38. There was a complete spectrum of ethnic groups, and education and income levels. About 15 percent of the sample was HIV-positive.

Taken as a whole, the data seemed to point in another surprising direction. Little in the aggregate findings suggested a crisis in gay health. For example, in terms of unprotected sex—which the survey defined as instances of either receptive or insertive anal sex without a condom during the previous six months—about 63 percent of the sample said they had none, about 23 percent said they had it with one man only, and about 14 percent said they had it with more than one man. The extent of unprotected sex in relationships during the period before the study was unknown, but it was somewhat reassuring that multiple-partner unprotected sex was less popular than it seemed it would be given widespread talk about barebacking. There was also evidence to suggest that, in many respects, social support was stronger than expected. As many as 80 percent of men in the sample thought they had a strong network of friends. On the other hand, when it came to finding new male friends, 54 percent said they found it to be quite difficult.

Findings such as these were perplexing, implying perhaps that the survey questions were not precise enough or that the effort to relate social status to safe sex was too ambitious for a survey. A deeper look into natural groupings in the gay community—HIV-positive, HIV-negative, and unknown status; single and partnered; young, middle, and older age—began to uncover important differences within these groupings. It also revealed further hints of the underlying frustration that accompanies gay men's experience of their ascribed social status.

City of Broken Dreams

Frustrated desire, often seen as a root cause of conflict, anger, and violence, is an age-old concept. Freud proposed psychoanalysis as a process of recovering unconscious desire to find a way out of depression. Thus, to discover and know one's desire was the goal of psychoanalysis. But when the object of desire is found to be unattainable, the resulting frustration may bring about a cascade of negative emotions and unpredictable consequences. What happens if frustrated desire is operative as a cultural condition of an identifiable population due to its apparent rank in the social scheme of things? Do gay men suffer subtle effects of the social position afforded them that goes beyond blatant discrimination?

Population health theory holds that social factors are first-order determinants, taking precedence over personal practices and even biological endowment.

Frustrated desire does help explain the alienation apparent among Vancouver's young gay men, especially men under 30 years old. It was expressed in three realms in the Community-Based Research Centre findings: cost of living, violence, and relationships. Here in a city full of gay men seeking paradise, insurmountable barriers to attaining it are everywhere. As many as 70 percent of the Vancouver sample said what they really want is a lifelong partner, but far fewer have actually attained anything close to that. While it may seem counter to gay mythology, among young gay men in the sample this percentage rose to 88 percent. But what are their chances of achieving this goal?

References

1. Stall R, Hays R, Waldo C, et al. The gay 90's: A review of research on sexual behaviors and HIV risk among men who have sex with men. AIDS. *2000; 14(Supp 3): S1–S14.*

2. Strathdee S, Hogg R, Martindale S, et al. Determinants of sexual risk-taking among young HIV-negative gay and bisexual men. Journal of Acquired Immune Deficiency Syndrome and Human Retroviruses. *1998; 19(1): 61–66.*

3. Labonte R. Population health and health promotion: What do they have to say to each other? Canadian Journal of Public Health. *1994; 86(3): 165–168.*

4. Mann J, Gostin L, Gruskin S, et al. Health and Human Rights. Health and Human Rights: An International Journal. *1994; 1(1): 6–23.*

5. Evans R, Barer M, Marmor T, eds. Why Are Some People Healthy and Others Not? The Determinants of Health of Populations. *New York: Aldine De Gruyter, 1995.*

6. Gubrium J, Holstein J, Buckholdt D. Constructing the Life Course. *New York: General Hall Press, 1994.*

Many gay men come to Vancouver with expectations that their education and skills will lead to fulfilling jobs, comfortable lives, and improved social status. While these men are often well-educated and earn relatively high incomes, such achievements turn out to be a condition of basic survival. Rents are so prohibitive, new city residents are forced into less desirable roommate relationships, and disposable incomes are inadequate to take full advantage of the recreational and cultural opportunities of a large, cosmopolitan city. The result is that gay migrants to Vancouver—and perhaps other large North American cities as well—must confront largely hidden social boundaries they were not expecting to encounter.

Forty-eight percent of respondents reported having experienced "gay bashing" at least once in their lives. Anti-gay violence may well frustrate attempts to "live the good life," but when it involves nearly half the community, the aggregate suggests a much more significant effect. This finding raised a red flag. Is anti-gay violence an indicator of diminished social rank, that first-order determinant in population health theory, and does its prevalence have an impact on HIV risk? The Vancouver study found that those who had been gay-bashed were more than twice as likely to have engaged in high risk sex than those who had not.

Finally, the differences in responses between single and partnered men uncovered another pattern. Overall, half of the younger men in the sample participated in unprotected sex, but most of it was with only one partner. This suggests that serial monogamy may be a central HIV prevention strategy for these men. Could access to "safer" unprotected sex be one of the reasons so many young men want a relationship? If so, is the difficulty of forming relationships under Vancouver's conditions having an impact on HIV risk, and is this ultimately a consequence of frustrated desire?

Among single men, another piece of evidence emerged: an underlying frustration that was not as apparent among gay men in general. Single men turned out to be less satisfied with Vancouver's living conditions, found it more difficult to meet new men, and were more likely to have sought care for mental health or relationship issues. They were also more likely to be engaged in multiple-partner unprotected sex, perhaps a barometer of frustrated desire. Considering only the single men who engaged in multiple-partner unprotected sex, the barometer rose much higher: they were also more likely to have been gay bashed, to have experienced relationship violence, and to use party drugs such as crystal.

Conclusion

Further exploration of these issues may begin to answer the question of how frustrated desire operates within the day-to-day construction of gay life and what it may mean for the future of gay culture. From the perspective of population health theory, frustrated desire seems a natural by-product of the social status, rank, and position afforded gay men. In gay culture itself, social status seems currently to be vested most in relationship status. Those in relationships have more of what most gay men desire: more income, more satisfaction with living, and more optimism about their own futures. For young gay men today, the desire for the good life is the desire for a stable partner, but the risks involved in achieving this may include violence and HIV infection. This suggests that the struggle for human rights for gay men may well be as important for HIV prevention as individual sexual health.

7. Trussler T, Perchal P, Barker A. Between what is said and what is done: Cultural constructs of gay men's HIV vulnerability. Psychology, Health and Medicine. *2000; 5(3): 295–306.*

8. Health Canada. What is population health? Health Canada. *2000: http://www.hc-sc.gc.ca/hppb/phdd.*

Authors

Terry Trussler, EdD is a co-founder and Director of the Community-Based Research Centre (CBRC) in Vancouver, a gay health think-tank that, in addition to its own research, supports the general involvement of community HIV organizations in prevention research. The CBRC facilitated an International Consensus Statement on Community-Based Research, which is available at www.hiv-cbr.net.

Clearinghouse: Culture and Norms

References

Amaro H, Raj A, Reed E. Women's sexual health: The need for feminist analyses in public health in the Decade of Behavior. *Psychology of Women Quarterly.* 2001; 25(4): 324–334.

Carmona JV, Romero GJ, Loeb TB. The impact of HIV status and acculturation on Latinas' sexual risk taking. *Cultural Diversity and Ethnic Minority Psychology.* 1999; 5(3): 209–221.

Fishbein M, von Haeften I, Appleyard J. The role of theory in developing effective interventions: Implications from Project SAFER. *Psychology, Health and Medicine.* 2001; 6(2): 223–228.

Flowers P, Smith JA, Sheeran P, et al. "Coming out" and sexual debut: Understanding the social context of HIV risk-related behaviour. *Journal of Community and Applied Social Psychology.* 1998; 8(6): 409–421.

Herdt G. Stigma and the ethnographic study of HIV: Problems and prospects. *AIDS and Behavior.* 2001; 5(2): 141–149.

Hou S, Basen-Engquist K. Human immunodeficiency virus risk behavior among White and Asian/Pacific Islander high school students in the United States: Does culture make a difference? *Journal of Adolescent Health.* 1997; 20(1): 68–74.

Kelly JA, Sikkema KJ, Winnet RA, et al. Factors predicting continued high-risk behavior among gay men in small cities: Psychological, behavioral, and demographic characteristics related to unsafe