



Winter 12-15-2017

CHANGES IN SEXUAL BEHAVIORS DUE TO THE UTILIZATION OF PrEP AS A PREVENTIVE METHOD FOR THE TRANSMISSION OF HIV

Michael D. Kaltenbach

University of Pennsylvania, mkalt@sp2.upenn.edu

Follow this and additional works at: https://repository.upenn.edu/edissertations_sp2

 Part of the [Social Work Commons](#)

Recommended Citation

Kaltenbach, Michael D., "CHANGES IN SEXUAL BEHAVIORS DUE TO THE UTILIZATION OF PrEP AS A PREVENTIVE METHOD FOR THE TRANSMISSION OF HIV" (2017). *Doctorate in Social Work (DSW) Dissertations*. 103.
https://repository.upenn.edu/edissertations_sp2/103

This paper is posted at ScholarlyCommons. https://repository.upenn.edu/edissertations_sp2/103
For more information, please contact repository@pobox.upenn.edu.

CHANGES IN SEXUAL BEHAVIORS DUE TO THE UTILIZATION OF PrEP AS A PREVENTIVE METHOD FOR THE TRANSMISSION OF HIV

Abstract

ABSTRACT

According to The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), approximately 33.4 million individuals throughout the world have been affected by HIV/AIDS in the last 30 years or so (Bonacquisti & Geller, 2013). The medication, Truvada, otherwise known as PrEP, has been introduced to serve as a harm reduction technique to combat the spread of HIV infection. PrEP is an antiretroviral drug that lowers the risk of HIV exposure. This is a qualitative study examining the sexual behaviors of gay and bisexual men prescribed PrEP as a preventive method for the transmission of HIV. I conducted 30 semi-structured in-depth interviews of people who had been prescribed PrEP for at least 30 days in three cities: Los Angeles, Philadelphia, and New York City. The results indicate that contextual factors shaped the sexual behaviors of participants on PrEP, leading them to lower risk at times, and elevate it at others. PrEP caused individuals to experience changes within their communication patterns with their medical providers and their sexual partners. The results shed light on the way people on PrEP engage in sexual and health-seeking behaviors, and help to develop a blueprint for the way service providers engage with this community.

KEY WORDS: PrEP (Pre-exposure Prophylaxis); HIV/AIDS; Truvada; HIV prevention; harm reduction; risky sexual behaviors; Cognitive Behavioral Therapy (CBT); Relational Cultural Therapy (RCT); qualitative interviews

Degree Type

Dissertation

Degree Name

Doctor of Social Work (DSW)

First Advisor

Toorjo Ghose, PhD

Second Advisor

Sabitha Pillai-Friedman, PhD, LCSW, CST

Keywords

PrEP (Pre-exposure Prophylaxis), HIV/AIDS, Truvada, HIV prevention, harm reduction, risky sexual behaviors, Cognitive Behavioral Therapy (CBT), Relational Cultural Therapy (RCT), Qualitative interviews

Subject Categories

Social and Behavioral Sciences | Social Work

CHANGES IN SEXUAL BEHAVIORS DUE TO THE UTILIZATION OF PrEP
AS A PREVENTIVE METHOD FOR THE TRANSMISSION OF HIV

Michael Dean Kaltenbach, LCSW

A DISSERTATION

In

Social Work

Presented to the Faculties of the University of Pennsylvania

In

Partial Fulfilment of the Requirement for the

Degree of Doctor in Social Work

2017

Toorjo Ghose, Ph.D.
Dissertation Chair

John L. Jackson, Jr., Ph.D.
Dean, School of Social Policy and Practice

Lina Hartocollis, Ph.D., LCSW
Dean of Students, School of Social Policy and Practice, DSW Program

Sabitha Pillai-Friedman, Ph.D., LCSW, CST
Dissertation Committee

Dedication

This dissertation is dedicated to the men who allowed me to hear their stories and intimate details of their sexual lives post decades after the initial HIV/AIDS crisis. Dedication also goes out to everyone who has ever regretted their behavior and has experienced fear as a result in the search for love and acceptance.

Epigraph

“Fear leads to anger. Anger leads to hate. Hate leads to suffering.”

---- Yoda, Star Wars, Episode I The Phantom Menace, 1999.

ACKNOWLEDGMENT

The author acknowledges and of deepest appreciation and sincerity would like to thank:

- University of Pennsylvania School of Social Policy and Practice
- Toorjo Ghose, Ph.D. for serving as Chair of my Dissertation Committee
- Sabitha Pillai-Friedman, Ph.D., LCSW, CST for serving as the second reader of my Dissertation Committee
- Lina Hartocollis, Ph.D., LCSW for her guidance and support throughout my entire education as a DSW student at University of Pennsylvania
- Tomoko Linney for your editorial assistance and for teaching me up-to-date APA style
- My friends and family members who supported me throughout the entire process of the doctoral program. Especially my Mom and Dad for always being 100% supportive of all of my endeavors, and always putting a huge smile on my face when I read their Facebook posts in response to mine. “We love you a bunch.” Also thank you to my niece, Aimee Stocking Brown for your IT assistance. Thank you Lupita Munguia for your knowledge on how to design charts and graphs on Excel.
- A huge thank you goes out to Rosco Ellis for his supportive and sometimes not so kind-hearted words that served to motivate me and to regain focus in order to complete the doctoral program. I also have the utmost appreciation for Rosco Ellis providing care for our dogs (Thalia and Lincoln) in Los Angeles so that I could pursue my dream of obtaining a doctoral degree.
- Paul Heffner, DSW, LSW (my classmate, colleague, and friend), thank you for being there with me through this entire process. You have always been there for me to vent

about school and work, and to provide moral support through our evening runs, our 5K fundraiser runs, happy hours, transportation to class, and much more. I don't know how I would have survived the program without study halls at your house with your famous cheese platters, dessert trays, and vino (while watching trashy shows on HBO).

- Ken Howard, LCSW, for being my number one colleague and for always inspiring me to strive towards my professional goals. You have always been there to write recommendation letters, verify my clinical experiences for licensure, and motivate me to be the best clinician I can be.
- My grandmother, Laura Mae Dechert, whose legacy continues to exist through memories of her words of wisdom from having only an eighth-grade education. I remember her telling me when I was younger, "You can have everything, and it can all be taken away from you. However, no one can ever take your education away from you." Her words have been my true inspiration in furthering my knowledge.
- The men who volunteered their time to participate in the study and were willingly open to express intimate details of their lives and sexual behaviors in support of research in hopes of protecting their own lives and the lives of others against HIV.

ABSTRACT

According to The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), approximately 33.4 million individuals throughout the world have been affected by HIV/AIDS in the last 30 years or so (Bonacquisti & Geller, 2013). The medication, Truvada, otherwise known as PrEP, has been introduced to serve as a harm reduction technique to combat the spread of HIV infection. PrEP is an antiretroviral drug that lowers the risk of HIV exposure. This is a qualitative study examining the sexual behaviors of gay and bisexual men prescribed PrEP as a preventive method for the transmission of HIV. I conducted 30 semi-structured in-depth interviews of people who had been prescribed PrEP for at least 30 days in three cities: Los Angeles, Philadelphia, and New York City. The results indicate that contextual factors shaped the sexual behaviors of participants on PrEP, leading them to lower risk at times, and elevate it at others. PrEP caused individuals to experience changes within their communication patterns with their medical providers and their sexual partners. The results shed light on the way people on PrEP engage in sexual and health-seeking behaviors, and help to develop a blueprint for the way service providers engage with this community.

KEY WORDS: PrEP (Pre-exposure Prophylaxis); HIV/AIDS; Truvada; HIV prevention; harm reduction; risky sexual behaviors; Cognitive Behavioral Therapy (CBT); Relational Cultural Therapy (RCT); qualitative interviews

TABLE OF CONTENTS

DEDICATION	II
EPIGRAPH.....	III
ACKNOWLEDGMENT.....	IV
ABSTRACT.....	VI
LIST OF FIGURES	X
Chapter 1: DESCRIPTION OF THE STUDY AND SIGNIFICANCE OF THE PROBLEM .	1
Introduction.....	1
Research Question	4
Statement of the Problem.....	4
Purpose of the Study	5
Significance of the Study	6
Chapter 2: REVIEW OF THE LITERATURE.....	7
Chapter 3: OVERVIEW OF THE THEORY	24
Conceptual or Theoretical Perspective	24
Cognitive Behavioral Therapy	25
Relational Cultural Therapy.....	27
Chapter 4: METHODS	30
Research Design.....	30
Orientation to the Interview Process.....	31
Setting	32
Sample Size and Recruitment Procedures.....	32
Sample.....	32
Inclusion Criteria	34
Exclusion Criteria	34
Administrative Arrangements.....	35
Data Analysis / Collection	35
Coding / Memo	37
Protection of Human Subjects	38
Timeline	39
Reflexivity Statement.....	41
Chapter 5: Results.....	43

Demographic Characteristics and Use of PrEP	43
Thematic Analysis	45
Attitude Towards PrEP	46
Changed Sexual Behaviors	47
Communication with Partners.....	55
Condom Usage or Other Safe Sex Practices.....	59
Discrimination or PrEP Whore Shaming.....	61
Effectiveness of PrEP	63
Improved Relationship with Medical Providers	65
Less Fear of Contracting HIV or Feelings of Safety with PrEP	68
Sexual Satisfaction.....	69
STDs or STIs.....	71
Substance Use	73
 Chapter 6: Discussion	 76
Summary of Results	76
Healthy Versus Risky Concepts of PrEP	76
Attitude Towards PrEP	76
Changed Sexual Behaviors	78
Communication with Partners.....	79
Condom Usage or Other Safe Sex Practices.....	80
Discrimination or PrEP Whore Shaming.....	81
Effectiveness of PrEP	82
Improved Relationship with Medical Providers	83
Less Fear of Contracting HIV or Feelings of Safety with PrEP	84
Sexual Satisfaction.....	84
STDs or STIs.....	86
Substance Use	87
Implications for Further Research	101
Implications for Social Work Practice.....	101
Implications for Theory	105
Implications for Social Policy	110
Strengths of PrEP Study.....	110
Limitations of PrEP Study	110
Conclusion.....	111
 APPENDICES	 113
A. Letters of Agreement from Subject Settings.....	114
B. University of Pennsylvania IRB Approval Letter	122
C. University of Pennsylvania Informed Consent Form.....	124

D. University of Pennsylvania Informed Consent and HIPAA Authorization Form	130
E. Participant Recruitment Flyer.....	133
F. Face-Sheet Data.....	136
Qualitative In-Depth Interview	136
G. Charts / Graphs.....	140
City of Residence/Number of Participants	141
Educational Level	142
Race.....	143
Relationship Status.....	144
Income.....	145
REFERENCES	146

LIST OF FIGURES

FIGURE

1. Sexual Preference or Orientation	44
2. How Long on PrEP	45
3. Number of Sex Partners in the Past Week	51
4. Number of Sex Partners in the Past 30 Days	52
5. Number of Sex Partners in the Past 6 Months	53
6. Prior to PrEP, Number of Sex Partners During a Year Time Span	54
7. Number of Sex Partners Engaged in Anal Sex with in the Past 3 Months	55
8. Substance Use	75
9. Healthy Versus Risky Concepts of PrEP: Attitude.....	76
10. Healthy Versus Risky Concept of PrEP: Changed Sexual Behavior.....	78
11. Healthy Versus Risky Concept of PrEP: Communication with Partners	79
12. Healthy Versus Risky Concept of PrEP: Condom Usage/Other Safe Sex Practices	80
13. Healthy Versus Risky Concept of PrEP: Discrimination/PrEP Whore Shaming	81
14. Healthy Versus Risky Concept of PrEP: Effectiveness of PrEP	82
15. Healthy Versus Risky Concept of PrEP: Improved Relationship with Medical Provider.....	83
16. Healthy Versus Risky Concept of PrEP: Less Fear of Contracting HIV/Feelings of Safety with PrEP.....	84
17. Healthy Versus Risky Concept of PrEP: Sexual Satisfaction.....	85
18. Healthy Versus Risky Concept of PrEP: STDs or STIs	86

19. Healthy Versus Risky Concept of PrEP: Substance Use 87

CHAPTER 1

DESCRIPTION OF THE STUDY AND SIGNIFICANCE OF THE PROBLEM

Introduction

Over the past 30-some years, human beings from around the world have been faced with the HIV/AIDS epidemic. In 2009, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), as many as 33.4 million people worldwide have been affected by HIV/AIDS within the last 3 decades (Bonacquisti & Geller, 2013). We have lost many lives due to the HIV virus, which causes AIDS (Acquired Immunodeficiency Disease). Every day, more and more people are becoming infected with the HIV virus. At the current moment, there is no set “cure” for HIV/AIDS. However, abstinence or condom usage during oral, anal, or vaginal sex is the most highly effective method to decrease the spread of the HIV virus. In recent years, yet another alternative method has surfaced in order to decrease HIV infection. People have been taking PrEP, Pre-exposure Prophylaxis, (the HIV medication, Truvada, which is used as a preventive method to stop the HIV virus from permanent infection). Matthews, Baeten, Celum, and Bangsberg (2010) state the following:

With PrEP, an HIV-negative individual takes antiretroviral medications to maintain blood and genital drug levels sufficient to prevent HIV acquisition, with a postulated mechanism of preventing initial viral replication. The recent introduction of potent antiretrovirals with low incidence of side effects, long half-life, and excellent genital tract penetration has made PrEP a potentially feasible option for reducing HIV transmission. (p. 1977)

According to the Associated Press (2014):

Many doctors and activists see immense promise for such preventive use of Truvada,

and campaigning hard to raise awareness of it as a crucial step toward reducing new HIV infections, which now total about 50,000 a year in the U.S. (para. 2)

One PrEP clinical study suggests the following:

Among gay and bisexual men, those who were given PrEP were 44% less likely overall to get HIV than those who were given a placebo. Among the men with detectable levels of medicine in their blood (meaning they had taken the pill consistently), PrEP reduced the risk of infection by as much as 92%. (California Department of Public Health, 2015, "Clinical Trial Summaries," para. 1)

PrEP is the most commonly used within gay communities in the U.S. because in the 1980s gay men had the highest casualty rate due to HIV/AIDS. Hart, Tulloch, and O'Cleirigh (2014) state:

The HIV prevalence among gay and bisexual men is 25.2% in San Francisco (Schwarcz et al., 2007) and 23.2% in Toronto (Remis et al., 2008), which is higher than the HIV prevalence among adults in much of sub-Saharan Africa (e.g., South Africa, 17.8%; UNAIDS, 2012). (p. 149)

HIV prevention interventions are most critically needed for gay and bisexual men due to the high HIV prevalence in the largest cities in the Western world (Hart et al., 2014). The use of PrEP has become quite controversial these past few years, and it can be compared to the moral and political dilemmas the birth control pill caused many years ago when it first became accessible to women.

Women account for the majority, and a growing proportion, of incident HIV infections in endemic areas. Currently recommended sexual HIV-prevention strategies for women include abstinence and condom use; both require the willingness of male partners and neither allows for conception. An HIV-negative woman may have difficulty requiring

that her partner initiate ART and maintain a controlled viral load prior to conception, or in having direct knowledge of his ART adherence or viral load. Periconception PrEP may offer a female-controlled protective option independent of her partner's initiation of, adherence to, and viral suppression with ART. (Matthews et al., 2010, p. 1977)

Like the birth control pill could prevent pregnancies, PrEP could possibly prevent the spread of the HIV virus. Perhaps, PrEP is the only safe sex practice most commonly used within the lesbian, gay, bisexual, transgender (LGBT) communities today. However, its usage opens up the possibility to other questions that need to be answered. Have people's sexual behaviors changed or have they become more promiscuous as a result of being prescribed PrEP? Has the use of PrEP as a preventive method actually decreased the number of newly diagnosed HIV infections in the United States? Some anti-PrEP protestors define the drug as the "party drug," because the pill gives individuals the freedom to have uninhibited sexual encounters without the worry of being infected by the HIV virus.

The proposed qualitative research study attempts to answer some of the above questions of obtaining a clearer interpretation of the sexual behaviors of individuals and what leads them to consider being prescribed PrEP instead of practicing abstinence or condom usage that have been proven highly effective in the past to stop the spread of HIV infection. The results of this study will identify characteristics that should be high-risk behaviors, and once identified interventions can be implemented in order to make HIV prevention more effective. If PrEP can help decrease HIV infections within the gay community effectively, perhaps non-homosexual communities could benefit from the usage as well. In the future if we still cannot come up with a "cure" for HIV/AIDS, PrEP will be an effective method to end the spread of infection at least in future generations. It is important to identify specific determining demographic and psychosocial

characteristics that influence people to use PrEP such as age, race, annual income, educational level, monogamy, substance use, HIV status of partner, and history of risky sexual behaviors. With this knowledge, we can also analyze the barriers or influences that may discourage a person from not utilizing preventive HIV methods. In conclusion, this research proposal will guide us into the understanding of how individuals' sexual behaviors have changed due to this little pill called PrEP, as a preventive method in this world where HIV/AIDS still exists.

Research Question

The proposed research question in this study is, how have sexual behaviors changed due to the prescription of PrEP as a preventive method for the transmission of HIV. What are the leading factors that contribute to the outcomes of PrEP? Such as the personal characteristics of age, race, annual income, educational level, monogamy, substance use, HIV status of partner, and history of risky sexual behaviors. How does the use of PrEP shape sexual and health behaviors?

Statement of the Problem

Over the past 30 years, HIV continues to impact the lives of many people throughout the world. As to date, there is no known cure to end the deadly disease; however, numerous preventive methods and advances in medical research have introduced techniques to assist in decreasing the transmission of HIV. One particular method that has proven to be effective in preventing the spread of HIV is through the prescription of the medication, Truvada. Truvada is commonly known as PrEP. As with all new medical interventions, the possible side effects may be a concern with the use of Truvada. We tend to be suspect of all new medical inventions and concerned about the effectiveness and the side effects of the particular medication. Another concern suggested by Matthews et al. (2010) is the following:

Cost will pose a major barrier to deployment of chronic PrEP for HIV prevention.

Ongoing trials study the effects of newer drugs, principally TDF and FTC/TDF. A recent cost-effectiveness study of daily PrEP with FTC/TDF for a men–who-have-sex-with-men population in the US predicted a cost of \$ 298,000 per year of life gained. (p. 1979)

Very little research has been done on PrEP; however, most of the research focuses on the effectiveness in decreasing the spread of HIV. In comparison, very little research has been done on how the use of PrEP has changed the lives of its users, especially in their sexual behaviors.

Purpose of the Study

A review of existing literature on PrEP reveals that there have been very few studies that focus on how sexual behaviors have changed due to PrEP usage and less research has been done on why some of these changes have occurred. Why are some people comfortable taking risks if they will benefit in some other way? What length will people go to in order to have that physical or emotional connection with someone of their interest? A qualitative study using in-depth semi-structured interviews focusing on the sexual behaviors of individuals prescribed PrEP as a preventive method for the transmission of HIV was conducted. All of the participants had already been prescribed PrEP for at least a total of 30 days, and were voluntarily selected to participate in roughly a 30-minute long interview held within the areas of Los Angeles, Philadelphia, and New York City to discuss their sexual behaviors and how their behaviors may have changed due to currently taking PrEP. The knowledge gained from the results of the study will allow us to gain insight on the participants' engagement in possible risky sexual behaviors. This insight can be used to facilitate further research that can develop cutting-edge interventions that can possibly make HIV infections a thing of the past.

Significance of the Study

This study will address the issues of how sexual behaviors have changed due to the usage of PrEP as a preventive method in the spread of HIV. The research data will suggest areas where clinicians can be more effective in working with clients/patients and identify areas where further interventions need to be developed in order to assist individuals in making healthy and effective decisions in regard to their sexual behaviors and preventive HIV methods. For example, if participants reveal that they are taking PrEP as prescribed, but engaging in condomless sex they could be more prone to acquiring other STIs. The data would show if the participants are in fact getting STIs as a result. With the gained knowledge, clinicians can develop more effective preventive techniques to assist their clients in obtaining optimal physical health.

CHAPTER 2

REVIEW OF THE LITERATURE

Research on PrEP and the individuals who use PrEP is still quite new and limited in their findings, especially in identifying psychosocial characteristics and demographics of individuals who decide to use PrEP or not. According to a study conducted by Golub, Kowalczyk, Weinberger, and Parsons (2011), “participants who said they would be likely to use PrEP did not differ from those who would not on age, education, or income” (p. 552). However, there are some similar characteristics of individuals who have decided to use PrEP.

If substance use does lead to high-risk sexual behaviors, it is important to understand the dynamics of the relationship in order to serve as preventive and educational efforts to decrease HIV infections. When an individual is under the influence of a substance such as drugs and/or alcohol, they may be more prone to engage in high-risk sexual behaviors. “Alcohol and drugs may impair awareness and lower inhibitions. Under such circumstances, individuals may forget or dismiss the need to practice safer sex or may have diminished ability to counter pressures to engage in risky sex.” (Dehart & Birkimer, 1997, p. 12). Since the individuals’ judgment is impaired, they may be less likely to practice safe sex or initiate a conversation with their sexual partner about their past sexual behaviors and histories of STDs. Intoxicated individuals may be so non-coherent that they are unable to communicate their sexual preferences or unable to say “no” to certain acts of disinterest (such as high-risk sexual behaviors like anal condomless sex). The findings in Critchlow Leigh’s (1990) study revealed that gay men, whose sexual partners had used alcohol, were less likely to engage in high-risk sexual behaviors. However, gay men who use other drugs and/or their sexual partners use cocaine are more likely to engage in high-risk sexual behaviors (Critchlow Leigh, 1990). Another issue to consider is the nature of the

drug and the effects on the users. Cocaine, methamphetamine, ecstasy, and other stimulants can create an aphrodisiac effect on the user causing them to engage in high-risk behaviors such as frequenting bathhouses or group sex parties. High risk sexual behaviors can be defined as behaviors that put people at risk for HIV or other sexually transmitted infections. These drugs could be used to intensify the sexual encounter; or the user may already engage in risky sexual behaviors regardless of substance use. On the flipside, Malatesta et al.'s study acknowledges that if a person has too much of a substance he may not be able to perform sexually in order to put himself at risk for high-risk sexual behaviors. Their study states:

Larger doses of alcohol can interfere with physiological sexual arousal and erection (e.g., Malatesta, Pollack, Wilbanks, & Adams, 1979), perhaps leading to a decreased probability of performing penetrative sexual activities (note that a slight negative effect for drinking was also found in heterosexual men). Such an effect would be expected from some depressant or narcotic drugs included in the "other" category, but most of the men who used other drugs reported using nitrites or amphetamines. (Critchlow Leigh, 1990, p. 209)

This study suggests that drugs and alcohol can cause physiological impairments that inhibit men from being able to obtain or maintain an erection making it more difficult for them to engage in high-risk sexual behaviors. However, they would put themselves in a greater risk if they took on the anal receptive sexual position role. This argument does not account for women, because their bodies react physiologically different from men under the influence of drugs and alcohol. So perhaps some substance use can aid in decreasing men from being able to perform sexually, but substance use does not necessarily lower the risk of sexual behaviors in women and anal receptive gay men.

The demographic of age may not necessarily be a strong predictor in differentiating what type of individual would use PrEP or practice safe sex. Shernoff (2006) defines “barebacking” as raw sex or condomless sex. Shernoff states:

Men of all ages are engaging in barebacking. Middle-age gay men who were sexually active before the onset of the AIDS crisis are foregoing the use of condoms . . . Men who practice safer sex for years and even decades reported experiencing safer sex fatigue or burnout as a reason for returning to sex without condoms. (2006, p. 107)

His study does not suggest that age is a determining factor in individuals who decide to use or not use PrEP. What leads to further discussion are the beliefs and opinions on condom usage and HIV prevention methods that could be relevant between the generational gaps. Younger generations view the HIV diagnoses as a treatable disease, so PrEP is just a pill to take for preventive purposes. Older generations may not be as convinced after experiencing the AIDS epidemic in the past 30 years.

The identifying demographics of education and annual income can impact an individual’s decision to practice safe sex or use HIV preventive treatments. “Whatever the type of family, African Americans average significantly fewer dollars than whites. . . The median net worth of white households is almost ten times that of black households” (Feagin & Feagin, 1996, p. 256). If an individual’s income is low their main priority is to pay for basic living expenses and a lesser priority to spend money towards preventive health care such as PrEP or preventive HIV treatment. Feagin and Feagin (1996) state:

In 1992 the median income for Mexican-origin families was only 59 percent that of European-origin families. . . In 1993 Mexican American families were almost four times as likely to be in poverty as European American families, and almost 40 percent of all

Mexican American children below eighteen years of age were living below the poverty line. (p. 306)

Some people in lower paying jobs are not eligible to receive health care benefits through their employers or the government, which may cause purchasing PrEP to be impossible without the insurance company's assistance. PrEP can be quite expensive. According to Perez-Figueroa, Kapadia, Barton, Eddy, and Halkitis (2015), "the estimated cost of PrEP is between \$8,000.00 and \$14,000 per year in the United States...As such, the role of cost as a potential barrier to uptake and long-term adherence to PrEP is a major concern" (p. 114). It is hoped that with the Affordable Health Care Act (ACA), health insurance will be more accessible to everyone. However, the ACA is constantly being threatened by the current presidential administration in the United States. If cost is not an issue, perhaps HIV preventive methods such as PrEP would be more widely used. The research study of Golub et al. (2011) states:

Over 35% of high-risk MSM (Men who have Sex with Men) in this sample reported that they would be likely to decrease condom use while on PrEP. Participants who reported that taking PrEP would decrease their condom use were more likely to be college educated, more likely to make over \$50,000.00 per year, and less likely to be substance dependent compared with those who reported that taking PrEP would not decrease their condom use. (p. 552)

People with higher education tend to value the education system more and are more likely to question or research topics that are unknown to them compared to less educated individuals. A person with limited education may not even be aware of some of the innovating HIV preventive methods such as PrEP being utilized today. Shernoff (2006) states, "in-school sex education, increased availability of condoms, and knowledge of HIV and safer sex all helped younger

people become aware of how to avoid HIV infection and other STDs” (p. 107). Shernoff further states that “these programs have done a great deal to decrease the amount of unsafe sex. . . , yet HIV infection among young people remains high. . . , especially among young gay men of color” (p.107). Shernoff brings up the question that even with safe sex education, the younger generations are not necessarily practicing what they are learning. Maybe it is not the lack of safe sex education, but perhaps there are other barriers such as the lack of access to PrEP or condoms that prevent young people from engaging in safe sex.

The practice of safe sex behaviors can be impacted by an individual’s race and ethnicity. Some races tend to be more medically compliant compared to others and more health conscious. Other factors could come into play that affect medical adherence such as education levels and socioeconomic status. Shernoff (2006) wrote:

Environmental stressors such as racism, homophobia, and economic disadvantage may play role in the rise of barebacking. Internalized homophobia can contribute to barebacking by creating an unconscious sense that a gay man is unimportant and undervalued, thus increasing his sense that he is expendable, and so too are the men with whom he has sex and from whom he seeks love and validation. Many gay men of color cite social inequities that result in lower education, lack of access to health care, substance use, and poor mental health as contributing to apathy regarding sexual risk taking. (p.107)

“In bivariate analyses, black participants were more likely than white participants to say they would use PrEP” (Golub et al., 2010, p. 5). However, little data have been found to support that black participants actually use PrEP more often compared to other races. Furthermore, people of color and other minority groups may be less likely to seek medical treatment or inquire about

safe sex practices such as PrEP due to language barriers or other factors based on their cultural differences. Some cultures or ethnicities have spiritual healers or other holistic medical practices that they prefer to utilize instead of typical modern westernized medicinal practices. Due to their cultural beliefs, some people focus more on receiving medical treatment, and may not necessarily see the benefits of preventive care. According to the 1999 study of Laumann and Youm cited in Blackwell (2008):

Specifically, the differences in prevalence rates of STIs and preference of sexual partners among various ethnicities can increase transmission of STIs from high-risk individuals to low-risk individuals. This is highlighted by data that indicate high-risk Blacks (for example, those who are HIV+) are more likely to choose partners from high-, moderate-, and low-risk profiles. In contrast, Whites are more likely to select partners whose risk is more concordant (i.e., high-risk with high-risk, low-risk with low-risk). (p. 308)

Just as the Internet can serve as an easy access means to recruiting for sexual encounters it could be used to promote safe sex practices or HIV prevention techniques as well.

The issue of monogamy plays a deciding factor if someone chooses to use PrEP or not. For this purpose, monogamy is defined by having only one sex partner. In his article, Grossman (2014) assumes that most people agree that if a gay couple is in a committed long-term monogamous relationship where both partners are the same serostatus, they really do not have a need to take PrEP or practice safe sex and HIV preventive methods. According to Dehart and Birkimer (1997):

Although intention to try was a significant predictor of condom use with steady

partners, expectations were a better predictor of condom use with nonsteady partners. This is consistent with Bagozzi and Warshaws (1990) suggestion that expectations come into play when barriers to successful action are involved. In sex with steady partners, relationship dynamics of intimacy, trust and cooperation may allow individuals to implement intentions successfully. With nonsteady partners, however, skills of negotiation and communication may be more important. Fear of rejection may prevent some persons from even suggesting condom use. Other individuals involved in casual sexual encounters may feel less comfortable implementing safer sexual behavior or countering partner resistance to safer sex. Encounters with non-steady partners may also be unforeseen, and condoms may thereby be unavailable.

(pp. 22-23)

People are at a greater risk for HIV and STI infections if they are not in monogamous relationships, and are not practicing safe sex. People who are not in monogamous relationship want to protect themselves and perhaps their partners so they would be more likely to use condoms, PrEP, or other safe sex practices to lower their risk of infections. The real issue here is if the non-monogamous individuals feel comfortable discussing or implementing safer sexual behaviors with their partners or not. One of the individuals in the couple may suspect his partner is having sex outside of the relationship if he suggests the need to utilize condoms within their sexual encounters. Other couples may choose to not use condoms, because they feel as if they are in a monogamous committed relationship. The issue of not practicing safe sex needs to be negotiated among the partners, and discuss the extent of openness in their relationship if perhaps one of the partners decides to have a sexual relationship outside of the couple (Perez-Figueroa et al., 2015).

A limited amount of research has been found stating that an individual affected by HIV is more likely to use PrEP or practice safe sex if his or her partner has been diagnosed HIV positive. However, due to the nature of the HIV disease, a HIV negative individual is at a higher risk of becoming infected if safe sex practices are not used during a sexual encounter with a HIV positive individual. Grossman (2014) reported:

If one partner is HIV positive and is undetectable on medication (viral load<40 copies/mL on some tests and <20 copies/mL on others), then the chance of passing HIV is reduced by 97% or so (conservatively). This is according to a number of studies—including the Partner study, which showed no transmission among over 700 serodiscordant couples who were not using condoms and where the HIV-positive partner was on suppressive antiretroviral therapy and the negative partner was not on PrEP. If the negative partner *is* on PrEP, and taking the medications reliably, then that person's risk of acquiring HIV is reduced by, let's say, 92% to 100% according to various studies. ("Undetectable Partner," para. 1)

Individuals with a history of risky sexual behaviors are more prone to using PrEP compared to someone who does not engage in risky sexual behaviors. Mutual masturbation and kissing are very low risk sexual behaviors. Someone who engages in low risk sexual behaviors may not see the need to use PrEP. People who religiously wear condoms are placed in a lower risk for infections. However, defective condoms may break and increase the chance of infection during risky behavior such as vaginal or anal sex.

One question remains to be explored: Why do people choose not to practice safe sex and wear condoms when evidence suggests condoms to be the leading protective measure against the infection of HIV and other STIs? According to Shernoff (2006), internalized homophobia could

be the leading cause contributing to the choice to engage in barebacking. The terms “barebacking,” “raw,” and “natural” are all slang terms used to describe having intentional unprotected anal intercourse (Madrid, 2007). On the issue of internalized homophobia, Shernoff (as cited in Madrid, 2007) says, “it creates an unconscious sense that a gay man is unimportant and undervalued, thus increasing his sense that he is expendable, and so too are men with whom he has sex and from whom he seeks love and validation” (“What Is Barebacking?,” para. 2).

Risky sexual behaviors can also include having numerous sexual partners, which increases the probability of contracting an infection. Wohlfeiler and Potterat (as cited in Blackwell, 2008) stated, “Concurrency implies having a network of multiple sex partners and going back and forth between them ---repetitive exposures among those in the network significantly increase the probability of transmission to all partners in the network” (p. 308). These sexual networks are easily organized through the internet and social media. Many of these men on social media apps such as Grindr and Scruff may misrepresent or not disclose their HIV status in their personal profile due to the anonymity of the internet. According to Blackwell (2008):

Ross et al. (2006) identified 20 % of HIV+ men in their sample misrepresented their serostatus. And whereas Tewksbury (2003) reported almost 71% of MSM reported a negative HIV serostatus in their online profile, more than 10% either didn't report their serostatus or reported it as unknown. This, combined with the more than 19% who reported their HIV serostatus as positive, indicates the number of potentially HIV+ partners to be close to 30%. (p. 309)

Blackwell uses the term MSM to identify men who have sex with men. Many gay men are using the Internet as a way of meeting other men to engage in immediate sexual relations. Many of

these men are unaware of the HIV status and/or STI history of the individuals with whom they are having sex. These compulsive and immediate sexual seeking encounters may lead to engaging in unprotected anal sex, which the Internet has made this practice easily accessible, affordable, anonymous, and acceptable. Horvath, Oakes, and Simon Rosser (2008) conducted a study examining the communication patterns through online profiles and in-person interactions in their association of having unprotected anal intercourse (UAI). The participants in the study were divided into the following three groups: Never tested for HIV group, Tested HIV negative group, and Tested HIV positive group. The results of the study suggest:

HIV disclosure was dichotomized as one factor (0 = No disclosure by either partner; 1 = Serodisclosure by at least one partner) given the high correlation (>0.90) between the participants revealing their HIV status and learning of the HIV status of their online and offline sexual partners. Communicating several times before meeting was not included in the following models as it does not represent a specific communication message unlike serodisclosure or communicating a preference for specific sexual experiences...Sexual communication via online profiles was similar for men in the Never Tested and Tested groups; however, differences emerged when participants directly communicated with their sex partners. . . By contrast, when directly communicating with their sexual partners, fewer men who have never been tested exchange HIV status information and made explicit agreements to use condoms during anal sex than those in the Tested group, although fewer of the Tested group negotiated the avoidance of anal sex...The Tested group was by far the largest group comprising 78% of participants in the study. HIV-negative disclosure and reporting a preference

for a safer sex in online profiles were high, matched by high rates of HIV status disclosure and preference against UAI during direct communications with sex partners. . . HIV+ MSM had a distinctly different communication pattern from both the Never Tested and Tested groups. Although one quarter of HIV + MSM accurately reported their HIV status on all of their online profiles, half did not report being HIV-positive in any, and one quarter reported being HIV-negative in some or all of their online profiles. Nondisclosure or misrepresentation of an HIV-positive status may be a consequence of HIV stigma, and fear that disclosing one's HIV-positive status will result in less men being interested in having sex with them. A high percentage of seeking high-risk sexual activity (i.e., UAI and party-and-play) was found among the HIV-positive group. It is possible that such communication is targeted toward other HIV+ MSM with whom the health risks associated with UAI may be reduced... Between 24% and 47% of MSM in all three groups reported UAI during anal intercourse with their last sexual partner. (pp. 745-753)

Also, according to Golub et al. (2010), “participants who reported 6 or more high-risk sex acts were more likely to indicate that they would use PrEP (OR = 2.71, 95% CI: 1.15 to 6.40) compared with their lower risk counterparts” (p. 552). Golub et al. further stated:

MSM who reported more risk behavior in the past 30 days were more likely to say they would use PrEP. This association may be an optimistic scenario for PrEP, potentially reducing the impact of Behavioral Disinhibition or Risk Compensation Models. To the extent that MSM who adopt PrEP are already engaging in high-risk behavior, PrEP may merely reduce risk in situations in which these men were unlikely to use condoms regardless of PrEP use. (p. 552)

Their study suggests individuals with a history of high-risk sexual behaviors will actually decrease their rates of HIV infections if they use PrEP, because in the past they usually would not use any preventive HIV method. Otherwise, it could be noted that people with histories of high-risk sexual behaviors may have already been HIV infected, so the use of PrEP would no longer serve as a preventive method.

So after having knowledge on all of the ways to live a healthy and safe lifestyle, one has to ask society why we are willing to take so many risks that could jeopardize our health and longevity of life. Underhill (2013) explains as follows:

According to risk homeostasis theory, we continually modify our risk-taking behaviors (within our ability to do so) so that our perceived risk approaches our individual target risk level. That is, we decide how much danger we find acceptable, and we make behavioral choices that we believe will bring us closer to that level of risk—similar to the way a thermostat activates heat or air conditioning when the temperature deviates from the chosen set-point. When we feel excessively safe and see potential benefits in behaving more riskily, we will increase our risk-taking to capture those benefits. (p. 384)

This theory suggests that individuals who take PrEP may not always use condoms during all of their sexual encounters, since they are depending on PrEP to protect them from HIV. This way they can experience the feeling of having “safe” condomless sex by only taking PrEP. Many theorists strongly believe in the term “harm reduction.” Harm reduction is often used with many therapists in working with clients struggling with substance abuse issues and the technique can also be utilized in encouraging clients to practice safer sex techniques. Harm reduction is the term coined to meet the client where they are at in the stage of making changes. It comes from

the concept that one uses strategies to minimize the risks involved with their behavior (Madrid, 2007). For example, a heroin user may use clean needles to decrease infections from I.V. drug usage, or an individual under the influence of alcohol may take public transportation home from the bar instead of driving themselves home in their car to eliminate driving under the influence of alcohol and avoid getting a DUI (Driving Under the Influence). Madrid (2007) claims:

Some have suggested that a harm reduction approach could be applied to barebacking, as follows:

- Reducing the number of partners
- Serosorting: Choosing partners on of the same HIV status
- Strategic positioning: An HIV-positive man taking the receptive (bottom) role during barebacking with an HIV-negative man
- Withdrawal: Pulling the penis out before ejaculation
- Negotiated safety: An agreement between two partners in a committed relationship to go through a process that will eventually lead to removing condoms during sex.

(“Harm Reduction?,” para. 3)

Critics suggest that if a partially effective prevention method is available to prevent the transmission of HIV, people may become overly optimistic about their safety, which may lead them to engage in other forms of risky behaviors (Guest et al., 2008). Some critics of the tenofovir disoproxil fumarate (TDF) HIV prevention trial suspected that the participants, whom were mostly female sex workers in Ghana, would decide to utilize condoms less frequently and increase the number of their sex partners as a result of participating in the trial (Guest et al., 2008). The results of Guest et al.’s (2008) study suggest:

Sexual risk behavior did not increase during the trial. Number of sexual partners and rate

of unprotected sex acts decreased across the 12-month period of study enrollment.

Certain subgroups of women, however, exhibited different growth curves. Data indicate that the HIV prevention counseling associated with the trial was effective. (p. 1002)

Further data results suggested that some of the female sex workers increased their number of clients due to feeling more safe in regard to their sexual practices, while others decreased the number of their clients due to not wanting to use condoms. Overall, the condom usage of the sex workers increased due to receiving HIV-negative test results, and having the combined knowledge of safer sex practices and an increased risk perception of HIV.

One cross-sectional study conducted in Peru suggested that “knowledge of sex partner HIV serostatus can influence perception of sexual risk and may inform harm-reduction strategies for men who have sex with men (MSM) and transgendered women (TW)” (Nagaraj et al., 2013, p. 1). The researchers concluded that many of the participants in the study, mainly MSM and TW, did not know their sexual encounters’ HIV status. However, if the participants knew their sexual partners for a longer period of time, they were more likely to know their HIV status.

Nagaraj et al. state the following:

The rate of knowledge of partner serostatus ranged from 8.3% for exchange sex partners to 32.6% for stable partners, much lower than that found in previous studies of MSM populations in the U.S. and Australia, which have reported knowledge of partner serostatus ranging from 15.6% for casual partners to 86.3% for stable partners.

(p. 3)

Further research is needed to find out if just knowing their sexual partners’ serostatus alone would encourage condom usage or changes in sexual behaviors. Analysis of partner communication and the effects on their sexual behaviors as a result would be valuable to explore.

This study had many of the following limitations: the data were self-reported and subject to recall and social desirability, and the sample population came from high-risk MSM in three Peruvian cities which may not be an accurate representation of the MSM and TW populations in Peru (Nagaraj et al., 2013).

Noar, Crosby, Benac, Snow, and Troutman (2011) conducted a study to “apply the attitude-social influence-efficacy (ASE) model to achieve a theory-based understanding of condom use among low income, heterosexually active African-American STD clinic patients” (p. 1045). The participants were all African-American. The reason is the following:

In 2005 they made up 49% of HIV/AIDS cases...In addition, heterosexual contact as a route of transmission is higher among African-Americans as compared to other racial/ethnic groups. In 2005, 74% of cases in women and 22% of cases in men were due to high-risk heterosexual contact. (Noar et al., 2011, p. 1045)

The results of their research suggest that the participants used condoms more frequently during casual sexual encounters compared to sex with their main partners. The researchers state the following:

Although analyses were conducted separately and thus statistical independence was maintained in each analysis, reports of condom use with main and casual partners (among the $n = 75$ who had both) were correlated $r = .20$. Also, as reported earlier, those with both main and casual partners used condoms more often (70%) with their casual partners than those with just casual partners (64%), although this difference was *not* statistically significant. (Noar et al., 2011, p. 1055)

Perhaps condoms are more widely used with casual partners because individuals are more likely to view people they do not know more a risk for STIs or HIV compared to their known intimate

partner (Noar et al., 2011). The main limitation in this particular study was that all the data collected were based upon self-report. Some of the information may not have been accurately provided. Semple et al.'s (2010) study indicated the following:

Social-cognitive factors, specifically lower self-efficacy for condom use was associated with unprotected vaginal and anal sex with FSWs (female sex workers). Studies of self-efficacy for condom use among Latino men of Mexican origin who have sex with women are few in number. However, several US-based studies of immigrant and migrant Latinos of mostly Mexican origin, including gay, bisexual, and heterosexual men, report an association between low self-efficacy for condom use and sexual risk-taking behavior. (pp. 1476-1477)

The results of their study were the following:

The average number of FSW partners in the past four months was 7.36 ($SD = 11.01$). Approximately 50% of the sample reported having unprotected vaginal or anal sex with a Tijuana-based FSW in the past four months. The mean number of unprotected vaginal, anal, and oral sex acts with FSWs during this time frame was 3.92 ($SD = 16.45$), 0.98 ($SD = 5.97$), and 5.92 ($SD = 19.2$), respectively. Clients from San Diego were significantly more likely than their Tijuana-residing counterparts to be non-Hispanic and have more years of education, and were less likely to have children and live alone. (Semple et al., 2010, p. 1475)

Younger Caucasian GBT (Gay, Bisexual, or Transgender) individuals with higher income levels, higher educational levels, less reported substance use, non-monogamous, and having a HIV+ partner will be more likely to use PrEP. Most of the research focuses on MSM and the data cannot be generalized to include women or on a global level. The research that does include

women as participants in the study tends to be employed as sex workers. More research needs to be conducted that includes female participants from diverse ethnic backgrounds, socioeconomic statuses, age groups, and so on in order to gain a better understanding of how sexual behaviors of the general population have changed due to the usage of PrEP. However, the research has focused on MSM populations because of the higher prevalence of HIV within the community in the past. Further research is suggested to have a better understanding as to how individuals' sexual behaviors have changed since they have been prescribed PrEP. We also need to continue to identify the demographics and psychosocial characteristics of individuals who use PrEP, so that the pharmaceutical manufacturers of PrEP can target these particular groups of individuals who could be more at risk for the transmission of HIV. It is hoped that if this targeted population benefits from PrEP usage the results of their usage decreases the spread of HIV. The rest of the general population will acknowledge the benefits and engage in the usage of PrEP as well. Until there is a proven cure for HIV, we as humans are all at risk for the infection of HIV.

CHAPTER 3

OVERVIEW OF THE THEORY

Conceptual or Theoretical Perspective

The research data from this study will be interpreted through the lenses of Cognitive Behavioral Theory (CBT) and Relational-Cultural Therapy (RCT). Aaron Beck is the founding father of CBT. His theory suggests the following:

Treatment is also based on conceptualization, or understanding, of individual patients (their specific beliefs and patterns of behavior). The therapist seeks in a variety of ways to produce cognitive change---modification in the patient's thinking and belief system---to bring about enduring emotional and behavioral change. (Beck, 2011, p. 2)

In 1995, the Jean Baker Miller Institute was created to further the work of RCT (Jordan, 2010). According to Jordan (2010), RCT "is built on the premise that, throughout the life span, human beings grow through and toward connection" (p. 1). Jordan further stated, "It holds that we need connections to flourish, even to stay alive, and isolation is a major source of suffering for people, at both a personal and cultural level" (p. 1). CBT and RCT are both valuable theories that can aid in gaining insight in interpreting the data from qualitative interviews on how sexual behaviors have changed with individuals prescribed PrEP.

CBT and RCT are applicable to this particular study because they suggest that human beings want to belong and connect with others, such as in creating intimacy. In order to obtain that connection one would want to explore how peoples' thoughts and behaviors are influenced and driven for that needed human attachment or connection. Some of these behaviors can be risky, but yet people all have a level of comfort in that they are willing to experience a certain

level of risk or sacrifice if it will lead them to a greater goal or reward, such as love or intimacy.

Rosario, Schrimshaw, and Hunter suggest the following:

The sexual risk behaviors of young gay and bisexual men must be understood within the context of the experiences and challenges that these young men confront in their lives. The current report proposes a model of sexual risk behaviors...that only incorporates traditional theoretical factors known to influence sexual risk behavior (i.e., safer sex intentions), but that also considers the realities of gay and bisexual men's lives. The model specifies pathways by which mental health concerns (e.g., psychological distress, substance abuse), population-specific challenges (i.e., the childhood sexual abuse and safer sex intentions) may explain sexual risk behaviors.

(p. 2)

It is imperative that we study how our thoughts play a factor in our sexual behaviors in order to develop prevention and treatment interventions.

Cognitive Behavioral Therapy

The cognitive model hypothesizes that people's perception of events influences their emotions, behaviors, and physiology (Beck, 2011). According to Beck (2011), the relationship of behavior to automatic thoughts "can be illustrated as follows: Core beliefs -> Intermediate beliefs (rules, attitudes, assumptions) -> Situation -> Automatic thoughts -> Reaction (emotional, behavioral, physiological)" (p. 36). The model suggests a progression in that an individual is in a situation or an event occurs, which causes the person to have automatic thoughts (thoughts that just pop in one's head without much thought), which then leads the individual to have a reaction (Beck, 2011). Often times people's inhibitions tend to be down when they are under the influence of substances, and they may be more likely to engage in risky sexual behaviors that

they may not have if they had been sober. According to Hershberger, Wood, and Fisher (2003), “As reported previously in the literature, sex behaviors seem more resistant to change than drug behaviors, as a larger proportion of participants reduced drug related risks than sex-related risks” (p. 230). According to CBT, an individual’s cognitive distortions or beliefs need to be restructured in order for change to occur. Weis (2014) states, “Cognitive restructuring involves three steps: (a) identifying distorted or irrational beliefs, (b) challenging the validity of these cognitions, and (c) replacing these incorrect thoughts with more rational, realistic beliefs” (p. 635).

An individual’s automatic thoughts can create unrealistic and/or negative thoughts that play on that person’s self-esteem. Negative self-esteem can facilitate a sense of vulnerability that could lead to self-destructive behaviors or feelings of helplessness or powerless doubt. According to Pachankis, Hatzenbuehler, Rendina, Safren, and Parsons (2015), “these cognitive, affective, and behavioral minority stress processes are associated with mental health problems and several health-risk behaviors, such as alcohol use, sexual compulsivity, and condomless anal sex” (p. 876). Pachankis et al. suggest that CBT is the preferred method for treatment and prevention and “well suited to improving cognitive, affective, and behavioral minority stress processes for several reasons” (p. 876). They clearly state the reasons as follows:

First, CBT locates present maladaptive behaviors in the context of their developmental function and current environmental contingencies, such as seeing depression and health-risk behaviors as learned responses for coping with minority stress. Second, CBT empowers clients to cope with adverse environmental circumstances such as minority stress by promoting coping self-efficacy. Third, CBT encourages the replacement of maladaptive cognitive, affective, and behavioral stress responses,

such as those emerging from minority stress and driving gay and bisexual men's adverse health. Fourth, CBT targets the universal risk factors disproportionately affecting sexual minorities. Therefore, encouraging adaptive reactions to stigma, such as locating the source of one's mental health problems in minority stress, drawing on personal resilience as a gay or bisexual man, and learning strategies for reducing maladaptive minority stress reactions such as internalized homophobia or rejection sensitivity have been argued to naturally lend themselves to a CBT approach. (p. 876)

CBT allows the client to challenge their distorted beliefs or thoughts and restructure them into positive affirmations. These positive affirmations can lead the individual to live and experience a more positive and productive life. According to Pachankis et al. (2015), "the adapted intervention targets both minority stress processes (i.e., rejection sensitivity, internalized homophobia, concealment) and universal risk factors (i.e., hopelessness, rumination, social isolation, unassertiveness) shared across gay and bisexual men's syndemic health conditions" (p. 877).

Relational Cultural Therapy

RCT focuses on how power dynamics affect human interactions. People feel disconnected during interactions when they are not heard, understood, or responded accordingly to by another individual (Jordan, 2010). Jordan, Walker, and Hartling (2004) state the following:

In a relational model of psychological development, disconnection from others is viewed as one of the primary sources of human suffering. Similarly, disconnection oneself, from the natural flow of one's responses, needs, and yearnings creates distress, inauthenticity, and ultimately a sense of isolation in the world. (p. 47)

When we feel disconnected from others, we often feel lonely and isolated. We may even feel like we have been shamed or ostracized from the dominant group or majority opinion. During this time we may search for acceptance, and may do anything to have that connection no matter what the cost may be. In their book, Jordan et al. (2004) discuss how power dynamics often play out by stating:

Dominant groups ensure their power advantage by directly and indirectly subverting the competence and limiting the power of connection among the subordinate groups. Karen Laing (1998) noted, “Isolation functions as the glue that holds oppression in place.” This is a profound truth. Undermining the sense of competence and courage of a person or a group also serves to keep oppression in place. Thus, to increase connection and a sense of competence, particularly among marginalized or disenfranchised groups, threatens prevailing norms and power dynamics. It is a revolutionary act. (p. 16)

Knowledge creates power, and being able to have the right and control to protect oneself can be empowering. “RCT views the individual as existing within a social context, which either contributes to a sense of connection and empowerment or shapes an experience of disempowerment and disconnection” (Jordan, 2010, p. 94). When we feel disconnected we may also feel shamed or discriminated against. Jordan (2010) states the following:

Shame is a contributing factor to much immobilization and a major source of chronic disconnection: “In shame, one feels disconnected, that one’s being is at fault, that one is unworthy of empathic response, or that one is unlovable. Often in shame people move out of connection, lose their sense of efficacy, and lose their ability to authentically represent their experience. (Jordan, 2000, p. 1008) . . . Shaming is a powerful way to

silence and isolate individuals, but it also plays a large role in silencing and disempowering marginalized groups whose members are strategically, if often invisibly, shamed in order to reinforce their isolation and thus their subordination.

(p. 29)

In conclusion, if we feel empowered and knowledgeable about an issue, we are more likely to make healthy positive personal choices and thus our behaviors will reflect the evidence. We are social creatures and have the innate need to connect with others. Over the years, HIV has been a stigmatizing disease due to the infection being spread through sexual intercourse and IV drug usage. PrEP may help to decrease some of the discrimination and stigmatization of the HIV disease due to gained knowledge and accessibility of the medication. PrEP may allow its users to further connect with their sexual partners in order to create greater intimacy if the fear of contracting HIV is decreased.

CHAPTER 4

METHODS

Research Design

The study utilizes semi-structured qualitative in-depth interviews to gather data of the participants' personal history exploring their thoughts and opinions in regard to their sexual behaviors since they have been prescribed PrEP. The data will allow meaning to the participants' sexual behaviors and perhaps how and why they have changed due to being prescribed PrEP.

Merriam and Tisdell (2016) state:

“Meanings are constructed by human beings as they engage with the world they are interpreting” (Crotty, 1998, pp. 42-43). Thus qualitative researchers conducting a basic qualitative study would be interested in (1) how people interpret their experiences, (2) how they construct their worlds, and (3) what meaning they attribute to their experiences. The overall purpose is to understand how people make sense of their lives and their experiences. (p. 24)

During the qualitative interviews, the researcher used mostly open-ended questions to gather the data. The researcher then analyzed, coded, and compared the data in order to identify common themes found. The following resources were necessary for human research protection and to maintain the confidentiality of the participants: all participants were given a random subject number to protect their identity, their interview responses were recorded on a digital voice recorder, and the researcher's lap top required a password in order to access the word document files from the transcribed interviews. All of these resources were stored in a locked brief case. All of the interviews were audio recorded in a quiet secured office with the researcher and the participant as the only two individuals present in the room. The researcher is educated at the

graduate level, and has had numerous years working within the field of social sciences. The researcher is fully aware and competent to carry out his research duties, and to provide a safe and confidential interview to the participants.

Orientation to the Interview Process

1. Discussed interview process and had the participant provide verbal consent after reading over the available Informed Consent form (Univ. of Penn Consent Form) (see Appendix C) and the University of Pennsylvania Informed Consent and HIPAA Authorization Form (see Appendix D).
2. Inquired if the participant has had any questions or concerns about the interview.
3. Informed interviewee the rules of confidentiality.
4. Reviewed guidelines for audiotaping the interview.
5. Discussed guidelines for receiving compensation for interviewee's participation.

The list of interview questions that were given to each of the participants in the study can be found in the Appendix section (See Appendix F). The information gathered from the questionnaire responses in regard to safe sex practices / risky sexual behaviors was interpreted by comparison to the Safe Sex Behavior Questionnaire (SSBQ; DiIorio, 2009), which was “designed to measure the frequency of use of recommended practices that reduce the risk of HIV exposure and transmission” (Fisher, Davis, Yarber, & Davis, 2010, p. 594). Construct validity of the scale was assessed using hypothesis testing and factor analysis. Fisher et al. (2010) state:

The SSBQ correlated in the predicted directions with the concepts of risk taking and assertiveness (DiIorio, Parsons, Lehr, Adame, & Carlone, 1993). Factor analysis revealed five factors with eigenvalues greater than 1.0: risky behaviors, assertiveness, condom use, avoidance of bodily fluids, and avoidance of anal sex. (p. 595)

Setting

Each individual qualitative interview was conducted in either the researcher's private practice psychotherapy office at: The Philadelphia Building, 1315 Walnut Street, Suite 1003, Philadelphia, PA 19107 or at 566 S. San Vicente, Suite 103, Los Angeles, CA 90048. If the participant could not meet at either one of those locations (such as for participants in New York City), the researcher rented a secure space that was quiet, private, and conducive to conducting an interview that can oblige by respecting the confidentiality of the participants. The researchers rented studio space at Champion Studio, 257 W. 39th Street, New York City, New York 10108.

Sample Size and Recruitment Procedures

Sample. The researcher used a non-probability/purposive quota sample to gather participants for the study from the communities of Philadelphia, New York City, and Los Angeles areas. The unit of analysis consisted of individuals. The researcher searched for participants through advertising by displaying a Participant Recruitment Flyer in the lobby or waiting rooms of the following clinical offices listed below. Each of these outpatient clinics provide medical and mental health services along with offering to prescribe PrEP to interested individuals. At least a total of 30 participants (10 from each geographical area) were selected to participate in the qualitative interview. The researcher expanded recruitment by uploading a copy of the Participant Recruitment Flyer to The Thrive Tribe website, IMPAC + Philly website, and PrEP Facts: Rethinking HIV Prevention and Sex on their social media pages since more participants were needed. The Thrive Tribe and IMPAC + Philly are both social network organizations that plan social gatherings for individuals who are HIV+ and their friends and families who are HIV+ friendly. Members of The Thrive Tribe and IMPAC + Philly may not be on PrEP since they have already been diagnosed with HIV; however, their friends and partners

perhaps have been prescribed PrEP. Damon L. Jacobs is the creator of the webpage, PrEP Facts: Rethinking HIV Prevention and Sex. The webpage was designed for people to have online discussions about PrEP. Many individuals who are currently taking PrEP respond to the website with their comments and experiences. These particular clinics and organizations were selected because they are located within five of the largest U.S. cities that have high homosexual populations that prescribe PrEP at their outpatient medical clinics. The sample was derived from the following clinics and social network organizations:

- Mazzone Center Family and Community Medicine in Philadelphia 809 Locus Street, Philadelphia, PA 19107: (215) 563-0658.
- The Lesbian, Gay, Bisexual, & Transgender Community Center in New York 208 W. 13th Street, New York, NY 10011: (212) 620-7310.
- LA Gay & Lesbian Center in Los Angeles 1625 Schrader Blvd., LA, CA 90028: (323) 993-7400.
- The Thrive Tribe in West Hollywood, CA: <https://www.thethrivetribe.org>
- IMPAC + Philly in Philadelphia, PA
- www.PrEP Facts: Rethinking HIV Prevention and Sex

Copies of the letters of agreement from subject settings can be found in the Appendices (see Appendix A). The above sites were chosen throughout various geographical regions within the United States to include ethnic diversity in the sample size. The participants were selected to participate in the qualitative interview once they contacted the researcher, and after being asked a few questions met the inclusion criteria for participation in the study. The researcher and the participant agreed on a scheduled time to proceed with the interview. The researcher's contact information was visibly presented on the Participant Recruitment Flyer (See Appendix E). Many

of the participants informed their friends and sexual partners of the study, so a fair number of the participants were recruited by word of mouth through referrals from previous participants.

Inclusion criteria. The inclusion criteria for the study included all males, females, and transgender persons, age 18 years and older who have been prescribed PrEP and have been actively taken the medication for the past 30 days as prescribed.

Exclusion criteria. The exclusion criteria in this particular study were anyone who has a cognitive deficit, and/or anyone who is not fluent in conversational English. Anyone who has already been diagnosed with HIV were also not allowed to participate in the study, since they would not be prescribed PrEP. Individuals who are in a current mental health crisis or experiencing a safety issue, such as suicidal or homicidal thoughts or plan at any time during the duration of the interaction with the researcher. Individuals who were under the influence or appeared under the influence of a substance were not eligible to participate in the interview process. The researcher asked the participants these additional questions prior to setting up an interview time.

1. Are you currently prescribed PrEP? If so, have you been taking the medication for more than 30 days?
2. Are you physically and mentally able to consent to participate in a 30-60 minute interview to answer questions in regard to your behavior in regard to the usage of PrEP?

If a participant reported or appeared to be in need of therapeutic services or any other assistance, the researcher provided the necessary and appropriate referral(s) to the participant.

Administrative Arrangements

Four identified facilities that are geographically located throughout the United States were chosen as research sites for the study, because they are located within five out of the largest U.S. cities that have larger homosexual populations that prescribe PrEP at their outpatient medical clinics. The sites were chosen due to their larger homosexual populations, because the sample is a better representation of the people who would use PrEP and of the population that had been largely affected by the HIV/AIDS epidemic in the past. The larger metropolitan location sites were also chosen due to their culturally and socioeconomically diversified populations. The cities located on the east coast tend to have higher populations of African-Americans and the west coast cities tend to have higher populations of Latino residents. Asian populations are more prevalent in the west coast as well. The researcher interviewed the participants accordingly, and there were a total number of 30 participants. Once the participant completely responded to all of the questions asked by the researcher, each participant was given a total of \$15.00 for compensation for their time and participation in the study (which included \$10.00 for his/her participation and \$5.00 for his/her transportation to the interview site). The benefit for this particular study was of larger knowledge gained from the study. The researcher informed the participants that the money earned from their participation was strictly a benefit and not an incentive for their participation.

Data Analysis / Collection

The participants' data were coded using an excel spreadsheet, which identified participants by the following categories on the interview face sheet. These categories consisted of: given subject number, gender, sexual preference / orientation, city of residence, age, educational level, race or ethnicity, relationship status, substance use, annual income, and how

long they had been taking PrEP. The researcher also documented the number of participants who refused or dropped out of the study. The researcher was the only one who had access to the data information. The data information will be deleted and destroyed once the researcher defends and submits the final copy of his dissertation. The researcher utilized documentation of notes and memos in analyzing the data. This researcher possesses 17 years of post-master's degree clinical experience in the field of social work. This researcher is a Licensed Clinical Social Worker in the State of California, in the State of New York, and in the Commonwealth of Pennsylvania. The researcher gathered the information and discussed any biases that occurred in the presentation of the data analysis. Furthermore, the researcher used his clinical skills in order to build a supportive and comfortable environment for the participants during the interview process, since the subject matter may have been extremely sensitive for some of the participants.

The researcher processed the data using coding, memos, and concept mapping. Once consent of participation was obtained, the researcher scheduled and conducted approximately 30-minute long qualitative interviews, which were audio recorded using an audio recording device and an additional back-up audio device as well. The researcher personally transcribed the first interview verbatim, and then hired the company Transcribe.Me to transcribe the additional 29 interviews. Immediately following each audio recorded interview, the researcher uploaded the audio recording to my private account with Transcribe.Me. Transcribe.Me staff transcribed my audio recorded interviews verbatim and once completed were available for my viewing within the secured file with Transcribe.Me online. The researcher then listened to the audio recorded interview while reviewing and editing the documented transcribed interview received from Transcribe.Me.

Coding / Memos

After listening to the audio recording and reviewing the edited version of the transcribed interview, the researcher wrote up memos from each interview. Memos consisted of the researcher's thoughts and impressions of each interview. The researcher wrote memos discussing the similarities and differences between each interview and identified various themes throughout the interviewees' responses. The researcher uploaded the completed transcribed interview into his file account with HyperRESEARCH. The researcher used the In Vivo coding program through HyperRESEARCH to code each line of dialogue from each of the 30 transcribed interviews. Saldana (2016) states the following:

In Vivo Coding has also been labeled “literal coding,” “verbatim coding,” “inductive coding,” “indigenous coding,” “natural coding,” and “emic coding” in selected methods literature. . . The root meaning of in vivo is “in that which is alive,” and as a code refers to a word or short phrase from the actual language found in the qualitative data record, “the terms used by [participants] themselves (Strauss, 1987, p. 33).

(p. 105)

Saldana further states that In Vivo Codes “capture ‘behaviors or processes which will explain to the analyst how the basic problem of the actors is resolved or processed’ (Strauss, 1987, p. 33) and help preserve participant’s meanings of their views and actions in the coding itself” (p. 109).

Concept codes were most widely used within the coding process. Saldana (2016) states:

Concept Codes assign meso or macro levels of meaning to data or to data analytic work in progress (e.g., a series of codes or categories). A concept is a word or short phrase that symbolically represents a suggested meaning broader than a single item or action – a “bigger picture” beyond the tangible and apparent. A concept suggests

an idea rather than an object or observable behavior. (p. 119)

Protection of Human Subjects

The safety and confidentiality of human subjects is extremely important, and their rights as participants needs to be addressed. Prior to participation in the study, the researcher obtained verbal consent from each participant stating that their participation was voluntary and not coerced in any manner. The participants were given a copy of the consent form derived from the University of Pennsylvania's Informed Consent Form for their viewing (see Appendix C). The participant was informed that they could withdraw from the study at any time. The researcher provided the following information to the participant: a clear statement of the study and the purpose of the study, any risks or potential risks that is anticipated, and any benefits for participating in the study. The participants in this study were at a potential low risk for physical, psychological, social, legal, or other harm since their only participation requirement was to respond to questions provided by the researcher in an interview format. The researcher was available to debrief and provide brief counseling if the participant had been even the slightest bit affected psychologically while completing the qualitative interview. If further psychological treatment was needed, the researcher would have provided a list of outside therapy referrals for the participant. The likelihood of physical or social risk was even less likely to occur, because the interview was conducted in a private office space free from societal view or distraction to abide by the rules of confidentiality. Breach of confidentiality was the biggest legal risk involved in the study, and the research team did everything in his or her power to protect each participant's confidentiality in the study. The participant was given a number to identify him/her while he/she participated in the qualitative interview with the researcher. The participants were informed of the confidentiality of the study and how their actual personal responses from the

interview would only be seen by the researcher and involved parties. Once the participant was assigned a participant number his/her contact information such as first name and contact phone number were deleted from the researcher's subject list. This information was previously gathered for the sole purpose of recruitment and to schedule the interview time for participation in the research study. Once the participant completely responded to all of the questions asked by the researcher, the participant was given \$10.00 for compensation for his/her time and his/her participation in the study. Transportation costs in the amount of \$5.00 was also provided for the participants. So the total compensation amount for participation was \$15.00. The benefit for this particular study was the larger knowledge gained from the study. The researcher informed the participants that the money earned from their participation was strictly a benefit and not an incentive for their participation. Participants were informed by the researcher of any acknowledgement of any additional alternative treatments that are made available. There really is not any alternative treatment other than PrEP at this time, except other safe sex practices such as condom usage. Literature on condom usage and safe sex practices was available to the participants if needed. The researcher informed participants of who to contact for general information about the study and how to contact the office of IRB if they had any concerns.

Timeline

I submitted this particular research study proposal to the Institutional Review Board (I.R.B.) around October 2016. Once the research study proposal was approved (see Appendix B), I posted my participation recruitment flyers for the study at the designated locations in hopes of selecting at least 30 participants interested in participating in the study. The qualitative interviews were scheduled as soon as possible, and the data collection commenced. I spent the following few months analyzing the data and drafting the findings. The results of the study were

WRITE-UP STUDY RESULTS FOR DISSERTATION X X

DEFEND DISSERTATION X

INFORM INVOLVED AGENCIES OF THE RESULTS X

Reflexivity Statement

After analyzing the data, I started to see some underlying themes such as internalized homophobia, stigmatization towards HIV and PrEP, slut shaming, bareback sex, intimacy and connection with partners (communication / disclosure), and rapport and communication with health care providers. Overall, I realized after hearing the participants' testimonials, PrEP actually serves as an anti-anxiety medication to decrease the fear of contracting HIV. I keep thinking of that unanticipated fear one experiences while sitting in the doctor's office or STD clinic while waiting for their HIV test results. Not to underestimate the impact of the horrific traumatic event of 911, but I cannot help but use the analogy of that fear and devastation when witnessing the second plane collide into the second tower of the World Trade Center. Right then and there, your life passes through you and you experience flashbacks of every sexual encounter you have ever had. Who wants to live in fear like that? Why do we take the risks we do? Is it for a greater benefit or reward? We all want to walk into a room and be socially accepted. We want to explore our sexuality and what feels good to our bodies, without having to experience the fear of catching something or the anxiety of not trusting where our partner(s) have been. All we want is a connection to be accepted. I would rather have something bad happened to me than to have it happened to my friends and/or family. Wouldn't it be great if we could control what happens to our bodies? I wish there was a pill I could take to make all my bad choices go away (especially from the previous night when I was not thinking so clearly). I'm tired of worrying if I am going to become HIV+ or not. All these thoughts I realized contributed to my own clinical

biases as the researcher analyzing the data. As a young gay man, I was just getting to explore my own sexuality when I first heard of the AIDS crisis in the 1980s. I too, have these same fears and social anxieties of these men participating in the study. Why wouldn't I? Think of how the media has portrayed lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ) culture in the past. We see tabloids stating: George Michael arrested for having sex in a public bathroom. Michael Jackson and his child sexual abuse allegations continue. These are just a few of our role models for the LGBTQ population. No wonder people of the LGBTQ community struggle more with social anxieties in order to "fit in" into the mainstream of society. Perhaps people will do anything in order to have that connection with another person, even if it is risking our own sexual health for that few minutes of intimacy. Why do we take certain risks? Do we do it out of love or for the search of love? People would rather have a committed trusting relationship rather than have multiple sexual partners of short-term sexual fulfillment.

CHAPTER 5

RESULTS

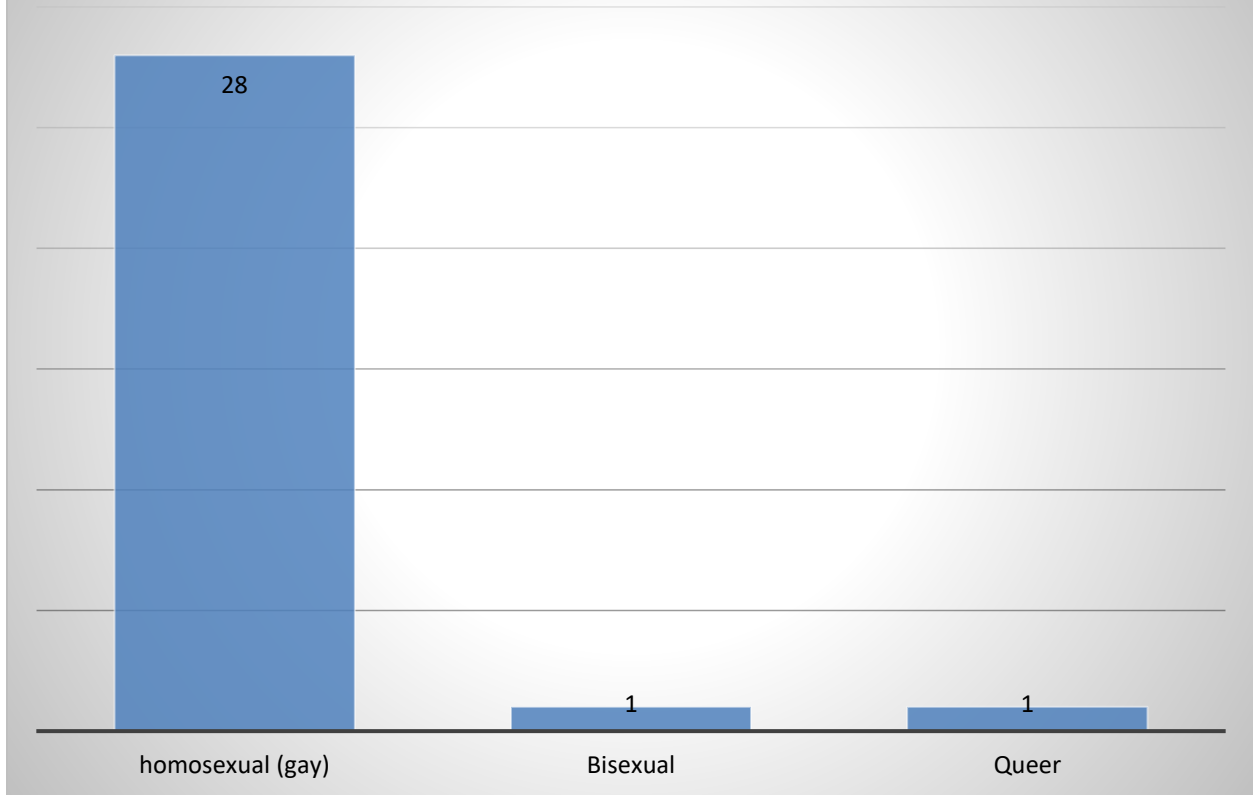
Demographic Characteristics and Use of PrEP

All participants ($n = 30$) were male. The ages of participants ranged from 23 to 61. Seven of the participants were in their 20s and of the following ages: 23, 26, 28, 28, 28, 29, and 29. Fifteen of the participants were in their 30s consisting of the following ages: 30, 31, 33, 35, 35, 36, 36, 36, 37, 37, 37, 37, 38, 38, and 39. Four of the participants were in their 40s and of the following ages: 40, 45, 46, and 47. Two of the participants were in their 50s of the following ages: 50 and 50 plus. The oldest two participants were both 61 years old.

All of the demographics and numerical data gathered from the 30 participants in the study were compiled into graphs and charts. The data suggest that the typical participant in the study was a single gay man in their mid-30s, who obtained a bachelor's degree, earns between \$50,000 and \$100,000.00 per year, admits to drinking alcohol weekly, and has been taking PrEP for about 3 to 3.5 years. Thirty-seven percent of the participants were of Euro-Caucasian descent, 20% were of Latino descent, 13% were of African-American descent, and 13% were of Asian and Pacific Islander descent. The remaining 17% of the participants were of biracial descent (See Appendix G).

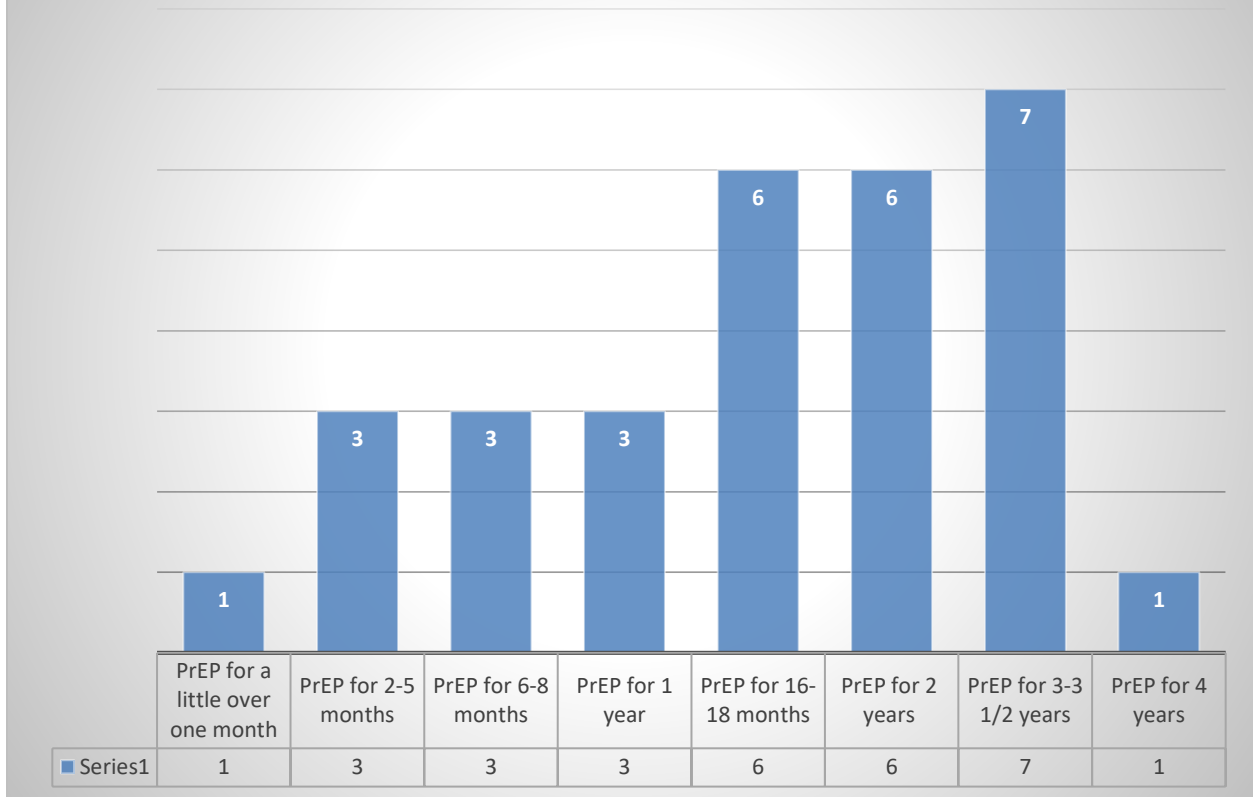
Of the 30 participants in the study, 28 of the participants identified as homosexual (gay) males. One participant identified as bisexual and another participant identified as "queer." He revealed that he identified as queer now because he recently was in a polyamorous relationship with two female-to-male transgender individuals. The participant disclosed that he was engaging in vaginal-penile sexual intercourse with these individuals, so he felt the term "queer" was more appropriate since he was not engaging in homosexual sex technically (See Figure 1).

Figure 1. Sexual Preference or Orientation



In order to be eligible to participate in the study, the participant would have had to been on PrEP for at least 30 days. Seven of the participants have been on PrEP for 3 to 3.5 years. A total of 10 of the participants have been on PrEP for less than 1 year (See Figure 2).

Figure 2. How Long on PrEP



Thematic Analysis

Eleven themes emerged throughout the coding and analysis process of the 30 interviews. The themes are as follows: attitude towards PrEP, changed sexual behaviors, communication with partners, condom usage or other safe sex practices, discrimination or PrEP where shaming, effectiveness of PrEP, improved relationship with medical providers, less fear of contracting HIV or feelings of safety with PrEP, sexual satisfaction, STDs or STIs, and substance use. A few subthemes emerged within some of the main themes. In regard to sexual satisfaction, the participants either wanted to improve their sex life through an increase in the frequency of sexual encounters or through having better quality over quantity of sexual encounters. In regard to substance use, the two subthemes emerged were on PrEP substance use and pre-PrEP substance

use. The themes and subthemes were reflective of the nuanced responses of the research study participants to questions regarding how their sexual behaviors have changed due to the utilization of PrEP as a preventive method for the transmission of HIV.

Attitude Towards PrEP

PrEP is a controversial topic right now in the community. There are pros and cons to the use of PrEP, and everyone seems to have some opinion or attitude about PrEP. Some of the participants believe that PrEP is something every gay man should take because everyone is at risk for HIV, and condoms break. They believe PrEP can make one feel sexually liberated, especially if one does not want to be confined to use a condom and prefer a heightened sensation that is not decreased by the barrier of a condom. PrEP reminds people that HIV is a possibility if they engage in unhealthy unprotected sex. Some people view PrEP as a proactive way in living a healthy lifestyle. However, PrEP is also viewed as the pill that gives them the freedom to engage in unprotected condomless sex. People admit to feeling sexually liberated on PrEP, especially if they enjoy bareback sex. The feelings of liberation are evident in that they can engage in sex and have a peace of mind in not worrying about catching HIV. However, many people speculate that the individuals who take PrEP are in fact engaging more in group sex and having multiple partners as a result. According to one PrEP user:

PrEP is an acceptable risk in safe sex. I don't think PrEP is considered safe sex but it's much safer. As long as you are engaged in sex I think it's never going to be 100% safe, so just that everything in life you engage the risk, you go for it. You have to take some risk, depending on what you like, what you don't like.

PrEP has been compared to the birth control pill in that it prevents one from contracting HIV just as the birth control pill prevents pregnancy. However, it can lead to feelings of liberation and

control over one's sexual health. PrEP also eliminates the stress people encounter when they may have slipped up or had unprotected (condomless) sex. Another participant stated:

I think PrEP is wonderful. It takes the monkey off your back if you do have a slip-up or any of that kind of thing. I think it makes, I guess, sex and intimacy fun again.

However, some people are concerned about the long-term effects of PrEP. They are also concerned about catching other STDs or STIs. According to another participant:

I think it's a bittersweet pill. I think it does do some good. I think it also does do some damage. I feel that there is responsibility to protect yourselves against any sort of STI, as well as HIV and AIDS as well, which I believe that PrEP sort of gives the freedom to engage in unprotected sex a lot of the times. However, I still think that it is a plus for a lot of different communities. As I am a Black male, HIV infections among young, gay minorities are mainly on the highs.

Changed Sexual Behaviors

The main focus of the study was to gain insight into how individuals' sexual behaviors had changed if at all after taking PrEP for at least the past 30 days. Ten of the participants revealed that social apps had allowed them to increase the number of partners and frequency of sexual encounters. Seven of the participants stated that it is easier to meet people with the help of dating apps such as Scruff and Grindr. According to one participant:

Now that I am on PrEP, I am having more sex without condoms, having sex with more groups of men, having more anonymous sex with strangers whom I do not know their phone numbers, and I get tested quarterly.

Some of the men said now that they are on PrEP, they do not necessarily use condoms when they engage in sex with a known HIV+ individual. Many of the participants revealed that since they

are on PrEP, they are more promiscuous, they are having sex more frequently, and they are not using condoms as frequently during their sexual encounters. Some participants' behaviors have not really changed too much, but they feel less anxious about contracting HIV. One participant stated in regard to his sexual behaviors:

My sexual behaviors have not really changed at all. PrEP has not changed my—I was fun before and I'm fun after PrEP is how I'll put it. And all PrEP has done is give me the peace of mind that I don't have to be in my head always freaking out. I can be the type that if I get something in my head, I will weekly go get tested. It gives me a little peace of mind that maybe that's not.

Being on PrEP encourages some people to be proactive in their sexual health and develop more intimacy with their sexual partners. One participant said:

Taking PrEP daily is a reminder that HIV is a possibility if I continue to engage in risky sexual behaviors. I have been sober from alcohol for 2 years and since I have been on PrEP I have been having less sex. However, my sex is more intimate. I am trying to incorporate a healthier lifestyle free of substance and problematic behaviors.

Some participants have admitted that their sexual behaviors have changed as result of being on PrEP. Most of the participants revealed that they are using condoms at a lesser rate now that they are taking PrEP. One participant even stated that he got on PrEP for the main reason of being able to have “bareback sex” (condomless sex). Some of the participants admit that they have begun to switch their sexual position, because since they are on PrEP they can engage in riskier behaviors and still be protected from the transmission of HIV. For example, some people prior to being on PrEP may have only been the inserter (top) partner in anal sex due to the position having a lower risk of contracting HIV compared to being the receiver (bottom) partner

during anal sex. This creation of deeper intimacy can be explained through the actual sexual acts of the partners. Many of the participants admit that now that they are taking PrEP, they feel secure about ejaculating or having their sexual partner ejaculate in each other's anus. They are also engaging in more anal sex as a result of being on PrEP. One participant confessed:

I admit to having condomless bareback sex with men and 2 years ago had sex with a woman. I admit that I usually ejaculate inside my partner's anus or vagina during a sexual encounter, and I recall that this behavior has not changed since I have been taking PrEP.

This particular participant's behavior had not changed; however, now that he is taking PrEP he can engage in the same condomless sex at a lesser risk of contracting HIV than before.

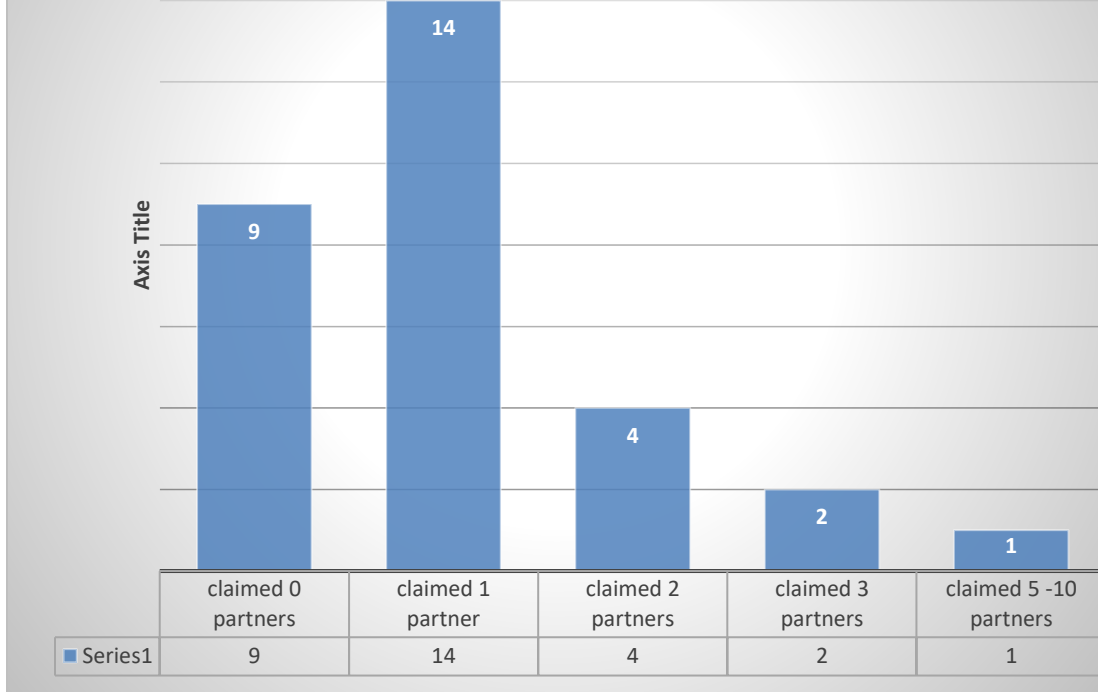
Others admitted that they have become more explorative of BDSM (bondage, discipline, sadism, and masochism) experiences such as piss, since they have been on PrEP. Some participants revealed that they are definitely more promiscuous and have multiple partners as a result of being on PrEP.

Some participants stated that social apps have increased their number of partners and the frequency of sexual encounters. They are also more likely to engage in group sex as well, since being on PrEP. People on PrEP admit that they are more likely now to engage in sex with an individual who is HIV+ than before they were taking PrEP. On the other hand, some participants have actually stopped acting out sexually or became less promiscuous since they have been on PrEP. They suggest that PrEP and being in a monogamous relationship has encouraged themselves to decrease the number of their sexual partners on a monthly basis. One participant suggests that being on PrEP made him more aware of what is going on and kind of made him want to change the way he was living his life within the sexual context. Another participant

revealed that since he has been on PrEP, he has sex less frequently but his sexual encounters are more intimate. He admits that he is trying to incorporate a healthier lifestyle free of substance and problematic behaviors, and being on PrEP allows him to fulfill. Lastly, other participants acknowledged that their sexual behaviors have not changed as a result of being on PrEP, because they have always been promiscuous or still continue to use condoms while on PrEP. But they do recall that they are able to enjoy their sex more, because they are less fearful about catching HIV since they take PrEP. Others reported that they feel less guilty after engaging in unprotected anal sex and that their anxiety has decreased as a result of PrEP usage. The following five graphs depict how many sexual partners each participant had during a specified time frame.

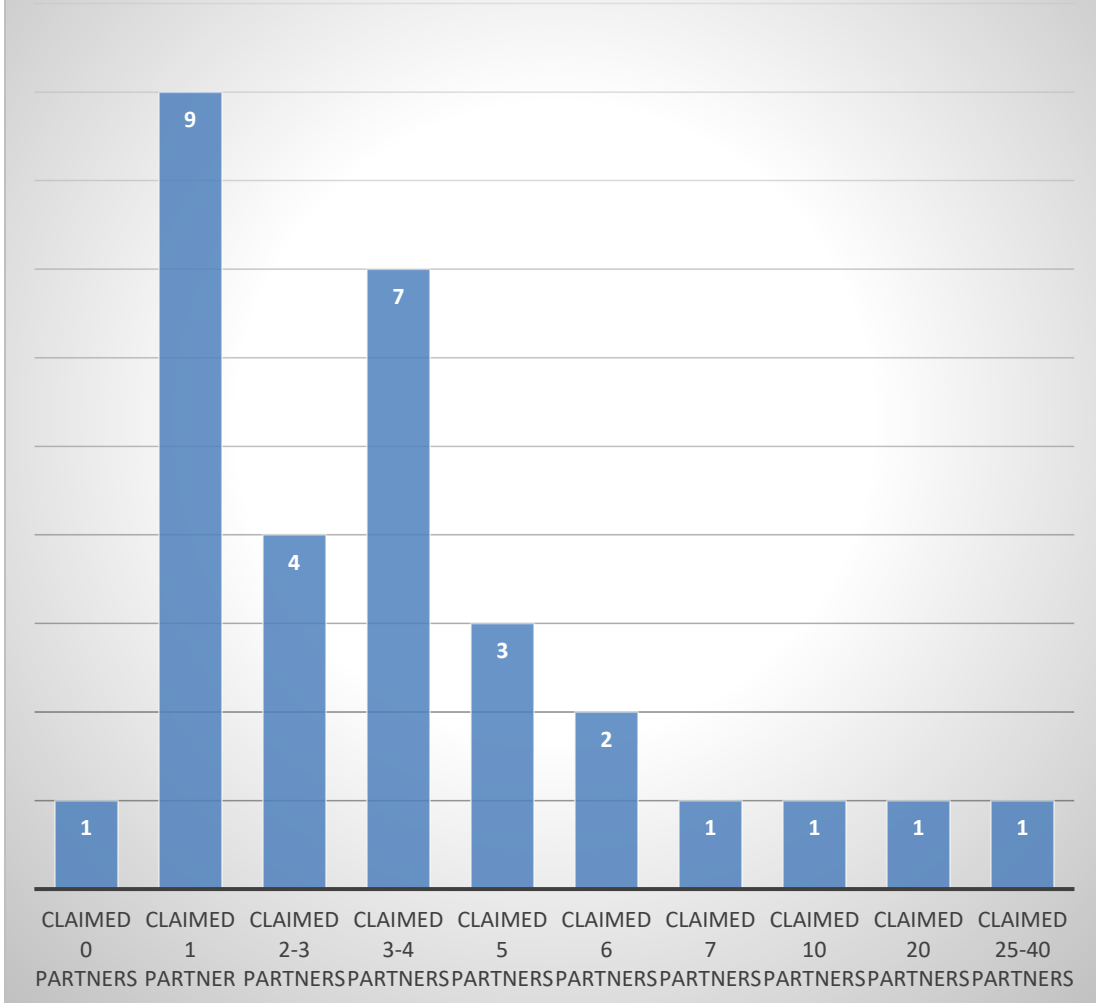
Fifteen of the participants revealed that they had sex with 14 partners within the past week. Nine of the participants stated that they had zero sex partners this past week (See Figure 3).

Figure 3. Number of Sex Partners in the Past Week



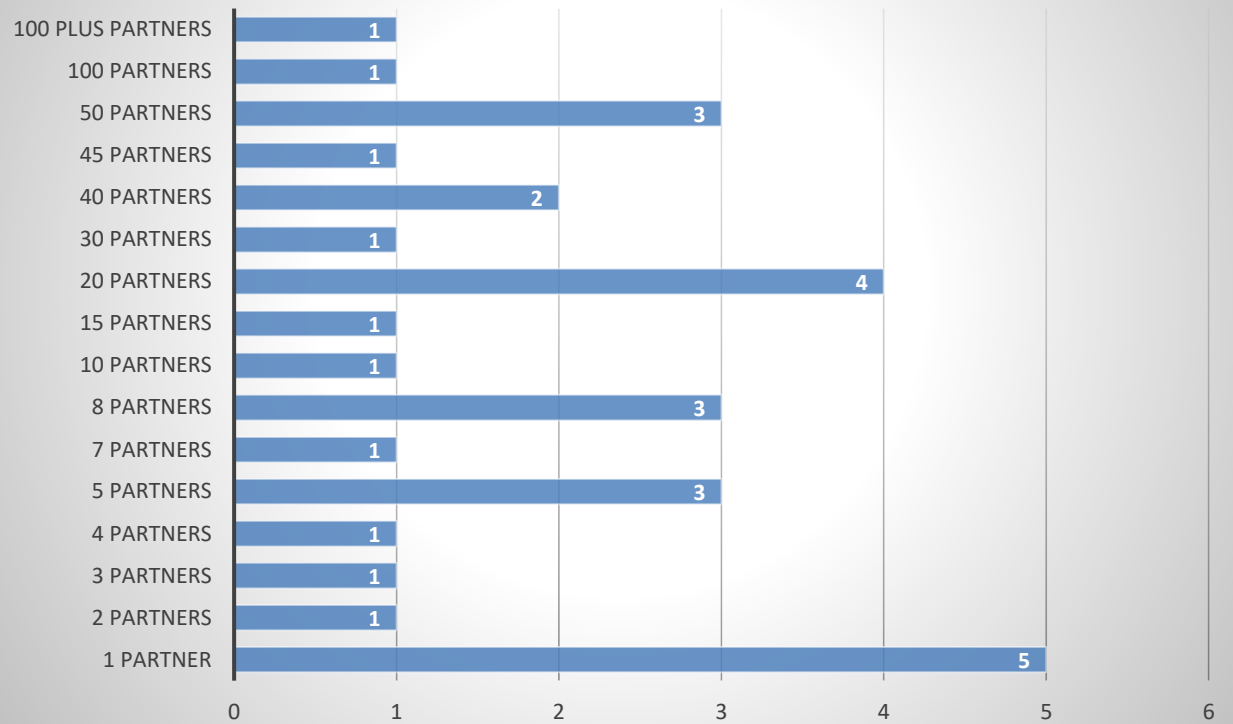
Nine out of the 30 participants had one sexual partner in the past 30 days. Seven of the participants claimed to have had sex with three to four partners in the past 30 days. One participant admitted that in the past 30 days he has had sex with approximately 25 to 40 partners (See Figure 4).

Figure 4. Number of Sex Partners in the Past 30 Days



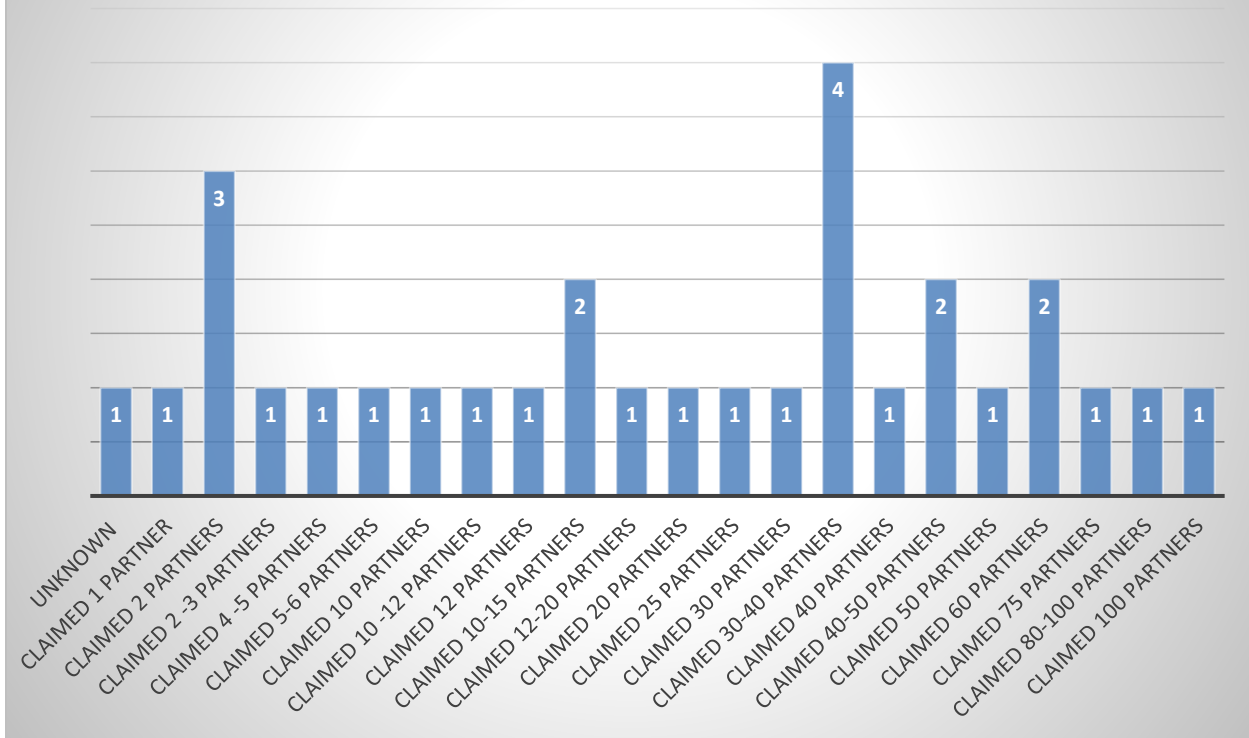
Five out of the 30 participants responded that they had a sexual encounter with one partner in the past 6 months. During the 6-month time span, four of the participants revealed that they have had 20 sexual partners. One participant disclosed that he had over 100 sexual partners in the past 6 months (See Figure 5).

Figure 5. Number of Sex Partners in the Past 6 Months



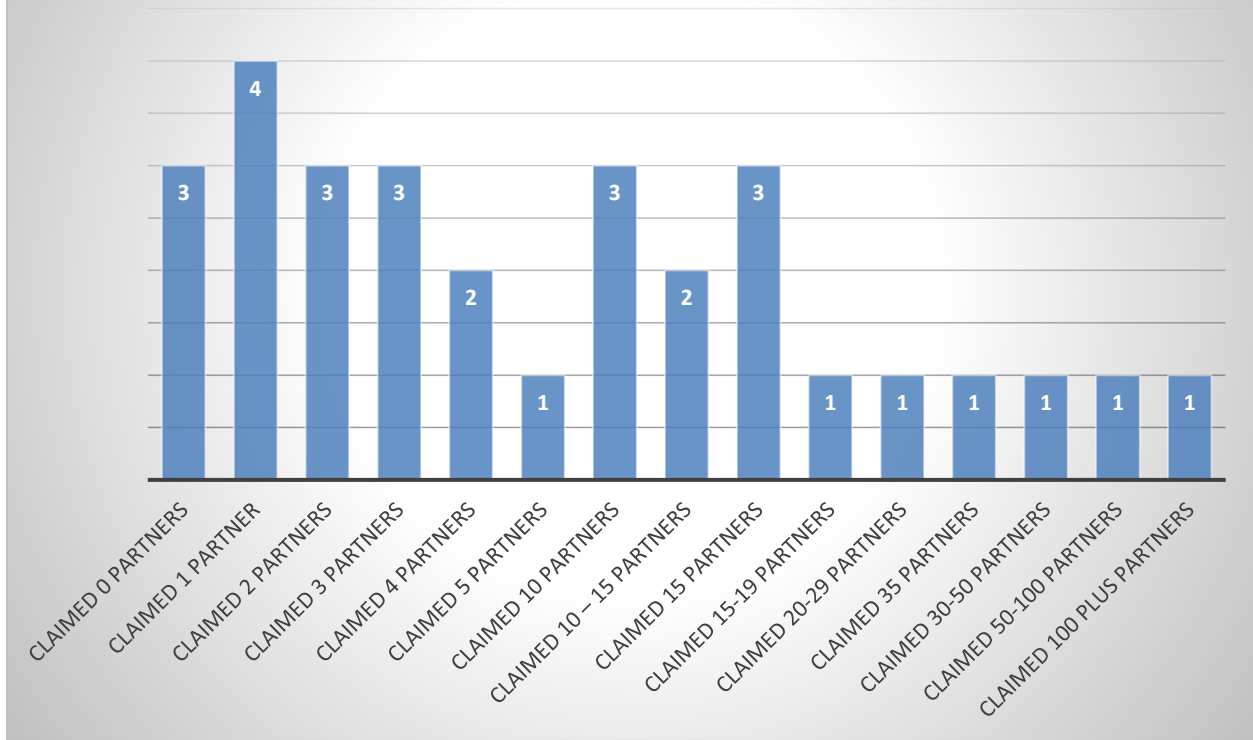
In regards to the number of sex partners prior to being on PrEP, one of the participants reported that he had only one sexual partner within a year time span. Four out of the 30 participants claimed to have had 30 to 40 sexual partners within a year time span prior to being on PrEP. Three of the participants have had 50 sexual partners, while one disclosed that he have had over 100 sexual partners within a year time span prior to being on PrEP (See Figure 6).

Figure 6. Prior to PrEP, Number of Sex Partners During a Year Time Span



Three of the participants currently taking PrEP responded that they have engaged in anal sex with zero partners within the past 3 months. Four out of the 30 participants claimed to have had anal sex with one partner in the past 3 months since being on PrEP. Three of the participants have had anal sex with 15 partners, while only one participant disclosed that they have had anal sex with over 100 sexual partners within the past 3 months (See Figure 7).

Figure 7. Number of Sex Partners Engaged in Anal Sex with in the Past 3 Months



Communication with Partners

The researcher wanted to explore whether being on PrEP has an impact on the communication among sex partners. Three participants reported that they are communicating about the same amount with their sexual partners about their HIV status. Five participants stated that they are communicating more with their sexual partners and discussing their HIV status with them as a result of being on PrEP. Three participants do not feel as if their communication or their relationship connection with their sexual partners has improved due to PrEP usage. Four participants admitted that they do not discuss their sexual history with each partner prior to engaging in a sexual encounter. One participant revealed that his communication with his friends has improved since he has been taking PrEP, but not with his sexual partners.

The results of the study suggest that approximately two-thirds of the participants believed that their communication and/or their relationship connection with their sexual partners has improved as a result of PrEP usage. They feel as if they are having more communication and more honesty in their disclosures, which creates more intimacy and connection with their sexual partners. One participant stated:

My sexual behaviors have not really changed since I have been on PrEP. However, so one of the things I know that I do these days is that I'm much more casual about condom use and about asking somebody's HIV status, because HIV doesn't come into the equation. I've protected myself from HIV so now I only need to worry about, "Is this person somebody I actually want to have sex with? Is this person somebody who I feel comfortable inviting into my home for whatever reason?" No longer do I even consider, "Is this a person who has HIV or not?" If he has HIV, is he on his meds? Is he regular? Is his viral load undetectable?" That's no longer a consideration. It means that I can put the biggest worry out of my mind.

Another participant stated that he would ask his partners if "they were clean," which meant if they were HIV-. He felt that his sexual partners could have lied in the past, but now that there is PrEP, and he feels protected, he does not really have the concern of whatever their status may be. Since being on PrEP, many of the participants realize that they feel more of a connection with their sexual partners because they are less fearful of catching HIV. Since they are on PrEP, they can be trusting that their partners are protecting themselves and vice versa. According to one participant:

I think my communication and relationship connection with my sexual partners have improved as a result of PrEP usage. My partners who are HIV positive, we can have

more candid conversations about HIV now. With potential partners, we can have more candid conversations. With my partner, who seroconverted recently, it's been good to be able to talk about things, and it's not the seroconversion that's brought us closer but our ability to, kind of, see the world from a somewhat more similar perspective, because we're both taking a pill regularly to address HIV. So that's just, all around, it's been super for me. I think it's helpful, just to have relationships I have.

Participants revealed that they are more casual and open about asking their partners' HIV status, because HIV does not come into the equation if PrEP is used. They admit that they can be more intimate with their partners, since they can still feel safe being on PrEP and not having to use condoms. A few participants agreed that more times than not they discuss their sexual histories with their partners; however, they admit when they are at sex clubs, sex parties, or bathhouses, they do not engage in such conversations with those sexual partners.

The other one-third of the participants in the study believe that since they have been taking PrEP, their communication and/or relationship connection with their sexual partners has not changed or has actually gotten worse as a result. Some of the participants believe that since they are on PrEP, they assume that everyone is on PrEP. Therefore, they do not need to discuss each other's HIV status, because they are safe being on PrEP and do not need to worry about anything. One participant stated that prior to being on PrEP he would discuss his sexual history with his partners in order to set ground rules of his comfort level and fear of catching an STI. However, now he does not even ask his partners' HIV status since he is on PrEP. Another participant agreed that his communication with his sexual partners has not improved; however, his communication with his friends has improved. His HIV+ friend asked him before he was on

PrEP why he was not taking PrEP if he is engaging in anal sex. He believes it is important to have a dialogue about the subject of PrEP. One participant said:

I believe that since I am on PrEP, my communication and connection with my sexual partners has gotten worse. People just assume that everyone is on PrEP, so they do not even discuss status or if they are negative about anything. It is kind of like, “I’m safe, so I’m not going to worry?” Now there is even less conversation about it.

Some of the participants continue to use condoms, so they only decide to ask their partners about their sexual history and HIV status if they decide not to use condoms during that particular sexual encounter. One participant claims that he does not believe his communication with his sexual partners has improved, but perhaps now that he is on PrEP the connection he feels with his partners while engaging in a sexual encounter has become stronger. He equates this connection with being on PrEP and feeling freer to engage in more intimate sexual behaviors with his partners.

Online dating and social network apps make it easier for people to meet each other and to negotiate sexual encounters. People can discuss one another’s HIV status easily and openly online, so the fear of rejection can be all sorted out before actually meeting in person. Another response given was:

I try to but I admit that I do not always discuss my sexual history with each of my partners prior to engaging in a sexual encounter. Sometimes that’s one thing that can make it easier online, which is kind of nice, is that you can have that clause before physical interaction, where you can say, “Hey, here’s what I deal with,” and I like that, because it actually allows me to screen people. If somebody is shocked

that some of my partners are HIV positive, that might be a problem. If somebody is shocked that sometimes I have sex without condoms, that might be a problem for some people but not for others. So these kinds of things have been very helpful for me, because if I get something, or if you get something, we need to be able to talk about that. There can't be shock between us, or whatever. So yeah.

Condom Usage or Other Safe Sex Practices

One question of concern in the study was the issue of condom usage, and if the frequency of condom usage had changed due to the participants taking PrEP. Many of the participants feel as if it is liberating to not wear condoms during sexual encounters. Others admit that they suffer from condom exhaustion, and that they do not like to wear condoms because it reminds them of the AIDS epidemic. Others reported having trouble maintaining an erection during sex while wearing a condom, and yet some people are allergic to latex condoms. Being on PrEP allows them to feel more intimate with their sexual partners, and believe they do not have to wear condoms to feel safe anymore. Overall, the results of the study revealed that most of the respondents are using condoms less frequently now that they are taking PrEP. Some responses stated that they used condoms 80 to 90% of the time prior to being on PrEP, and now on PrEP they used condoms about 10% of the time. A less drastic change was reported by some revealing that before PrEP they used condoms 60 to 75% of the time, and 40% of the time after being on PrEP. One participant said that his condom usage has not changed since he has been taking PrEP; however, he admits to only using condoms about 90% of the time he engages in sex. Yet another participant claims to have used condoms 99% of the time. Others claim that they always use condoms, unless they are in a monogamous relationship, regardless of whether they are on PrEP. One participant who is currently in a relationship claimed that:

Now my partner and I are both on PrEP, so we do not use condoms. I am versatile, and my partner and I ejaculate inside one another.

Another participant claims to use condoms 100% of the time during his first sexual encounter with someone; however, if they engage in sex for a second encounter they will discuss and agree to not use condoms if they are both on PrEP. When asked if his condom usage had changed since he has been on PrEP, one PrEP user said:

My condom usage has not changed much since being on PrEP, because I hardly used condoms that much before either.

The participants are aware of the risks of catching an STI or STD from not using condoms; however, they admit that they are willing to take that risk because most STIs and STDs are treatable and not life threatening. PrEP can allow the individuals to feel sexually liberated by not wearing a condom, and still possessing a layer of protection that is provided by being on PrEP.

One participant revealed:

Well, I think that PrEP has changed people's attitudes about not wearing condoms. So there's times where people think it's okay just to have them removed and remove them without saying anything. So I think if I wasn't on PrEP that would still kind of be a fear in my mind, and although it still is, it's a lot less.

Many of the participants agreed that they would rather have that connection with their sexual partners than to have a latex barrier impede on their intimacy. One participant stated:

Prior to PrEP I used condoms about 60-70% of the time, and now after being on PrEP I use condoms about 50% of the time. I rarely allow someone to ejaculate in my anus during sexual encounters, but do allow it more after being on PrEP.

Furthermore, some of the men revealed that they mainly still use condoms as a birth control method if they engage in vaginal sex. However, a few of the participants acknowledged that they still use condoms at about the same rate as they had prior to being on PrEP. Therefore, if the condom breaks for some reason, PrEP still allows them that added protection in the prevention of HIV. In regard to condom usage since being on PrEP, one participant responded by stating:

I feel safer with PrEP, but admit that I use condoms about 99% of the time I have sex. I rarely have had bareback sex.

Discrimination or PrEP Whore Shaming

The researcher wanted to inquire if the participants have experienced discrimination or any type of negative feedback when they have informed others that they are taking PrEP. Eight participants revealed that they had been discriminated against or received negative feedback when they disclosed to others that they are on PrEP. One participant reported that he has yet to experience discrimination or negative feedback as a result. Another participant claimed that if he were to be “slut shamed,” it would be because of his actions and not because he is on PrEP. Some of the respondents in the study revealed that they have been slut shamed for being on PrEP, and called “Truvada whore” or “HIV whore” by friends and people they have met on social media dating apps such as Grindr and Scruff. They believe that some people think that being on PrEP increases people’s high-risk sexual behaviors. One participant revealed that he disagrees with the author, Larry Kramer (who allegedly coined the term, “Truvada whore”), on his belief that “PrEP is inhibiting true romantic intimacy.” PrEP has also been nicknamed “slill” defined as “slut pill” by one participant. A few participants experienced discrimination within their interactions with nurses and medical providers. The nurses were informed that they take PrEP,

so they blatantly did not want to treat the patients, assuming that they were HIV+. Critics of PrEP believe that the medication is toxic and that it can affect one's bone density, kidneys, and liver that will eventually kill a person. One participant believes people criticize PrEP, because of ignorance derived from misunderstanding the true purpose of PrEP. He said that those people do not realize that one needs to communicate with his doctors and monitor his liver and kidneys while he takes PrEP. One participant who has experienced discrimination for being on PrEP said:

I have experienced discrimination from being on PrEP. It was more towards people assuming, using words like slut in a negative way. People saying it makes you a Truvada whore, we heard that a couple times. People saying, it's a poison, it's going to kill you. It's not healthy. It's worse than getting HIV. Why would you do that to your body as a negative person? Are you doing it just so you can bareback? Are you doing this—what about bone density? What about everything else?

Others reported that they decided to take PrEP because they were sick of living with HIV stigma, and were tired of being scared of catching HIV. The all agreed that they want to enjoy their sex lives without any worries.

On the other hand, some participants revealed that they have never experienced any discrimination or negative feedback from others when they disclosed that they were taking PrEP. These individuals actually believe that PrEP has paved the way to decreasing negative stigma with being HIV+. They go on to state that so many people nowadays are HIV+, and they are living healthy lives taking their medications. HIV is a manageable disease like diabetes. However, HIV+ individuals have to take care of themselves and they can live a long healthy life. According to one of the PrEP users:

Taking PrEP is a safeguard for the people taking it, I think it's a safeguard for that, because you can't rely on people that I think, many people are very untrustworthy and not very forthcoming in terms of their status. Yeah. I mean not so much right now, but in the past there used to be a negative stigma with being HIV positive. I think PrEP has decreased the stigma. I think so because nowadays so many people are HIV positive, and get into this medication, I mean they're living with it. It's like living with any other disease, like diabetes or what have you. It's manageable. And you can lead a long life as long as you take care of yourself.

One participant revealed that he does not recall being discriminated against for taking PrEP, but suggest that, "maybe we Truvada whores are all running in the same circle". Not everyone has experienced discrimination or has been whore shamed by others for being on PrEP, according to one particular participant. He goes on to state:

I have not really experienced any discrimination or negative feedback from others when I informed them that I am taking PrEP. However, I have been slut shamed in the past. Yeah, and I mean, gays are more slutty than everyone else. You know. I think the only people that would...I think it sort of comes from our own culture. Like it's more of an inside slut-shaming than anything else.

Effectiveness of PrEP

One question of concern in the usage of PrEP is how effective PrEP really is in decreasing the spread of HIV. Five participants believe that PrEP is extremely effective, and one of the participants actually works in the medical field. Some of the participants admitted that they have only heard of two documented cases in which PrEP was not effective in stopping the contraction of HIV. Many of the participants agree that PrEP is approximately 90-99% effective

in stopping the spread of HIV. A majority of the participants in this study believe that PrEP is highly effective in decreasing the spread of HIV, and would approximate that PrEP has an effective rate of between 92-99 % based on research. They believe it is effective as long as the person is medically compliant. One participant said that:

PrEP is an acceptable risk in safe sex. I do not think PrEP is considered safe sex but it's much safer. As long as you are engaged in sex I think it's never going to be 100% safe, so just that everything in life you engage the risk, you go for it. You have to take some risk, depending on what you like, what you don't like.

Some of the participants agreed that knowing the effectiveness of PrEP has allowed them to not be afraid to have sex. One participant stated that research found that if a person takes two doses of PrEP (Truvada) in one week it will reduce infection to an effective rate of 72%, if they take four pills per week the effective rate will be approximately 96%, and at a rate of 99% if the person takes more than four pills per week. Another participant stated that the research he read revealed that PrEP is 94% effective if PrEP is taken four times a week, and 99% effective against the spread of HIV if taken six to seven times days per week. When asked about his thoughts and beliefs about the effectiveness of PrEP, one participant revealed:

I believe from the studies that if you take PrEP at least four times a week, you're pretty much 94% protected. If you take it, I believe six or seven-- every day, you're actually 99% protected from HIV. However, I know there are strains that are resistant to the PrEP or the typical Truvada, but those are a very, very small minority. So I'm not too concerned, although there are new strains that are coming up and people have been expressing some concerns with PrEP use.

However, others expressed feeling a little anxious over hearing the news that there have been two cases of individuals who had been taking PrEP seroconverted and tested positive for HIV. One participant disclosed that he continues to be promiscuous, and still has not tested HIV+ since being on PrEP. He openly recalls:

To be honest with-- shit happens on PrEP. I can tell you that sometimes there could be five partners in a month and sometimes there could be 12 partners in a night. I don't know any of their names. I have top to bottom, to take load after load. And every test has come back negative. So, I think it's very highly effective.

Improved Relationship with Medical Providers

One question the researcher wanted to gain insight was if PrEP improved the participants' relationships and faith in the healthcare system and how difficult it was for them to obtain PrEP. Seven of the participants revealed that their relationships with their health care providers have not changed since they have been on PrEP. They have always been open to discuss their sexual health issues with their doctors or they make a point to see a gay friendly doctor. One particular PrEP user expressed his thoughts by saying:

I believe my relationship with my doctor and the healthcare system has totally improved since I have been taking PrEP. One of the, I guess, stipulations of being on PrEP is you have to go back every 3 months to get tested of-- HIV testing, but also how it's affecting kidneys and liver, and I'm assuming other organs. So you're in the doctor every 3 months getting blood tests and everything else. So it's great. You see the doctor all the time and know that you're healthy. Accordingly, my doctor is gay and has been fantastic along with my local pharmacy.

Ten of the participants stated that their relationships with their medical providers have improved since they have been taking PrEP, and they openly discuss their sexual behaviors as a result.

When asked if his relationship has changed with his medical providers, one participant stated:

I believe that being on PrEP has improved my relationship and faith in the healthcare system. But my only concern-- well, despite that Gilead has made the drug to prevent HIV-- well, my only concern is the fact that, well, those who aren't insured, well, who have to pay for it-- well, I think it's like in between \$1,500 to \$3,000. And what surprised me was the fact that a few friends of mine who happen to live in Canada only pay a tenth of the amount, uninsured or otherwise, so. Well, technically, it's kind of like a love/hate thing going on, but mostly good.

Some of the participants felt their relationships with their health care providers have not changed since they have been on PrEP. However, a majority of the participants felt they have more faith in the health care system, and they have improved their communication with their medical providers as a result of being on PrEP. Some of the participants revealed that prior to being on PrEP, they rarely had doctor's appointments unless they had a specific medical issue.

Furthermore, they rarely discussed their sexual history with their medical providers; however, now they openly discuss their sexual history and they get tested for STDs and STIs at their 3 months appointment as well. Some participants revealed that PrEP gives people the confidence to interact with the medical system and to advocate for themselves and others. Being on PrEP has also led many of the participants to take a more proactive stance in developing healthier approach to other aspects of their lives, such as eating healthier, exercising more, decreasing substance use, and taking measures to decrease stress.

One participant cannot tell if his communication with his medical providers has opened up more, because he switched doctors to a gay oriented clinic for that reason. For another person, his relationship and faith in the healthcare system has remained the same since he has been on PrEP. He recalls that he has always been self-aware of his health and has always been comfortable going to doctors and speaking with them. He has no issues with learning about insurance and how to handle whatever needs to be taken care of for his medical care. So being on PrEP just means going to the doctors a lot more frequently. According to another participant:

Feels like not getting HIV, being able to assure my HIV+ partner that he is not going to infect me, feeling like a resource in the community (because I know about PrEP and has experience with it), getting into the doctor more regularly, knowing my health, and feeling more confident are all benefits of being on PrEP. PrEP gives him a certain kind of confidence for interacting with the medical system, and even as far as advocating for myself and others.

For most of the participants, it was not that difficult to obtain PrEP. Participants with Medi-Cal insurance stated that it was difficult at first to get on PrEP and to have it covered by the insurance. Another individual stated that 3 years ago his insurance company refused to cover the cost of PrEP. However, one participant revealed that he had a doctor through the Affordable Health Care Plan who had no idea about PrEP. He had to switch to a doctor at the LGBT Center in order to receive PrEP free of charge. He recalled that when he was working he could purchase private insurance for \$158.00 per month, but he could not afford to buy his PrEP prescription for \$1,200.00 per bottle for a 30-day supply. For many of the PrEP users, the medication is currently covered by their insurance. Some people are responsible to pay a co-payment of \$25.00 to \$34.00 for the medication, but others receive a co-payment waiver through the

manufacturing company, Gilead, that makes the PrEP medication, Truvada. One participant purchases PrEP online through an email website called *iwantprepnw*. The Truvada medication comes from Hong Kong and can be purchased for approximately 50 British pounds for 30 tablets. However, one individual actually feels as if his relationship and communication with his medical providers has gotten worse since he has been on PrEP, because he had to switch doctors in order to find a medical provider that knew about PrEP. He felt as if he had to educate his doctor about PrEP.

Less Fear of Contracting HIV or Feelings of Safety with PrEP

The researcher wanted to find out if the respondents have less fear of contracting HIV and/or if they feel safer now that they are taking PrEP. Twenty participants admitted that since they have been on PrEP, they no longer have a fear of contracting HIV. They can finally relax, worry less, and enjoy sex without stressing out about the aftermath ramifications. However, three participants admit that they still have a fear of acquiring HIV. One participant revealed that since he has been on PrEP, he is able to reassure his HIV+ partner that he is not going to infect him and he feels like a resource to the community because of his knowledge and experience with PrEP. A majority of the participants in the study admit that since they have been on PrEP they no longer have a fear of catching HIV. PrEP has allowed the participants to have a peace of mind. They have less fear in getting infected with HIV, and feel comfortable engaging in condomless bareback sex and ejaculating inside one another's anuses. Others revealed that they can only control what they themselves do, and that they cannot always control what others do. So PrEP is like a back-up plan. A PrEP user revealed,

I believe PrEP is a good extra protection, and it gives people more of an excuse to be a little more reckless than they may normally be. Being on PrEP makes me a

little less anxious, because I know I have that extra barrier.

One participant stated that being on PrEP has allowed him to engage in unsafe sex with his partner, and now he does not have to worry about his partner cheating on him and infecting him with HIV. Others believe people are taking PrEP in order to take the fear of HIV out of the equation of an intimate encounter. The anxiety around sex is removed by the use of PrEP. All of the participants revealed that they enjoy their sexual encounters more because they feel less fearful of contracting HIV, and they feel less regretful if they engaged in condomless bareback sex the night before. On a different note, three of the participants admit they are still fearful of catching HIV even though they are on PrEP. They believe everyone is at risk for HIV, so they take PrEP and still use condoms for the added protection. When asked if he feels safer and has a lesser fear of contracting HIV since he has been taking PrEP, one participant responded:

I believe people are taking PrEP in order to take the fear of HIV out of the equation of an intimate encounter. You can worry about other things, but you don't have to worry about HIV anymore. And so what it does is it makes for peace of mind, much more relaxed, much more intimate. It means that after every time somebody has sex, you don't have to be panicking and worrying about, "Oh, my God, I got a cold 2 days later. Is that me converting?"

Sexual Satisfaction

The researcher wanted to find out if people on PrEP are satisfied with their sex lives, and if they contribute their satisfaction to being on PrEP. Overall, about 28 out of the 30 participants were satisfied with their sex lives. The participants were further asked if they could change anything about their sex lives what it would be. A majority of the participants said they would prefer to have better quality over quantity in their sexual encounters. Yet some of the

participants admitted that they would like to increase the frequency of their sexual encounters.

One PrEP user stated:

I contribute being on PrEP as a factor of why I am satisfied with my sex life. Absolutely, peace of mind and taking that aspect out of the equation, as well as opening-up a population I might not otherwise have considered for encounters, who aren't as diligent about testing. I have always been promiscuous so my sexual behavior has not changed much, but the main thing after being on PrEP has allowed me to enjoy my sex more and be less fearful.

The participants' responses in the study suggested that overall the individuals were satisfied with their sex lives. However, the participants revealed that if they could change something about their sex lives, they would either want an increase in the frequency of sex or want better quality over quantity in sexual encounters. Two of the participants want more quality within their relationships compared to the quantity of sexual partners. Increased communication with their partners leads to greater quality of sex and intimacy. They feel that true intimacy can be present because PrEP allows the individuals to not have to wear condoms. One participant recalls that when someone has an orgasm inside you, it makes the entire sexual experience more intense and more memorable. They admit that their being on PrEP makes condomless sex less taboo.

According to another participant:

I am satisfied with my sex life, but I feel more comfortable about having bareback sex with my partner and not having to worry about if he's cheating on me. That's a benefit of PrEP. He doesn't want to be on PrEP. He'd prefer that I go off PrEP.

Many of the participants wish they have a steadier sexual encounter with the same person and would like to be a part of a stable committed relationship. One participant said that:

I am becoming more interested in an intimate relationship right now, and getting tired of fucking random people.

PrEP allows people to have a peace of mind due to a lesser fear of contracting HIV, as well as opening up the dating pool to include a population of HIV+ individuals to have sex with without fear of contraction. Some participants would like to increase the frequency of sexual encounters but with fewer partners. On the other hand, one participant stated that he would be more satisfied with his sex life if he had more frequent sexual encounters and more intimacy with his partners. He does not feel as if being on PrEP is the cause of his satisfaction or dissatisfaction of his sex life, but contributes it more to being old and insecure. One unsatisfied participant responded by saying:

I am not satisfied with my sex life, because I still panic after sex. I would like to not panic after every time I engage in sex. I will continue to use PrEP and I will think if I'm really suitable in sex behavior. And if I think I will still do sex, I will also use condom as well, condom plus PrEP.

STDs or STIs

The researcher was interested in finding out if people on PrEP are being diagnosed with STDs or STIs more frequently than before they were on PrEP. Approximately five out of the 30 participants revealed that they have never been diagnosed with an STI or STD before or after being on PrEP at this time. Six participants contracted gonorrhea prior to being on PrEP, but reported that they have not gotten an STD or STI since being on PrEP. One PrEP user disclosed that:

Prior to being on PrEP, I was dx. with syphilis, and have not been dx. with a STD/STI since I have been taking PrEP.

Three participants contracted chlamydia before being on PrEP, but have not been diagnosed with anything after being on PrEP. Two participants were diagnosed with syphilis prior to being on PrEP, but have not had an STD or STI since being on PrEP. One participant revealed that he had contracted crabs from a female when he was younger, and he contracted syphilis since he has been taking PrEP. One participant revealed:

My friend is a physician's assistant and told me that he has seen an increase in STD cases as a result of PrEP, especially syphilis.

However, one participant never had any STDs or STIs until he started taking PrEP, and then he was diagnosed with chlamydia. One participant was diagnosed with chlamydia before and after being on PrEP. Another participant was diagnosed with syphilis and gonorrhea prior to being on PrEP, and then diagnosed with chlamydia after being on PrEP. Another participant admits that he was:

Dx. with chlamydia prior to being on PrEP, and dx. with gonorrhea after being on PrEP.

Two individuals were diagnosed with syphilis prior to being on PrEP, but have had all negative STD and STI tests after being on PrEP. One participant revealed that he was diagnosed with gonorrhea and chlamydia prior to being on PrEP, and diagnosed with chlamydia since he has been on PrEP. Besides PrEP, he stated that he is also using preventive methods to avoid catching other STDs. He has acne and uses a type of antibiotic called Minocycline, which actually is used as a secondary treatment for chlamydia, gonorrhea, and syphilis. One of the arguments against PrEP is that more people may be diagnosed with an STI or STD while taking PrEP, because they no longer use condoms. Five participants have never had STIs before being

on PrEP, and no STIs after being on PrEP. When asked about STDs and STIs, one participant responded:

I have arguments with people stating that STDs are on the rise. I believe people were not using condoms before the HIV+ / AIDS epidemic and STDs have always been readily frequent.

Substance Use

Critics have considered PrEP the “party drug.” A question of concern is that a person on PrEP will be more inclined to use substances and engage in riskier sexual behaviors while under the influence of substances. Five participants reported that their substance use is the same before and after being on PrEP. The researcher of this study was interested in exploring the substance use of PrEP users and to see if their substance use has changed since they have been prescribed PrEP. According to one participant:

Sober from cocaine and alcohol for the past two years. Substance use lowered my inhibitions, and I was definitely more promiscuous under the influence of drugs.

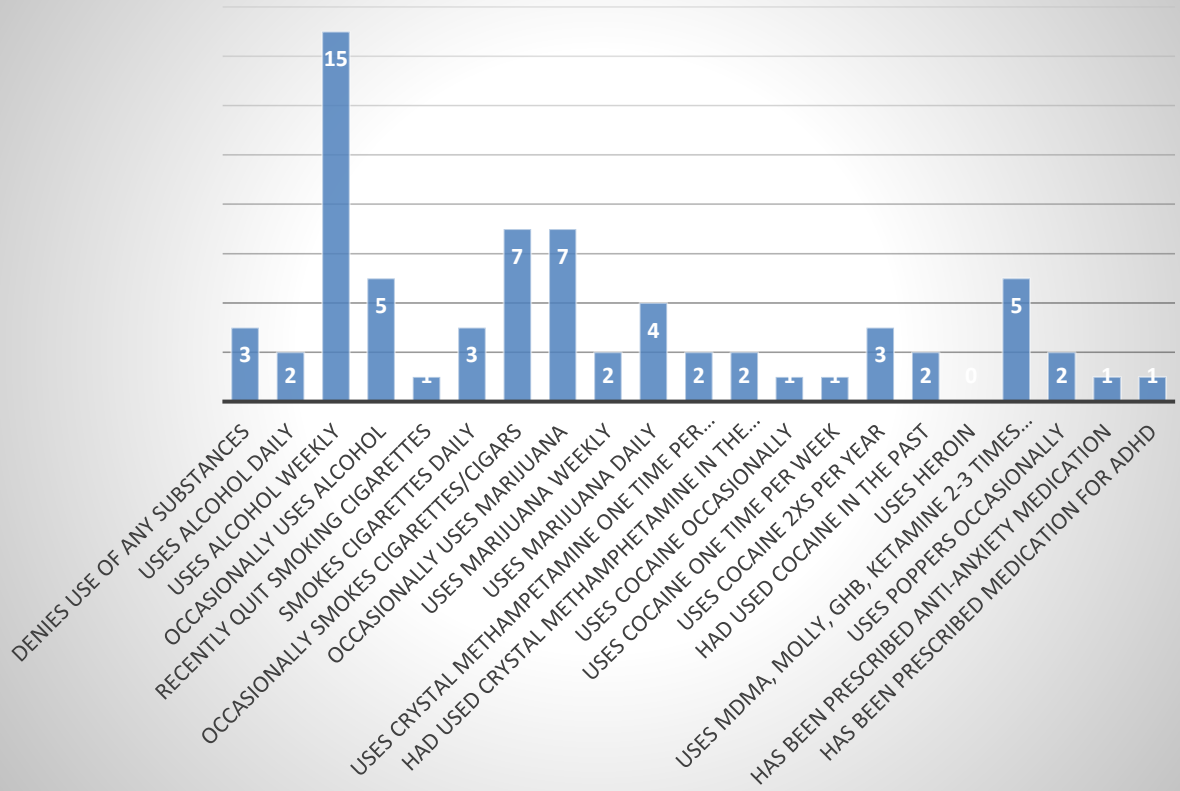
More than half of the 30 participants in this particular PrEP study revealed that they use alcohol a lot of the time they engage in a sexual encounter. Participants agreed that they and/or their partners use alcohol about 90% of the time they have sex. Marijuana is the next most frequent substance used by the participants. One participant stated that during sexual encounters, he and his partners use the following substances: marijuana, Gamma Hydroxybutyrate (GHB), Ketamine, Molly, and Ecstasy. He recalled that his substance use has remained the same since he has been taking PrEP. All of the 30 participants agreed that their substance use has not changed since they have been taking PrEP. Therefore, one question of concern is that if people are willing to use substances during their sexual encounters, are they more likely to engage in

unprotected sex as well, since they may not be in the full mental capacity to make the decision to practice safe sex? One participant disclosed that he has been sober from cocaine and alcohol for the past 2 years. His substance use lowered his inhibitions, and he was definitely more promiscuous under the influence of drugs. In regard to the topic of substance use, one participant said:

I admit that my partners and I are sometimes under the influence of alcohol and/or marijuana during sexual encounters. With them it was like alcohol or weed. With me it's just weed and alcohol too. I haven't caught people, man. I mean, I'm not seeing it out there. I know who they are out there when they do meth, but that's a whole different realm. At one time I would have been like 5 years ago but not now. I'm aware of it, of my sexual situation now than ever before because I've been educated now.

In regard to substance use, 50% ($n = 15$) of the participants currently taking PrEP responded that they drink alcohol on a weekly basis. Twenty-three percent ($n = 7$) of the 30 participants claimed to smoke cigarettes and /or cigars occasionally. Another 23% ($n = 7$) admitted to occasionally smoking marijuana. None of the participants interviewed had used heroin. Seventeen percent ($n = 5$) of the participants revealed that they use MDMA, Molly, GHB, and/or Ketamine 2 to 3 times per year (See Figure 8).

Figure 8. Substance use



CHAPTER 6

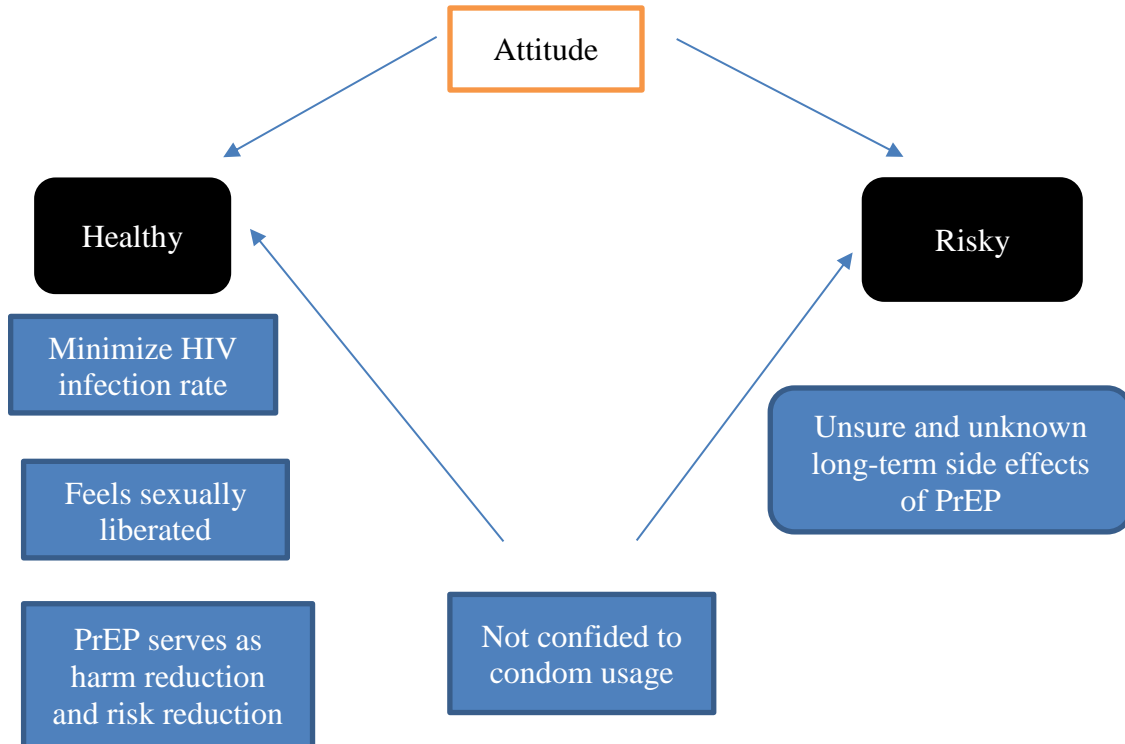
DISCUSSION

Summary of Results

Healthy Versus Risky Concepts of PrEP

The participants' attitudes towards PrEP hinges on healthy beliefs compared to risky uncertainties. They have a healthy attitude towards PrEP in that it serves as a preventive method to stop the spread of HIV. They also believe that PrEP allows them to feel safe enough in order to not have to use condoms as a preventive method from HIV. However, not having to feel confided to use condoms can also be a risk factor. The participants are also concerned about the risk of long-term side effects of PrEP usage (See Figure 9).

Figure 9. Healthy Versus Risky Concepts of PrEP: Attitude



Many of the younger generations did not witness how the gay population was basically wiped out by the HIV/AIDS epidemic in the 1980s and early 1990s. So they see the HIV virus as something that can be managed by just taking a pill, similar to the treatment of diabetes or any other long-term medical condition. In comparison, the older generations still have a hard time realizing that the HIV virus is not a death sentence anymore, and can be treated or managed by taking HIV medication as prescribed.

The participants' sexual behaviors changed in healthy and risky ways due to the usage of PrEP. They revealed that the healthy behaviors involved having easier access to meeting guys on the Internet or through dating apps to meet up for sex. The participants stated that they can now be more explorative and intimate with their sexual partners, since they are on PrEP. Some of the participants felt that their sexual behavior has not changed because they still use condoms with their monogamous partner. The participants admitted that they are more promiscuous and having sex more frequently. However, being more promiscuous and having sex more frequently can also be a risky behavior because their behavior can put the participant at risk for contracting other STDs or STIs. Other risky behaviors include using condoms less frequently, engaging in bareback anal sex and allowing ejaculation in the anus during sex, and having sex with anonymous sex partners (See Figure 10).

There are healthy and risky components of the participants' communication with their partners since they have been taking PrEP. Communication with their partners improved, because being on PrEP has made them more open to discuss their sexual history and create greater intimacy with their partners due to feeling safe from being on PrEP. They feel as if they are protecting themselves, and having an open dialogue about PrEP helps to decrease the stigmatization of STDs or STIs and HIV. On the flip side, communication with their partners

has decreased because they assume that if they are taking PrEP everyone else may be on PrEP. They feel safe being on PrEP, so they are willing to take the risk of having bareback sex. They may feel as if discussing their sexual history with their partner may ruin the intimate moment, and that their partner's HIV status and/or sexual history does not really matter since they themselves are being protected from HIV (See Figure 11).

Figure 10. Healthy Versus Risky Concepts of PrEP: Changed Sexual Behaviors

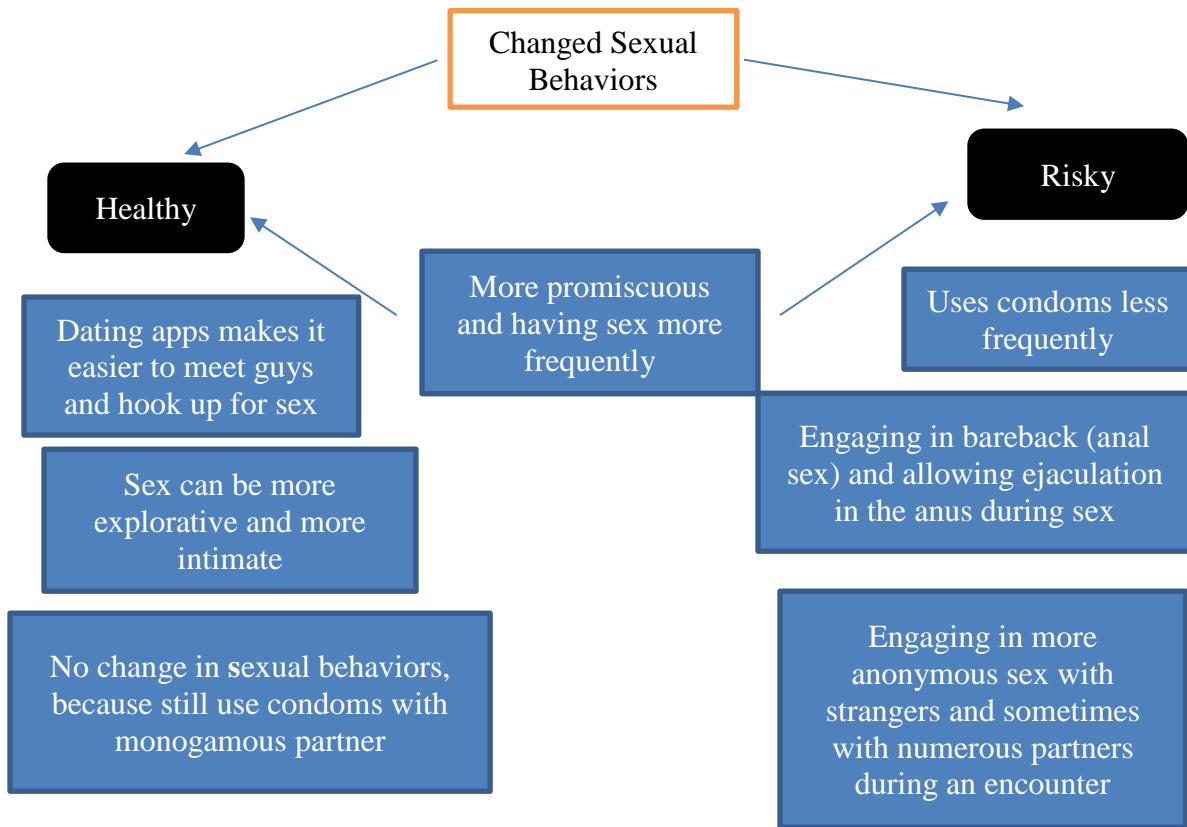
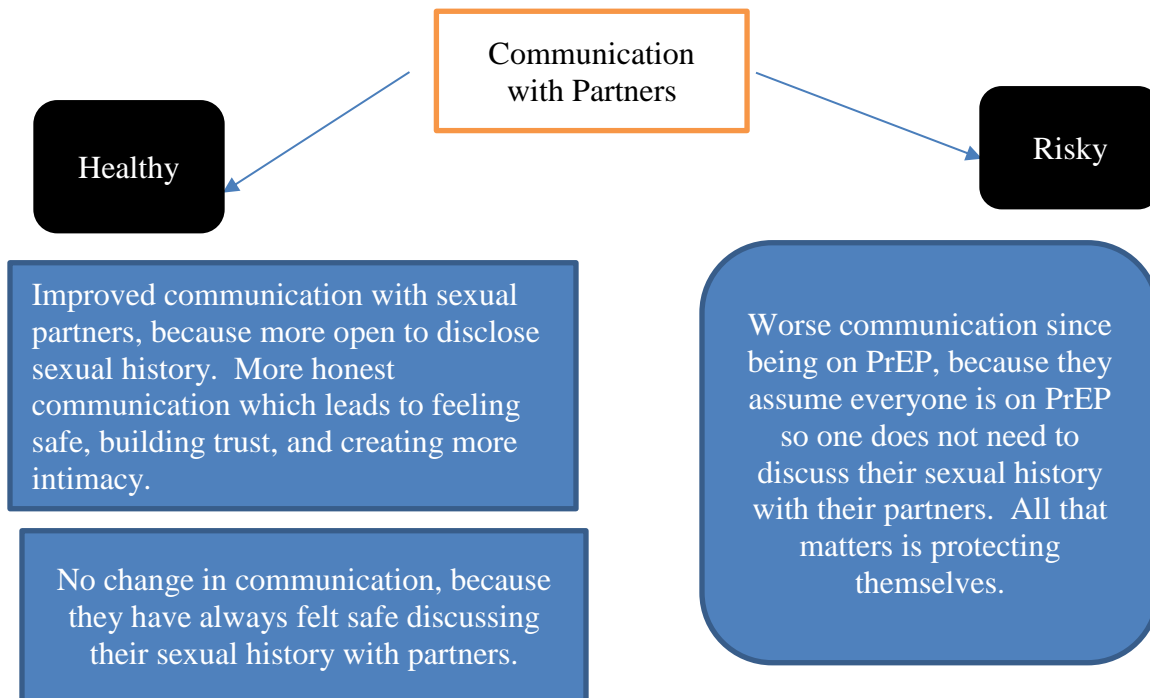
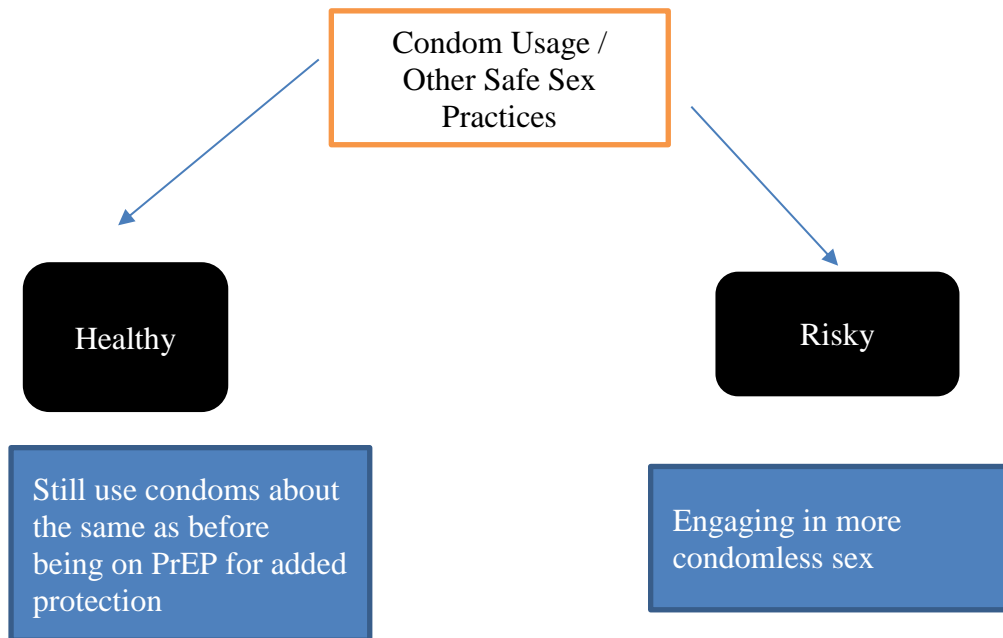


Figure 11. Healthy Versus Risky Concepts of PrEP: Communication with Partners



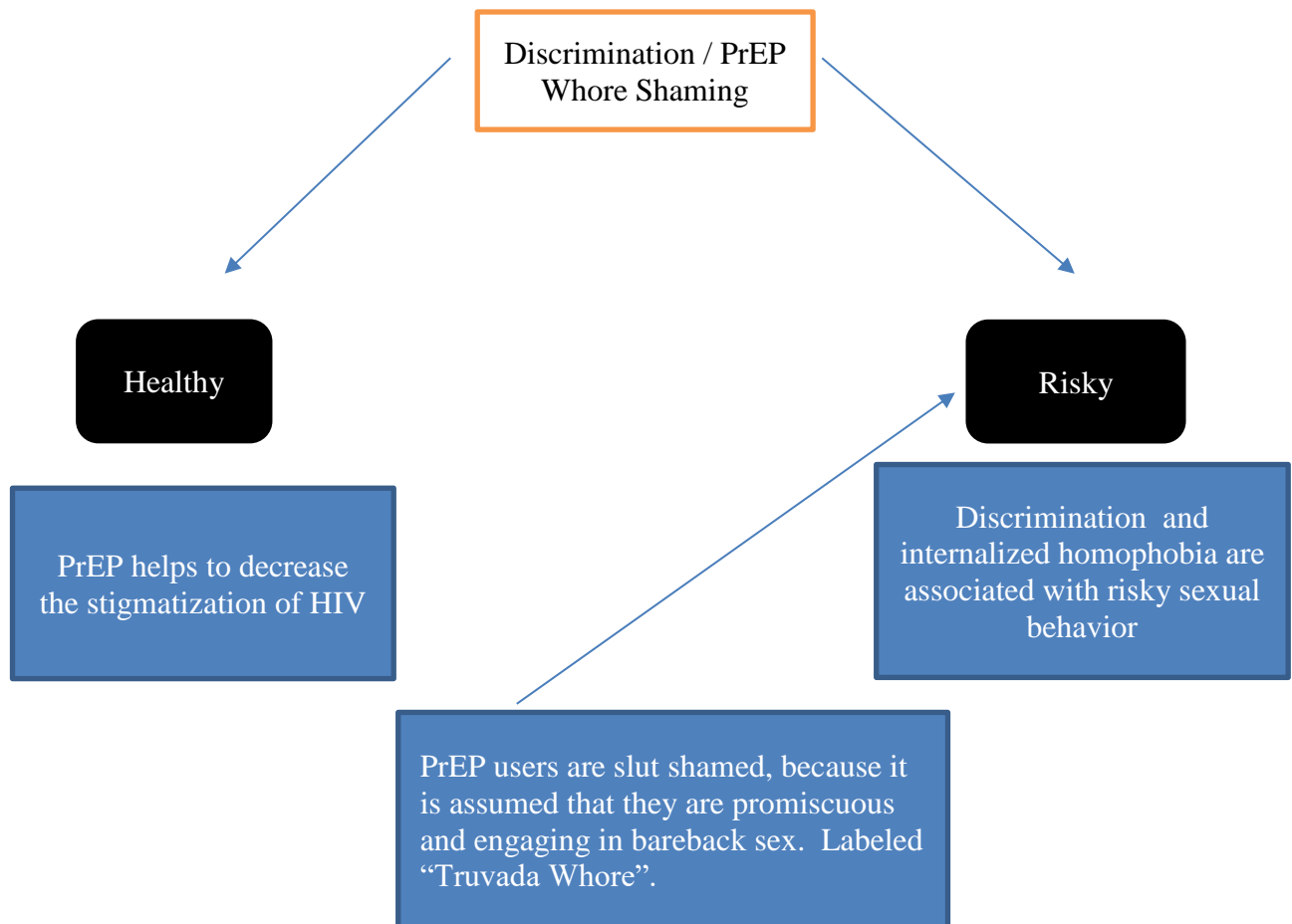
Since being on PrEP, the healthy approach to condom usage and other safe sex practices of the participants has been to continue using condoms at the same rate as they had prior to being on PrEP. So they feel as if PrEP provides them added protection from the spread of HIV. However, the use of PrEP could be discouraging people from utilizing condoms, which may put them at a greater risk for other sexually transmitted diseases (STDs) or sexually transmitted infections (STIs). The risky approach to condom usage has been that the participants are using condoms less now that they are taking PrEP. They believe that PrEP protects them from HIV, so they are willing to engage in bareback sex (See Figure 12).

Figure 12. Healthy Versus Risky Concepts of PrEP: Condom Usage / Other Safe Sex Practices



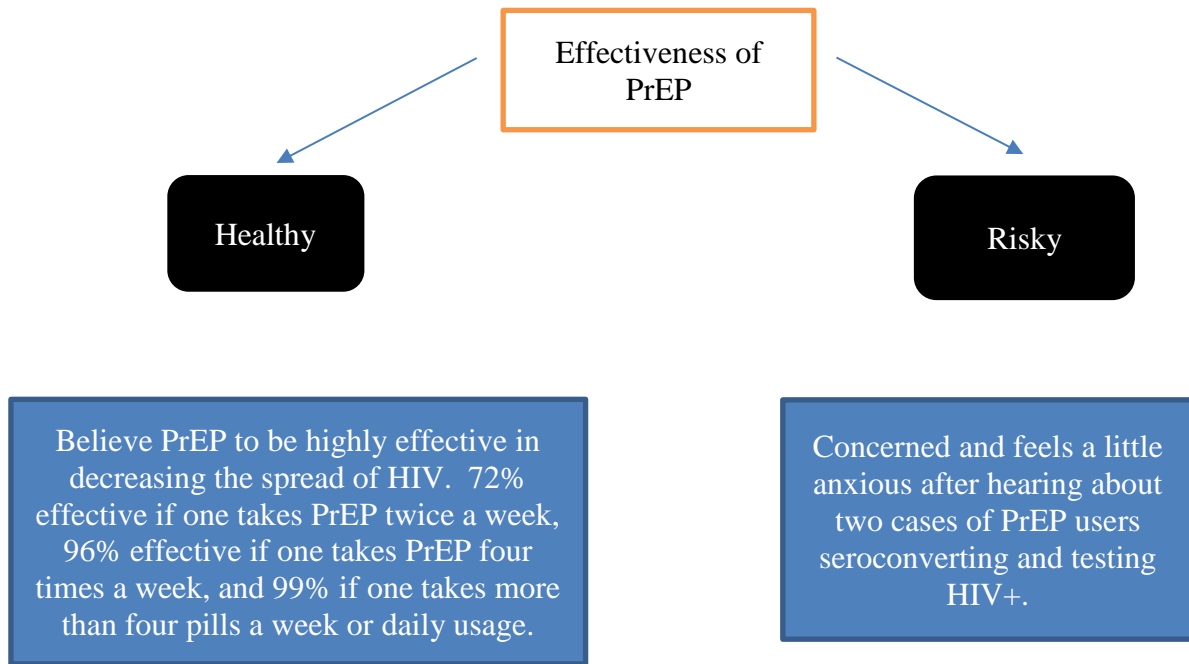
According to the participants, PrEP can cause healthy and risky results in regard to discrimination and PrEP whore shaming. Since PrEP is becoming more widely available and used more frequently, PrEP users are facilitating a decrease in the stigmatization of HIV. However, discrimination and internalized homophobia are associated with risky sexual behavior. It is often assumed that PrEP users are more promiscuous and engaging in condomless sex with numerous partners (See Figure 13).

Figure 13. Healthy Versus Risky Concepts of PrEP: Discrimination/PrEP Whore Shaming



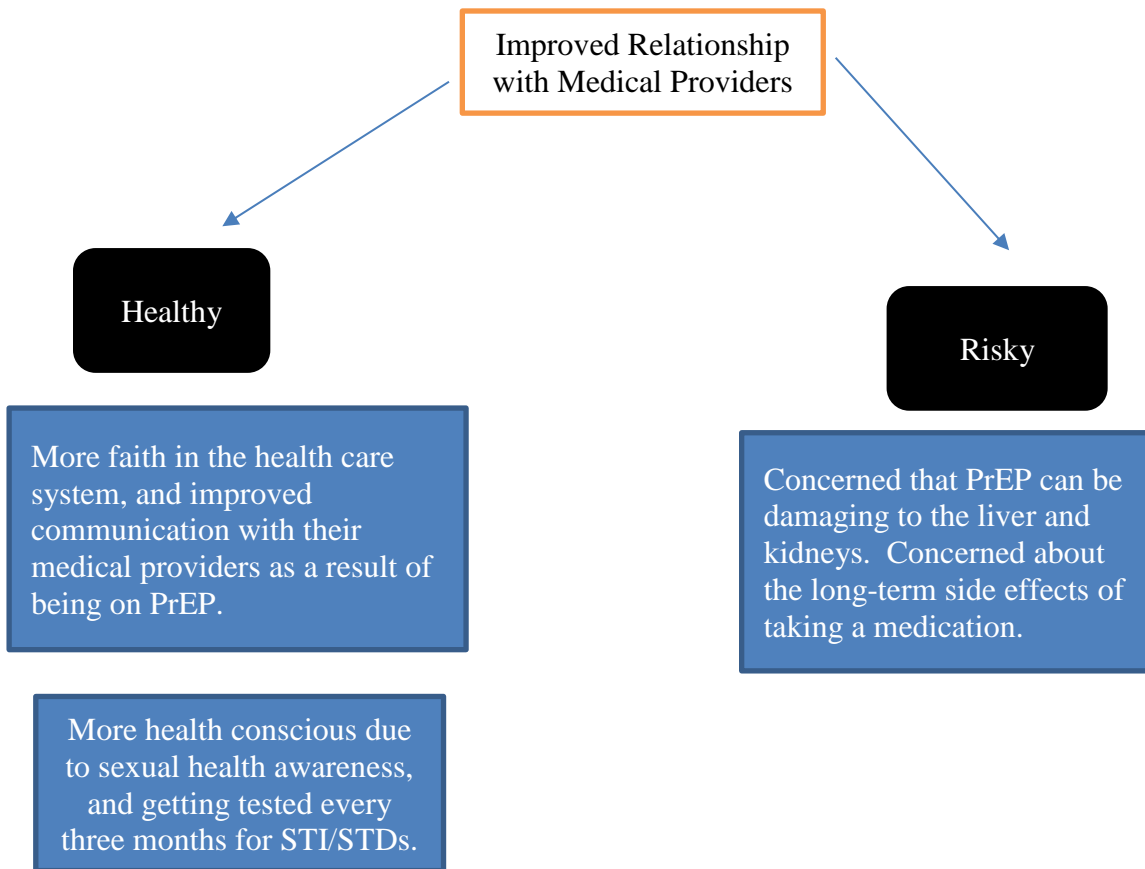
The participants' believe that a healthy aspect of PrEP is that it is extremely effective in decreasing the chances of contracting HIV. However, they still acknowledge that nothing is 100% effective and that taking PrEP and having bareback sex can still be risky behavior. Some of the participants are concerned because there have been cases of people taking PrEP and still being infected with HIV (See Figure 14).

Figure 14. Healthy Versus Risky Concepts of PrEP: Effectiveness of PrEP



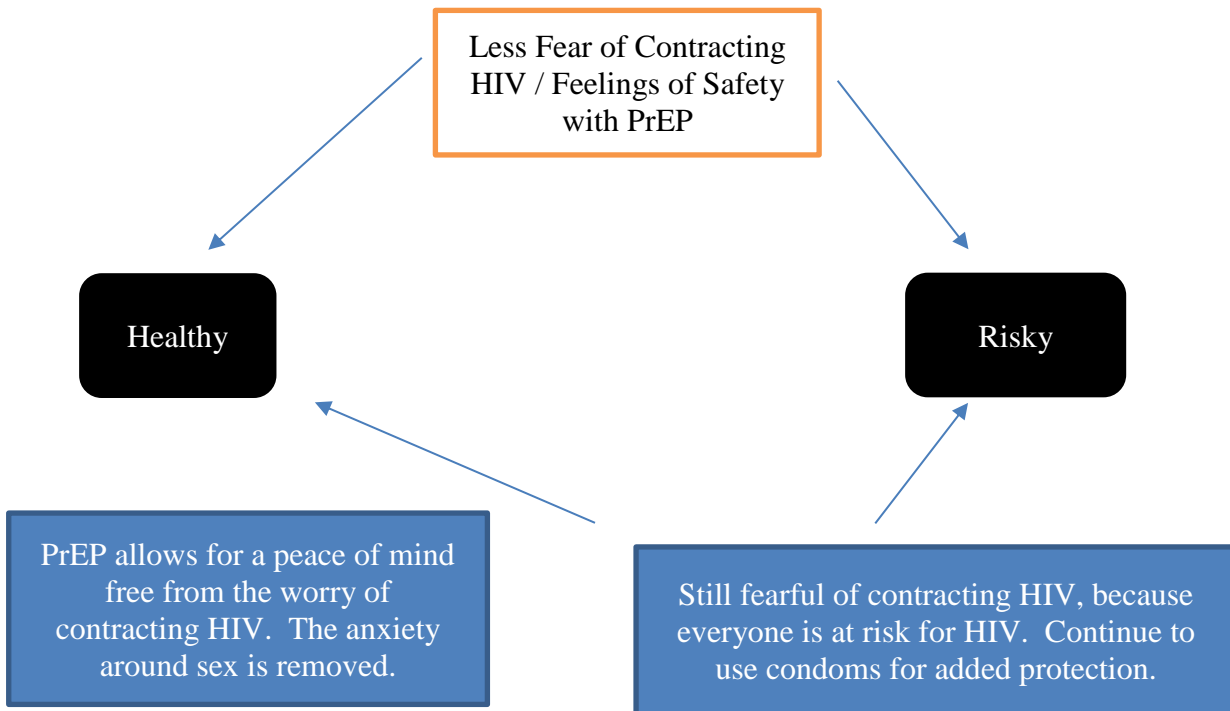
On a healthy note, some of the participants feel since they have been on PrEP, their relationship with their medical providers has improved because they have contact with them every 3 months for routine testing. They are more aware of their sexual health and feel more comfortable discussing their sexual history with their providers. However, some of the participants are still concerned about the long-term risks of PrEP usage and the damage it can cause to the liver and kidneys (See Figure 15).

Figure 15: Healthy Versus Risky Concepts of PrEP: Improved Relationship with Medical Providers



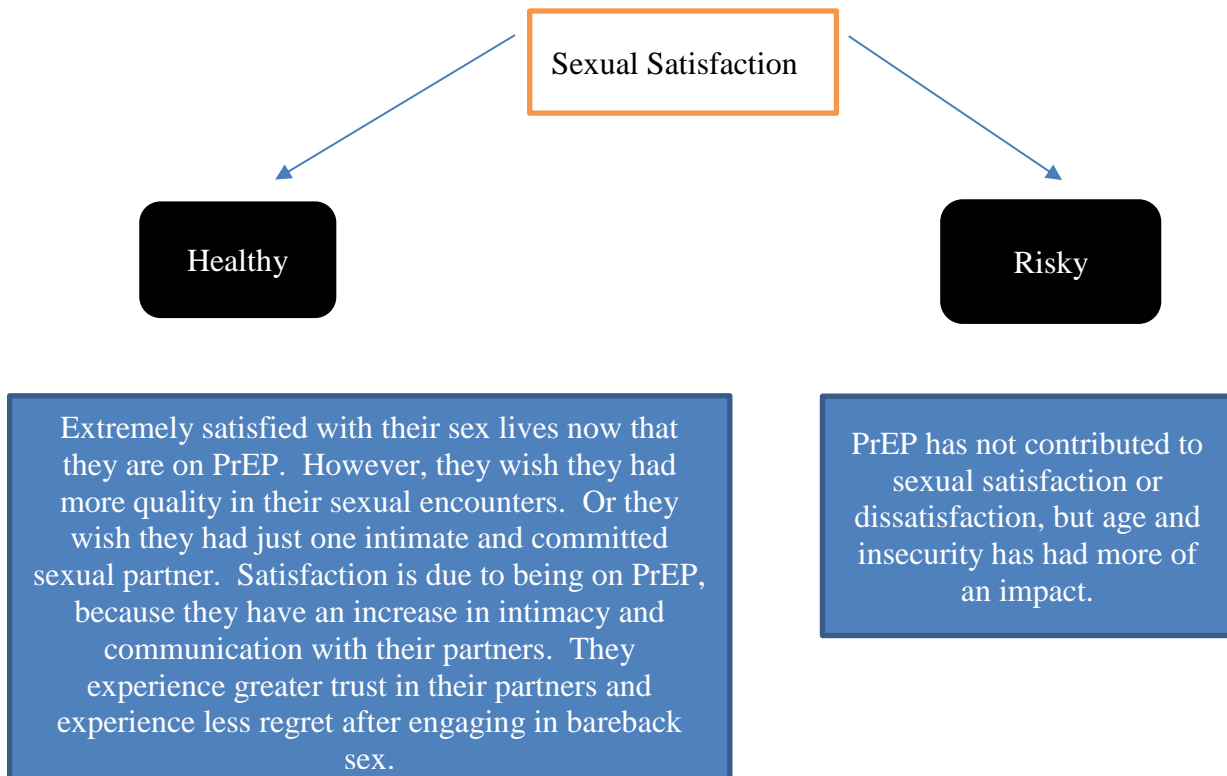
The participants' experience less fear of contracting HIV and feel a sense of safety from being on PrEP. This feeling of safety creates a healthy approach to their sexual health. They tend to worry less and are less regretful and concerned if they engage in condomless sex or the condom breaks during intercourse. However, some of the participants are still fearful of contracting HIV, because they realize everyone is at risk. They may use condoms for added protection (See Figure 16).

Figure 16. Healthy Versus Risky Concepts of PrEP: Less Fear of Contracting HIV/Feelings of Safety with PrEP



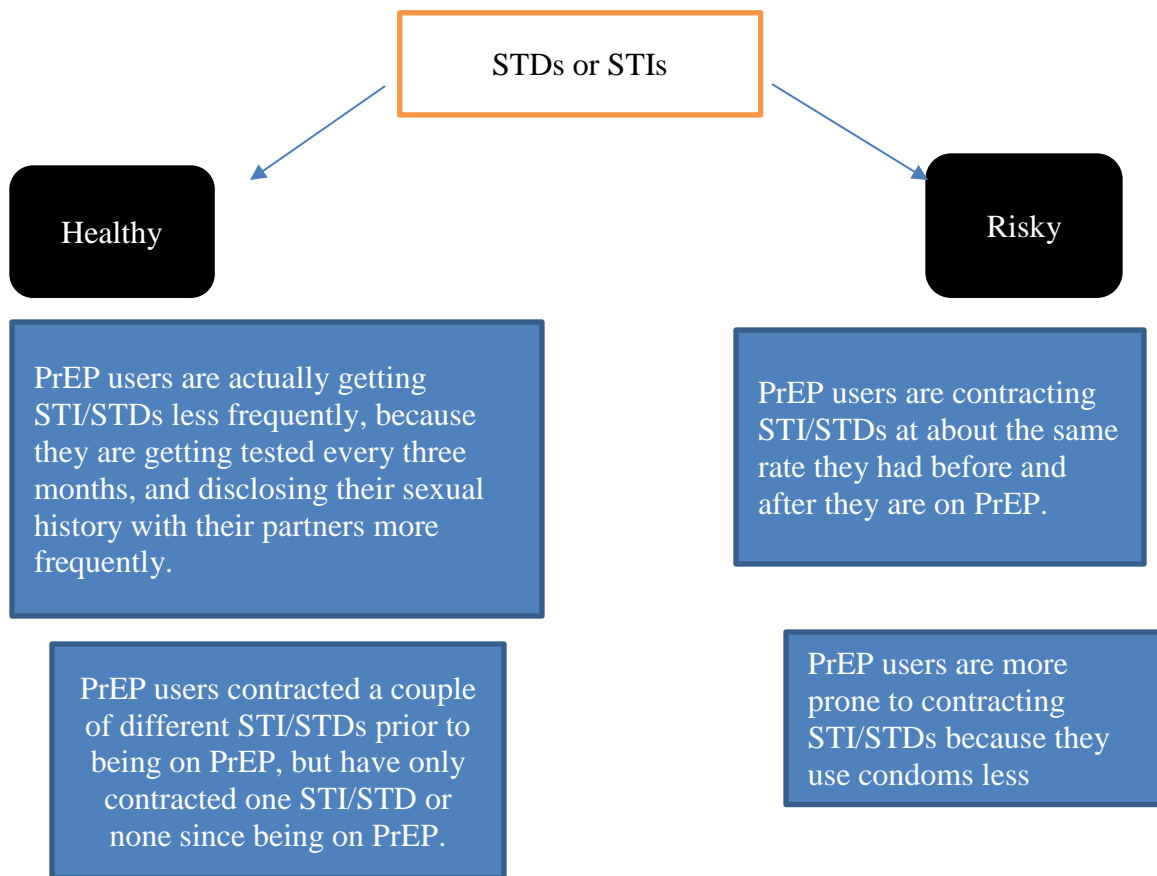
Overall, most of the participants are extremely satisfied with their sex lives, and they contribute their healthy sex lives to the use of PrEP. They revealed that PrEP allows them to feel safe and secure that they will not get infected with HIV. This sense of security and trust in their partners is a result of having greater communication and intimacy with their sexual partners. However, the participants acknowledge that they would rather have more quality than quantity of sex. However, this greater intimacy may lead to further explorative risky sexual behaviors that can have a negative effect on their sex lives. Feelings of insecurity can result after engaging in risky behaviors. The participants realize that PrEP does not necessarily add to the dissatisfaction of their sex lives, but instead their insecurities stem from their age or their physical appearance (See Figure 17).

Figure 17. Healthy Versus Risky Concepts of PrEP: Sexual Satisfaction



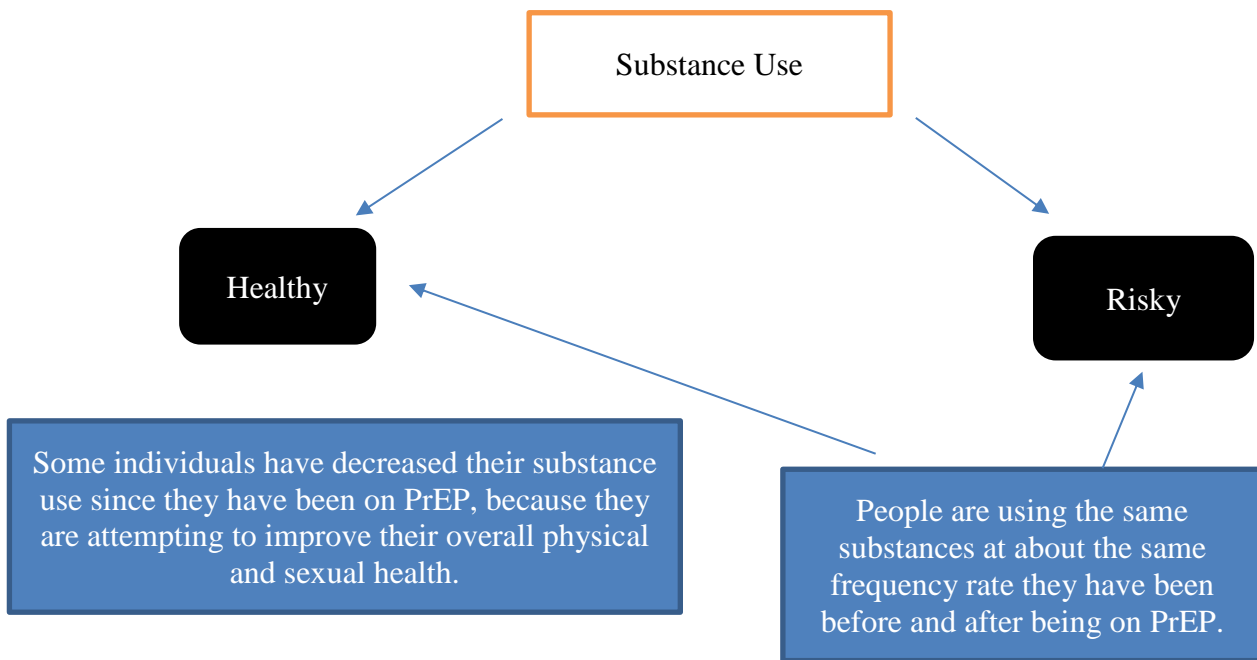
According to the participants, PrEP has caused them to take a healthier approach to improving their sexual health. They are getting tested more frequently for STDs or STIs, and discussing their sexual histories with their partners. However, the participants stated that they are having sex more frequently with numerous partners and not using condoms as frequently during their sexual encounters since they have been taking PrEP. Their behaviors may suggest that the participants are more prone to the risk of catching an STD or STI now as a result. However, the data suggest that participants are actually getting STDs or STIs less frequently. If they had been infected with a couple of STDs or STIs prior to being on PrEP, they may have contracted only one STD or STI or none after being on PrEP (See Figure 18).

Figure 18. Healthy Versus Risky Concepts of PrEP: STDs or STIs



Some of the participants said that since they have been on PrEP, they are attempting to improve their overall physical and sexual health. As a result, they are decreasing their substance use as well. Other participants admitted that they still continue to take the same risk in the frequency and amount of substance use as before they were taking PrEP. Others continue to use substances sometimes while engaging in sex. However, they may be more likely to refrain from condom usage if they are under the influence of substances. PrEP at least decreases the chances of an individual becoming affected with HIV if condoms were not used (See Figure 19).

Figure 19. Healthy Versus Risky Concepts of PrEP: Substance Use



The main focus of this particular study was to find out how sexual behaviors have changed due to PrEP usage. The following themes emerged from the qualitative interviews of the 30 participants: attitude towards PrEP, changed sexual behaviors, communication with partners, condom usage or other safe sex practices, discrimination or PrEP whore shaming, effectiveness of PrEP, improved relationship with medical providers, less fear of contracting HIV or feelings of safety with PrEP, sexual satisfaction, STDs or STIs, and substance use. The data were interpreted through the theoretical framework of CBT and RCT.

Attitude Towards PrEP

People have a variety of attitudes and opinions about PrEP. Some individuals are concerned about the long-term effects of taking PrEP. Little research has been done on the long-term effects of PrEP, since it is fairly a new drug. Overall, the participants in the study had a positive attitude towards PrEP. Supporters of PrEP state that PrEP is an effective strategy used in the prevention of HIV, helps to reduce stigma in the LGBTQ community, and empowers people who use it. PrEP is viewed by some people as another layer of protection if the person is using condoms. People believe PrEP minimizes the infection rate of contracting HIV and actually serves as a harm reduction technique in HIV prevention.

Changed Sexual Behaviors

Overtime and as individuals develop through life's stages, their sexual behaviors may change as a result. People may decide to engage in riskier sexual behaviors if they have not experienced negative consequences as a result of their behaviors.

According to Rouche (1995), sexual risk taking has always existed and that it's inherent in any sexual life. An example would be syphilis, and barebacking is just another point on the continuum of risky practices (Le Talec, 2007). We have noted

that habits change as a function of each individual's life's journey, and hypothesize that unprotected sex could be a way of reinforcing one's masculinity. Being HIV positive could even be the mark of a "masculine" homosexuality, a way to be gay without the feminine stereotype. . . Gay identity is based a hierarchy of sexualities, with heterosexuality at the top, as well as on insults that equate homosexuality with a kind of feminization. (Thomas, Mience, Masson, & Bernoussi, 2014, p. 157)

Social media and social networking dating apps such as Grindr and Scruff have contributed to the change in the participants' sexual behaviors. Paul, Ayala, and Choi (2010) state:

Use of the Internet as a fast and efficient means of accessing sexual partners has grown in popularity among men who have sex with men (MSM) and has been linked with number of sexual partners, sexual risk behaviors, and sexually transmitted diseases. (p. 528)

They realize that it is a lot easier to meet people and they can arrange to meet up for a sexual encounter any time they are available. People can openly reveal in their online profiles that they are on PrEP and solicit a sexual encounter. This way a person can talk to another person online and find out what the other person wants so they can come to an agreement about their anticipated sexual encounter.

Internet –mediated sexual hook-ups enable one to negotiate such contracts in the privacy of one's homes --- perceived by our respondents as an advantage. This creates a curious paradox where one's most private space both serves as a haven and isolates one while encountering racial and ethnic prejudice. (Paul et al., 2010, p. 535)

Another finding from this study revealed that as a result of being on PrEP, people are engaging in sex more frequently, and having more partners as a result. "HIV risk disengagement

among gay men may be elicited more in public sex environments where sexual practices occur anonymously and/or spontaneity in ‘heat of the moment’ and sexual risk is often regarded as ‘permissible’” (Yi & Sandfort, 2010, p. 205). They are more open to explore sexual behaviors they would have not normally pursued prior to being on PrEP such as engaging in bareback anal sex and allowing their sexual partners to ejaculate in one another’s anus. PrEP users feel less anxious about having sex and feel as if they can be more intimate with their partners.

Communication with Partners

This study was interested in finding out if people are communicating more with their partners about their sexual histories now that they have been taking PrEP. The topic of HIV is such a controversial and socially stigmatized disease that it probably makes it difficult for people to talk about. “Among gay men in the United States, conversations about HIV are connected to discussions (or silences) about sex” (Spieldenner, 2016, p. 1694). The participants in the study revealed that being on PrEP helps to reduce the tension or stigmatization of having to discuss issues involving HIV. Many of the participants felt that they are now more open to discussions with their sexual partners about STDs and STIs and the option of using condoms during their sexual encounters.

The limits of public health knowledge and nuance about queerness could impact the uptake of PrEP. Every part of queer life --- whether identified as gay, MSM, bisexual, trans, straight, or down low --- has unique ways of communicating to sexual partners and social networks. There are shared values and common experiences that frame these groups and connections. (Spieldenner, 2016, p. 1694)

An individual will disclose personal details of their lives depending upon the type of relationship they have with the other person. “Gay males feel more comfortable talking about their sexual

encounters when it involves a stranger, but less likely to give intimate details if the sex is with your partner” (McDavitt & Mutchler, 2014, p. 492). According to McDavitt and Mutchler (2014), three main factors that could “obstruct or facilitate participant’s access to open dialogue about sex and sexual health” (p. 475) are the following:

(a) *judgmentalism* expressed toward people who engage in sexual risk behavior or have multiple sex partners, (b) *comfort or discomfort* with talking to friends about relationships or sex, and (c) *receptivity* to dialogue with friends about sexual health.

Each factor affected participants’ sexual communication scripts in unique ways.

(McDavitt & Mutchler, 2014, p. 475)

There are differences in the communication among gay men with their female straight friends versus with other gay men. Gay men tend to be competitive towards their gay male friends, or they slut shame one another in regard to their sexual behaviors. Slut shaming can obstruct further communication about sexual risk. However, when communicating with their female friends they tend to discuss details of their relationship with their partner, while minimalizing the details of their actual sexual encounters. Among conversations with their gay male friends, they will openly disclose intimate details of their sexual acts (McDavitt & Mutchler, 2014). Gay men may feel more comfortable discussing their sexual escapades in great detail with their gay friends, because they may feel as if they can relate more with one another since they may engage in the same sexual behaviors. There could also be the issue of gaining acceptance and appearing more desirable to other men, such as in a competition. Who is more popular with other men, and seen more sexually desirable?

Young gay men may have been inhibited by their own internalized stigma regarding gay male sexuality. In addition, experiencing stigma can increase one’s subjective degree of

stigma consciousness--- heightened attentiveness to prejudicial attitudes in others (Pinel, 1999). Growing up in a heterosexist context (Herek, 2000, 2009) may leave some young gay men particularly sensitive to being stigmatized by friends, and disinclined to actively challenge stigmatization of gay male sexuality. However, this self-protective tendency may also thwart efforts to educate friends and help them become more comfortable discussing a topic of special importance to the young gay men themselves. (McDavitt & Mutchler, 2014, p. 491)

A few of the participants actually believe that their communication with their sexual partners has not changed or has gotten worse since they have been on PrEP. The communication may have worsened, because people on PrEP could be less concerned about catching HIV since they have “the added protection of PrEP.” They may also assume that their sexual partners may be on PrEP too, so perhaps that is why they have decided not to use condoms. Otherwise, people then would suspect that they do not need to use condoms unless their sexual partner suggested that condoms to be used. They may believe that their partner only wants to use condoms if they are not currently taking PrEP.

Although PrEP has the potential to open up discussions about sex, it seems to be part of a way to eclipse those conversations --- as if all sex involved anal penetration, as if pleasure were bound by the presence of condoms, as if the desire to have sex is indicative of a suspect character. (Spieldenner, 2016, p. 1694)

About 96% of the people interviewed would rather have a committed trusting relationship rather than have multiple sexual partners of short-term sexual fulfillment.

Condom Usage or Other Safe Sex Practices

The participants in this study were asked if they use any methods of protection during sexual encounters prior to and after being on PrEP. They were also asked what percentage of the time they use condoms, and whether the percentage changed since they have been taking PrEP. Some people disclosed that they may choose not to use condoms, because they are allergic to latex or they prefer to the natural feeling when they are penetrating their partner(s) during a sexual encounter. The participants' responses suggest that over all their condom usage has decreased in frequency since they have been taking PrEP. Critics of PrEP argue that individuals are engaging in more condomless sex since they have been taking PrEP. According to Thomas, Mience, Masson, & Bernoussi,

The rate of condom use declines year after year while cases of unprotected sex multiply and are, for some, become a conscious choice, especially when it comes to the practice of barebacking. These new infections raise questions about attitude towards risk, risk-taking and the violation prevention messaging. However, we can't consider such questions about risky sexual behavior without taking into consideration the idea of desire and its relationship to pleasure and transgression. Knowing that the possible consequences include contracting a disease as serious as HIV/AIDS, what motivations could be behind such sexually risky behavior? (2014, p. 156)

Practically all of the 30 participants admitted that the frequency of their condom usage had decreased, since they have been on PrEP. Some of the men actually never really used condoms that much prior to being on PrEP, so now that they are on PrEP they are at least being more proactive in their sexual health in protecting themselves from contracting HIV. Prieur explains, "Sex is more than actions and positions. Actions carry meanings. Accepting semen has been an

important value in the gay culture, a way of showing devotion and belonging” (as cited in Yep, Lovaas, & Pagonis, 2002, p. 6). “Conversely, using protective measures can constitute a negative image, and refusing semen may indicate rejection and distrust” (Yep et al., 2002, p. 6). One participant recalls that if he and his partners agreed to not use condoms, he would request them not to ejaculate inside of his anus during the sexual encounter, although, on occasion when he felt an intense connection with his sexual partner, he actually asked him to ejaculate inside his anus to feel that psychological connection. He admits that now that he is on PrEP, he sometimes actually seeks out men who want to engage in bareback sex and ejaculate inside of him during sex.

According to Spieldenner (2016), “PrEP potentially represents the ambivalence of loss --- the loss of condoms in gay sex. . . Within the paradigm of ‘safer sex,’ this condomless connection is marked ‘unsafe’.” (p. 1693). Beadnell et al.’s (2005) study found that adolescents who have fewer sexual occasions with a small number of partners are more likely to use condoms more consistently. However, the individuals who have larger number of sexual incidents with only one monogamous partner tend to use condoms inconsistently. Individuals who have larger number of sexual incidents with two partners tend to use condoms inconsistently as well. In conclusion, the major risk-takers in the study were individuals who have had large numbers of sexual encounters with multiple partners while using condoms inconsistently. The data suggest that female teens have fewer partners and are less likely to use condoms during their sexual occasions. Beadnell et al. (2005) further state:

Predictable from what is known about teens was that the groups characterized by inconsistent condom use or few partners reported higher use of birth control methods other than male condoms. Members of these groups probably had greater concern

about pregnancy than disease transmission due to low perceived risk for STD acquisition (for some, because of having a steady partner). (p. 198)

Discrimination or PrEP where shaming

The stigmatization of an HIV/AIDS continues to exist due to how the disease is contracted. HIV is spread through bodily fluids such as blood, vaginal secretion, and semen. IV drug users and gay men are the highest populations at risk for contracting HIV. Some people when inquiring about their sexual partner's HIV status, ask the question "Are you clean?" Stating that a person is clean if he or she is HIV-, thus if a person has been diagnosed HIV+ one is considered "dirty". This particular question perpetuates the stigmatization of HIV. According to Grant Smith et al. (2016), "several studies have found that discrimination and internalized homophobia are associated with greater likelihood to engage in behaviors that place gay and bisexual men at higher risk for HIV" (p. 399). Grant Smith et al. also state:

Among young gay and bisexual men ages 18-22 years, those who reported engaging in condomless anal sex were less accepting of their gay identity ... Conversely, young gay and bisexual men ages 14 – 21 who reported fewer instances of condomless receptive anal sex and fewer sexual partners." (p. 399)

Many young gay men engage in risking sexual behaviors when they are in their earlier stages of developing their sexual identity. This perhaps could be a result of curiosity led by the need to feel connected and accepted. During the earlier stages of the coming out process, it is important for gay men to identify with other likeminded individuals.

PrEP usage is also often discriminated against, since PrEP is used as a protective method in decreasing the spread of HIV. "Barebacking," --- the practice of having unprotected gay anal sex --- has often been associated with contamination and an unacceptable gay identity (Thomas,

Mience, Mason, & Bernoussi, 2014; Yep et al., 2002). This tension --- the desire to have bareback sex with the social stigma associated with it --- can be mitigated through the identification of PrEP usage.” (Spieldenner, 2016, p. 1692). Critics of PrEP users suggest that people mainly want to take PrEP so they can engage in unprotected sex and have sexual encounters with multiple people. PrEP is often ridiculed as the “party pill” and its’ users are considered sluts or whores because they engage in unprotected sex with multiple partners. Spieldenner (2016) states the following:

The PrEP whore is a form of slut shaming. It insists that those who use PrEP are somehow taking a prevention shortcut, a copout from the responsible use of condoms (Associated Press, 2014). In this framework, gay men using PrEP deserve to be shunned --- socially and sexually. The irony of this construction is that gay men living with HIV are usually stigmatized as sluts. Therefore, both health outcomes --- the use of PrEP to prevent HIV acquisition and an HIV infection --- lead to the label “whore.”

In the HIV epidemic, slut shaming can be problematic, because it has a tendency to silence discussions about sex among gay men (McDavitt & Mutchler, 2014).

Gay men have had decades of promoting discussions about gay sex --- first through Gay Liberation and then through HIV prevention and activism (Dowsett, 1996:

Hayes, 1981). These conversations have been particularly important in developing community norms around sex, and communicating sex practices in a heteronormative world where young queer people are not taught the intricacies of same-sex. (p.1691)

Stigmatization and shaming are concepts identified in RCT. When we silence or shame someone we power over them and make them feel less than or ostracized. The worst punishment in the world besides death is to have an incarcerated individual in the prison system placed in

solitary confinement. The underlying message here is that the individual has been taken away from society due to “bad behavior,” but worst of all is not able to engage socially with other people who displayed “bad behavior.”

Slut shaming and stigmatization of HIV can also be exacerbated within the gay culture due to internalized homophobia. According to Yi and Sandfort (2010), “Among gay men, internalized homophobia – negative attitudes toward one’s own homosexuality and a negative self-concept as a gay man – exerts complex psychological conflicts in engaging same –sex encounters and internalized homophobia may impede avoidance of unprotected anal intercourse” (p. 205). Gay men may feel less than and different from mainstream society. They may have grown up believing cognitive distortions that people in their past perhaps de-masculinized them due to possessing feminine characteristics, or degraded them or shamed them for being attractive or engaging in sexual behaviors with the same sex. Many religions believe homosexuals are sexual deviants, and homosexuality used to be diagnosable in the *Diagnostic Statistical Manual* (DSM) as a mental health issue. Young men that are not comfortable with their sexuality may not feel comfortable advocating for the use of condoms or practicing safer sexual practices. Thomas et al. (2014) state:

Internalized homophobia appears to be an essential element of the construction of the identity among gay men. A real “coping strategy”, it allows firstly a protection from the surrounding environment, but in a second step becomes harmful to the development of healthy self-esteem. (p. 155)

Effectiveness of PrEP

The researcher wanted to find out what people on PrEP actually believe to be true about the effectiveness of PrEP in decreasing the spread of HIV. Overall, the participants agreed that

PrEP is about 90 to 100% effective and protects individuals from contracting HIV as long as the individual is compliant taking the medication on a daily basis. Some of the participants do have concerns regarding the long-term effects of being on PrEP, and if PrEP is as effective when taken with other illicit drugs and/or pharmaceutical medications.

Improved Relationship with Medical Providers

The standard guidelines required by the CDC for being on PrEP is that the individual meet with their medical provider every 3 months to get lab work done, to test for HIV, to test for STI and STDs, and to check their liver and kidneys. Like some medications, PrEP can be damaging to one's kidneys or liver. So, it is important to have these tests done every 3 months to make sure PrEP is not damaging these important organs. Most of the participants believe that their communication and relationship has improved with their medical providers, since they have been on PrEP. They have found themselves now to openly be able to discuss their sexual history with their medical providers, and they have more faith in the healthcare system. However, some of the participants had experienced difficulty finding a doctor who was knowledgeable about PrEP. They actually had to switch to a specialist doctor or a physician who specializes in working within the LGBTQ community. PrEP is becoming more easily accessible and affordable now that most insurance companies cover the medication, Truvada. Gilead, the pharmaceutical manufacturers of PrEP (Truvada) provide consumers a co-payment waiver for the medication.

Less Fear of Contracting HIV or Feelings of Safety with PrEP

It took almost a decade to finally come up with enough research to support that HIV is only contracted through blood and bodily fluids (excluding tears and saliva). Even with more

knowledge on HIV, many people still live in constant fear of contracting HIV after every sexual interaction.

Considered a modern plague, AIDS terrorized and was synonymous with physical and psychic degeneration followed by an early death. The condition of its emergence and of its evolution thus make AIDS inseparable in the public consciousness from homosexuality. It has also made it inseparable from gay identity, as HIV/AIDS overshadows sexual encounters between heterosexuals: “Has this guy got it? Will I catch it?” (Thomas et al., 2014, p. 157)

The participants realized that they take PrEP for a peace of mind, and that they can only control what they do. They cannot control what other people do, so PrEP is like a backup plan. Overall, the participants do feel as if PrEP protects them from contracting HIV, and relieves their anxiety and fear of becoming HIV+ each time they engage in condomless sex.

Sexual Satisfaction

Through this lens, we may better understand the emotional meaning that safer or unsafe sex may carry. Many feel that safer sex is detached, void of devotion, and physically less satisfying. On the other hand, many indicate that intercourse without a condom brings them closer and increases feelings of intimacy. O’Hara writes, “Feeling a man’s dick inside me, condomless – that’s when the sex becomes spiritual in its intensity.

Communion, in the truest sense. Integral to that closeness is the knowledge that he intends to leave a piece of himself inside me; his cum, like the sex itself, has a psychological value far beyond anything physical” (Yep et al., 2002, p. 6)

Many of the participants contribute their satisfaction with their sex lives due to being on PrEP, because they can feel more of a connection with their sexual partners. Being on PrEP has made

some people more communicative with their sexual partners, which has led to greater intimacy. They feel freer and have less regret after engaging in condomless bareback sex and experience less anxiety towards sex in general.

STDs or STIs

One of the main arguments against PrEP is that people on PrEP use condoms less frequently and therefore are more prone to contracting STDs or STIs. PrEP users stated that taking PrEP every day is a constant reminder that there are other STDs and STIs out there. PrEP is like a subconscious warning.

For STDs, high frequency of intercourse is a risk factor because when unprotected, it offers increased opportunities for disease transmission. Frequent change in sexual partners is also an important component of risk-taking since it exponentially increases the possibility of contacting someone who is infected. (Beadnell et al., 2005, p.193)

Even though STDs and STIs are on the rise, it appears as if individuals on PrEP are contracting STDs and STIs at about the same rate as before they were on PrEP. So if PrEP users are using condoms at a lower rate, why hasn't the rate of STDs and STIs increased? One possible explanation for this scenario could be that the CDC requires all people on PrEP to have routine testing every 3 months for HIV, STDs and STIs, and for kidney and liver damage. So, it is possible that these routine check-ups and further awareness of STDs have actually decreased the frequency of contracting an STD or STI.

Substance Use

PrEP has been coined as the “party drug” that is frequently used at sex parties and during sexual encounters along with some of these most frequently used substances: marijuana, GHB, ecstasy, molly, crystal methamphetamine, and cocaine. The present study found that the

majority of the participants' substance use did not increase or change once they started taking PrEP. However, a couple of the participants actually decreased their substance use since they have been on PrEP, because they are attempting to live healthier lifestyles. They are trying to live healthier lives by being proactive in taking care of their sexual health and decreasing their substance use. The results from the study by Gold and Skinner (1992) suggested, "for both young and older gay men in Melbourne, the consumption of alcohol or drugs is not among the factors that help convert a temptation to have unprotected intercourse in to actual behavior" (p. 1028). Are people more likely to engage in unsafe sex if they are under the influence of substances? According to Beadnell et al. (2005), the individuals who used condoms inconsistently with many partners are considered high-risk in their study. This high-risk group consisted of mostly males and were found to use more alcohol and other substances during sexual activity compared to other groups of individuals.

Implications for Further Research

This particular study on PrEP could be improved upon if the participants also consisted of straight men, straight women, bisexual women, lesbians, and transgender individuals. Unfortunately, gay men and bisexual men were the only participants in the study, so the results of the study cannot be generalized to depict other populations. One participant made the suggestion, and the researcher agreed that another question should be added to the interview that asks if people on PrEP are now more likely to engage in sexual encounters with HIV+ undetectable people.

Implications for Social Work Practice

The research literature on PrEP has progressed over the past year. A year ago, the research was focused more on the effectiveness of PrEP in stopping the spread of HIV. However,

recently more and more research is being conducted on how individuals are socially impacted by their PrEP usage. If we can gain insight into these social and psychological aspects, perhaps we can develop more effective interventions, which protect individuals from HIV and other infectious diseases while allowing them to engage in healthy and sexually satisfying behaviors. “The foundation of any efforts to change risky behaviors are communication and empowerment” (Yep et al., p. 11). PrEP users can gain a sense of empowerment by taking a stance on their health care and taking safe responsible actions for their sexual behaviors. As social workers, we can take this gained knowledge about the sexual behaviors of PrEP users and encourage our clients to improve conversations with their medical providers and sexual partners. Social Workers can teach their clients harm reduction techniques to further decrease the risk of HIV infection, such as discussing their sexual histories with their partners. Social Workers can assist clients in role playing ways to disclose their sexual histories. The results of the interviews revealed that the participants are decreasing their use of condoms by choice, so knowing this information Social Workers can go where their clients are at and create harm reduction techniques that are more compatible to their clients’ actual sexual behaviors.

As a clinician, I would want to come up with an intervention to address the issue that participants / PrEP users stated that they are more satisfied with their sex lives now that they are on PREP, because they are having lots of more intimate sexual encounters with various random men, feel free to openly engage in bareback sex, and have less fear of contracting HIV since they are currently taking PrEP. But then why when asked what they would change about their sex lives most of the participants revealed that they idealistically want just one male partner to engage in sexual relations. This is an example of cognitive dissonance which occurs because the participants thoughts are not parallel with their behaviors. Cognitive dissonance is a term used

within Cognitive Behavioral Therapy (CBT). The clinician works with the client to lessen the dissonance in that the individual's thoughts are in sync or correspond to his or her behaviors. The clinician would encourage the client to identify reasons why his or her behavior does not fit with the ultimate goal of having one sexual partner. After identifying probable reasons why, the client's promiscuous behavior does not correspond with the goal of monogamy, then the clinician and client can brainstorm possible interventions that can facilitate growth towards the client's end goal, such as in this case finding that ultimate monogamous partner. Therapeutic interventions should be used to assist the client in improving communication with their partner. Excellent communication among partners creates greater intimacy; which will eventually lead to an increase in sexual satisfaction.

This particular research study is extremely important in the field of social work and within the study of human nature, because it involves sexual behavior. Besides gaining insight into sexual behaviors, which can lead us to finding the knowledge to decrease STDs and further eradicating the spread of the HIV virus. We as humans by nature are sexual beings and sex is one of our driving forces. Sexual behavior can be the enhancement of attachment and the necessary behavior for procreation in order to create life. According to the WHO (2006) quoted in Buehler (2014):

Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (p. 40)

Buehler further states that couples have expressed this as “Sex is the time when I feel closest to my partner” or “I feel most in love with my partner after we’ve had sex” (p. 43). Sexual experiences “also activate a variety of neurochemical events that create an emotional attachment” (p. 43). Emotional attachments are what bond our relationships.

Pachankis, Rendina, Ventuneac, Grov, and Parsons (2014) state that “gay and bisexual men are significantly more likely to report maladaptive cognitions, such as low self-worth and hopelessness, across the life course than heterosexual men” (p. 769). Pachankis et al. (2014) continue:

Gay and bisexual men might experience more cognitive biases specifically about sex given their disproportionate exposure to childhood sexual abuse, minority stressors around sexual orientation, and the secrecy and shame that often surrounds an emerging gay or bisexual identity across much of early development. (p. 679)

For further social work implications, it is necessary for clinicians to work with gay and bisexual men to identify and challenge their cognitive distortions in order to create thoughts and opinions that would lead to healthier sexual practices.

Cognitive approaches in these treatments facilitate accurate appraisals of the potential consequences of a given sexual activity and foster self-efficacy for controlling one’s problematic sexual behavior. Further, treatment approaches for other behavioral excess problems (e.g., substance abuse, pathological gambling) employ cognitive restructuring techniques ranging from abstractly construing tempting stimuli (e.g., Hofmann, Deutsch, Lancaster, & Banaji, 2010) to interfering with the automatic processing of temptations (e.g., Wiers, Rinck, Kordts, Houben, & Strack, 2010). These techniques ultimately build self-efficacy for behavior change, more adaptive beliefs

about the problem behavior, and self-control (Marlatt & Gordon, 1985). An intervention that aimed to facilitate insight into self-justifications for recent unprotected anal sex among men who have sex with men yielded a 60% reduction in unprotected anal sex among recipients compared to no change among a group who received standard HIV risk-reduction counseling (Dilley et al., 2007). The results of numerous relapse prevention studies examining change cognitions about one's problematic behavior can, in fact, lead to reductions in that behavior. (Pachankis et al., 2014, p. 679)

Implications for Theory

The findings of this particular study address and support major components of CBT and RCT.

Early on, gay men learn to hide their homosexuality by hiding the signals that could give them away. Meyer and Dean (1998) propose that hostility to gays negatively shapes their self-perception and pushes them toward weak self-esteem. Seeing one's self as socially stigmatized reinforces self-hatred (Locke, 1998). The effect of stigmatization on the construction of self-identity was described by Plummer (1995) and later by Cody and Welch (1997). For gay men, the feeling of stigmatization brought by homosexuality pushes them toward negative thoughts and reinforces the feeling of alienation and exclusion. Feelings of shame and being closed off in secrecy or silence are the result. (Thomas et al., 2014, p. 158)

All humans have thoughts that are termed "automatic thoughts," because they just pop in our heads automatically. These thoughts can be negative or positive, but the negative thoughts tend to create problems for us in our development.

Gay and bisexual men are significantly more likely to report maladaptive

cognitions, such as low self-worth and hopelessness, across the life course than heterosexual men. . . . Gay and bisexual men might experience more cognitive biases specifically about sex given their disproportionate exposure to childhood sexual abuse, minority stressors around their sexual orientation, and the secrecy and shame that often surrounds an emerging gay or bisexual identity across much of early development. (Pachankis et al., 2014, p. 679)

Cognitive behavioral therapists work with clients to identify and challenge these automatic thoughts that can sometimes be considered a cognitive distortion. We humans tend to view these cognitive beliefs as absolute truths, and in all actuality, they are distorted by our interpretations. An example of a cognitive distortion could be that “all gay males are considered second class citizens and are less compared to other humans.” If a young gay man was told that exact phrase when he was younger, he may learn to believe the statement to be true.

Cognitive approaches in these treatments facilitate accurate appraisals of potential consequences of a given sexual activity and foster self-efficacy for controlling one’s problematic sexual behavior. Further, treatment approaches for other behavioral excess problems (e.g., substance abuse, pathological gambling) employ cognitive restructuring techniques ranging from abstractly construing tempting stimuli. . .to interfering with the automatic processing of temptations. . . .These techniques ultimately build self-efficacy for behavior change, more adaptive beliefs about the problem behavior, and self-control. . . .An intervention that aimed to facilitate insight into self-justifications for recent unprotected anal sex among men who have sex with men yielded a 60% reduction in unprotected anal sex among recipients compared to no change among a group who received standard HIV risk-reduction counseling. . . . The results of numerous relapse

prevention studies examining other health-risk behaviors demonstrate that interventions that change cognitions about one's problematic behavior can, in fact, lead to reductions in that behavior. (Pachankis et al., 2014, p. 679)

CBT can be an effective treatment in addressing problematic issues often encountered by gay and bisexual men.

Project PRIDE is a novel primary-HIV-prevention intervention for young gay and bisexual men. It is delivered in an engaging group format that integrates cognitive and behavioral techniques to help participants develop adaptive coping strategies and increase their safer sex skills. Although the social support aspects of the group may be helpful to decrease loneliness, in order to achieve sexual health and substance use goals, the skill-building exercises may be the most useful. The findings from the case studies suggest that Project PRIDE may reduce condomless anal sex, alcohol use, and loneliness, and may increase self-esteem. (Grant Smith et al., 2016, p. 407)

CBT is evident within this particular study on PrEP. Many of the participants were gay men and had admitted during their interviews that they experience anxiety in regard to their sexual behaviors. Their anxieties and cognitive distortions could stem from internalized homophobia or fear of catching HIV. These cognitive distortions could prevent the participants from engaging in open conversations with their sexual partners and/or their medical providers.

Many of the themes that came out of the participants' responses in the study are parallel to concepts of RCT. "RCT draws on aspects of psychodynamic and feminist theory in developing a model that emphasizes the primacy of human connection and relationships" (Jordan, 2010, p. ix). Most of the participants in the study revealed that they prefer to have more quality

relationships with their sexual partners compared to the quantity of sexual encounters.

According to Jordan, Walker, and Hartling (2004):

Connection, not self or even self-in-relation, was now (and still is) at the center of the model. . . connection is at the core of human growth and development. Isolation is seen as the primary source of human suffering. We believe that human beings grow through and toward connection. When we are hurt, misunderstood, or violated in some way, when we attempt to represent our experience to the injuring person and we are not responded to, we learn to suppress our experience and disconnect from both our own feelings and the other person. If, on the other hand, we are able to express our feelings and the other person responds with care, showing that we have had an effect, then we feel that we are effective in relationship with others, that we matter, that we can participate in creating growth-fostering and healthy relationships. Ultimately, we feel anchored in community and we experience relational competence.

(p. 2)

The participants in the study want to feel that intimate connection with their sexual partners. They are human, and they want to feel connected with others and be accepted for who they are. This desire for intimacy was evident in their responses for engaging in bareback condomless sex. This need for connection could inhibit the participants from advocating for safer sex practices, due to the fear of rejection or feeling of disconnection with their sexual partners. According to Jordan (2010):

Shame is a contributing factor to much immobilization and a major source of chronic disconnection: “In shame, one feels disconnected, that one’s being is at fault, that one is unworthy of empathic response, or that one is unlovable. Often in shame people

move out of connection, lose their sense of efficacy and lose their ability to authentically represent their experience” (Jordan, 2000, p. 1008) . . . Shaming is a powerful way to silence and isolate individuals, but it also plays a large role in silencing and disempowering marginalized groups whose members are strategically, if often invisibly, shamed in order to reinforce their isolation and thus their sub-ordination: “Isolation is the glue that holds oppression in place” (Laing, 1998, presentation). (p. 29)

As gay men, the participants are already members of a marginalized group. Perhaps that is why they are even more destined to have that connection with other gay men. The LGBTQ community can serve as the family of affinity for some individuals. Many members of this community are often scrutinized and discriminated against by their biological families, so in order to have a sense of “kinship of spirit” members of this community create their own family dynamics through friendships of likeminded individuals.

Implications for Social Policy

Social policies need to be in place in order for PrEP to continue to be an effective preventive method in decreasing HIV infections. The policy created by the CDC mandating that all individuals who are taking PrEP are required to meet with their physician every three months for routine testing for STIs/STDs, liver panel, and kidney functioning tests in order to receive a prescription of Truvada (PrEP) is needed and to be strictly reinforced in order to decrease the side effects of the medication. Furthermore, it is recommended for a policy to be in place that requires all healthcare providers during routine check-up appointments to obtain sexual history screening from all patients and mandated STD/STI testing if they are sexually active. Everyone who is sexually active is at risk for contracting HIV. Due to the wide spread use of Viagra (medication used to treat erectile dysfunction) and more senior adults living longer; there has

been an increase in STDs/STIs in the elderly populations. The older generations are becoming more sexually promiscuous and are prone to engage in condomless sex because they are no longer at risk for pregnancies. However, they are now at a greater risk for contracting HIV or other STDs/STIs. If these policies are in place, they will help to promote individuals engaging in healthy sexual behaviors as a harm reduction alternative to having condomless sex.

Strengths of PrEP Study

The main strength or benefit of the study is that it helps the reader learn about how sexual behaviors have changed due to PrEP usage. PrEP has proven in many accounts that it could possibly be an effective approach to stop the spread of HIV. Therefore, with this knowledge we can create and develop interventions that can further protect its users since we have gained insight into their sexual behaviors. The data suggest that people are choosing to not use condoms, because they are feeling protected by just taking PrEP. This study has informed us of the communication that is occurring with PrEP users and their sexual partners and/or medical providers. Improved communication will lead to more individuals making informed and healthy decisions towards their physical, mental, and sexual health.

Limitations of PrEP Study

The main limitation of the study was that it was a qualitative study consisting of 30 interviews. The findings cannot necessarily be generalized to the general public. Unfortunately, due to limitations and resources it was not practical to conduct more than 30 qualitative approximately hour-long interviews. The researcher attempted to diversify the participants by race, socioeconomic status, geographical region, and age. The study was open to various genders and sexual orientations or preferences; however, all the participants in the study identified as all gay, queer, or bisexual males. There were no females, no heterosexual males,

nor transgender participants involved. The participants were all from larger cities in which there are many people to interact. For example, if the participants were from smaller communities, they may not have the opportunity to be as promiscuous since their options of sexual partners are limited.

However, the study allowed the reader to gain insight in how sexual behaviors have changed due to the usage of PrEP. This gained knowledge could possibly lead to further development of efficient preventive interventions that can decrease risky sexual behaviors through a harm reduction approach and with future HIV infections. This knowledge is only representation of a select few individuals that agreed to participate in the study, and the information gathered cannot be held accountable for a majority representation of the general population.

The participants were very comfortable and open about discussing their sexual and substance use histories. However, their responses may not be a good generalization of other individuals who take PrEP that are not as open about talking about intimate details of their lives. Furthermore, the researcher was a gay man so the participants may feel less judged and be more likely to openly discuss their sexual histories. Furthermore, in fear of judgement, the participants may have downplayed their use of substances and/or the number of sexual partners or STI/ STD histories.

Conclusion

In conclusion, the study revealed that a majority of the participants believe PrEP is an effective method in the prevention of HIV. Their sexual behaviors have changed in a variety of ways due to PrEP usage. It is safe to conclude that most of the participants in the study admit to being more promiscuous and having sex with numerous partners as a result of feeling safer and

less fearful of catching HIV. The gay men in the study are definitely using condoms at a lesser rate or not at all now than compared to before they were taking PrEP. They believe being on PrEP has improved their communication with their health care providers and has changed their communication with their sexual partners. On one level, being on PrEP has encouraged some participants to openly discuss their sexual history with their partners and they are more open to discuss their sexual interests. However, in opposition, some participants disclosed that being on PrEP has actually caused them to be less communicative with their sexual partners. Some participants assume that since they are on PrEP they are at least protecting themselves. So they do not necessarily care about their sexual partners' sexual histories, so they do not even think to engage their sexual partners into the discussion. In regard to STDs and STIs, if the person had an STD or STI before being on PrEP, he or she either had an STD or STI after being on PrEP or have not been diagnosed with one thus far. PrEP has not influenced participants to use substances more frequently. All 30 of the participants agreed that they are using the same substances and at the same frequency before and after being on PrEP. According to Yep et al. (2002), "a majority of men in the study by Aspinwall and associates agreed with the statement, "It is hard to change my sexual behavior because being gay means doing what I want sexually" (p. 7).

APPENDICES

APPENDIX A

Letters of Agreement from Subject Settings

Michael Kaltenbach, DSW Student, LCSW

**University of Pennsylvania
The Philadelphia Building
1315 Walnut Street, Suite 1003
Philadelphia, PA 19107**

**566 S. San Vicente, Suite 103
Los Angeles, CA 90048**

June 1, 2016

***MAZZONI CENTER FAMILY AND
COMMUNITY MEDICINE***

809 Locust Street, Philadelphia, PA 19107
(215) 563-0658
vcanavin@mazzonicenter.org

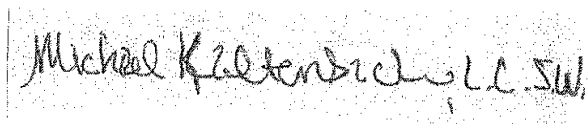
Re: Research study on PrEP

Dear Valerie Canavin, Office Manager:

Hope you are doing well. I would like to start off by introducing myself. I am a doctoral student at the School of Social Policy and Practice at the University of Pennsylvania. I am planning to conduct a qualitative research study on PrEP, as a preventive method for the spread of HIV, for my dissertation research. I will obtain the approval of the study from the IRB through the University. I am requesting your permission to display the attached participant recruitment flyer in the waiting room of your organization. I will be conducting interviews for the study with the participants in my private practice office located in Philadelphia and/or Los Angeles if feasible. Otherwise, I will be conducting the interviews in a closed office space where privacy and confidentiality can be respected.

Thank you for allowing your patients/clients the opportunity to be a part of my research. I look forward to meeting with you once the study has been completed to share the research results.

Sincerely yours,



Michael Kaltenbach, DSW Student, LCSW
mkalt@sp2.upenn.edu
(323) 646-1139

Michael Kaltenbach, DSW Student, LCSW
University of Pennsylvania
The Philadelphia Building
1315 Walnut Street, Suite 1003 **566 S. San Vicente, Suite 103**
Philadelphia, PA 19107 **Los Angeles, CA 90048**

June 1, 2016

***THE LESBIAN, GAY, BISEXUAL, & TRANSGENDER COMMUNITY
CENTER***

208 W. 13th Street, New York, NY 10011
(212) 620-7310
info@gaycenter.org

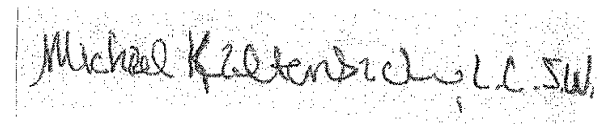
Re: Research study on PrEP

Dear Levi Butcher, Patient Liaison:

Hope you are doing well. I would like to start off by introducing myself. I am a doctoral student at the School of Social Policy and Practice at the University of Pennsylvania. I am planning to conduct a qualitative research study on PrEP, as a preventive method for the spread of HIV, for my dissertation research. I will obtain the approval of the study from the IRB through the University. I am requesting your permission to display the attached participant recruitment flyer in the waiting room of your organization. I will be conducting interviews for the study with the participants in my private practice office located in Philadelphia and/or Los Angeles if feasible. Otherwise, I will be conducting the interviews in a closed office space where privacy and confidentiality can be respected.

Thank you for allowing your patients/clients the opportunity to be a part of my research. I look forward to meeting with you once the study has been completed to share the research results.

Sincerely yours,

A handwritten signature in black ink that reads "Michael Kaltenbach, LCSW". The signature is written in a cursive style and is positioned above a horizontal line.

Michael Kaltenbach, DSW Student, LCSW
mkalt@sp2.upenn.edu
(323) 646-1139

Michael Kaltenbach, DSW Student, LCSW
University of Pennsylvania
The Philadelphia Building
1315 Walnut Street, Suite 1003 **566 S. San Vicente, Suite 103**
Philadelphia, PA 19107 **Los Angeles, CA 90048**

June 1, 2016

THE THRIVE TRIBE
<https://www.thethrivetribe.org>
West Hollywood, CA 90069

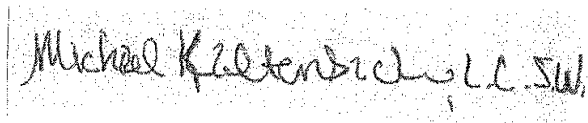
Re: Research study on PrEP

Dear Kevin James, Board of Director:

Hope you are doing well. I would like to start off by introducing myself. I am a doctoral student at the School of Social Policy and Practice at the University of Pennsylvania. I am planning to conduct a qualitative research study on PrEP, as a preventive method for the spread of HIV, for my dissertation research. I will obtain the approval of the study from the IRB through the University. I am requesting your permission to post the attached recruitment flyer on your organization's website or Facebook page. I will be conducting interviews for the study with the participants in my private practice office located in Philadelphia and/or Los Angeles if feasible. Otherwise, I will be conducting the interviews in a closed office space where privacy and confidentiality can be respected.

Thank you for allowing your patients/clients the opportunity to be a part of my research. I look forward to meeting with you once the study has been completed to share the research results.

Sincerely yours,

A handwritten signature in black ink that reads "Michael Kaltenbach, LCSW". The signature is written in a cursive style and is positioned above a horizontal line.

Michael Kaltenbach, DSW Student, LCSW
mkalt@sp2.upenn.edu
(323) 646-1139

Michael Kaltenbach, DSW Student, LCSW
University of Pennsylvania
The Philadelphia Building
1315 Walnut Street, Suite 1003 **566 S. San Vicente, Suite 103**
Philadelphia, PA 19107 **Los Angeles, CA 90048**

June 1, 2016

IMPAC + Philly

Philadelphia, PA 19107

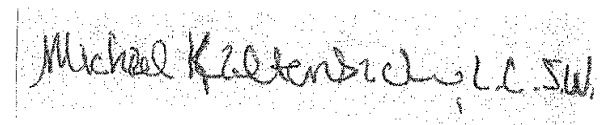
Re: Research study on PrEP

Dear Vishnu Om, Board of Director:

Hope you are doing well. I would like to start off by introducing myself. I am a doctoral student at the School of Social Policy and Practice at the University of Pennsylvania. I am planning to conduct a qualitative research study on PrEP, as a preventive method for the spread of HIV, for my dissertation research. I will obtain the approval of the study from the IRB through the University. I am requesting your permission to post the attached recruitment flyer on your organization's website or Facebook page. I will be conducting interviews for the study with the participants in my private practice office located in Philadelphia and/or Los Angeles if feasible. Otherwise, I will be conducting the interviews in a closed office space where privacy and confidentiality can be respected.

Thank you for allowing your patients/clients the opportunity to be a part of my research. I look forward to meeting with you once the study has been completed to share the research results.

Sincerely yours,

A handwritten signature in black ink that reads "Michael Kaltenbach, LCSW". The signature is written in a cursive style and is positioned above a horizontal line.

Michael Kaltenbach, DSW Student, LCSW
mkalt@sp2.upenn.edu
(323) 646-1139

Michael Kaltenbach, DSW Student, LCSW
University of Pennsylvania
The Philadelphia Building
1315 Walnut Street, Suite 1003 **566 S. San Vicente, Suite 103**
Philadelphia, PA 19107 **Los Angeles, CA 90048**

June 1, 2016

L.A. LESBIAN, GAY, BISEXUAL, AND TRANSGENDER CENTER

1625 Schrader Blvd.
Los Angeles, CA 90028
(323) 993-7400
gdiaz@LALGBTCenter.org

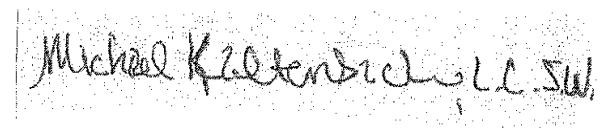
Re: Research study on PrEP

Dear Gil Diaz, Communications Manager:

Hope you are doing well. I would like to start off by introducing myself. I am a doctoral student at the School of Social Policy and Practice at the University of Pennsylvania. I am planning to conduct a qualitative research study on PrEP for my dissertation research. I will obtain the approval of the study from the IRB through the University. I am requesting your permission to display the attached participant recruitment flyer in the waiting room of your organization. I will be conducting interviews for the study with the participants in my private practice office located in Philadelphia and/or Los Angeles if feasible. Otherwise, I will be conducting the interviews in a closed office space where privacy and confidentiality can be respected.

Thank you for allowing your patients/clients the opportunity to be a part of my research. I look forward to meeting with you once the study has been completed to share the research results.

Sincerely yours,

A handwritten signature in black ink that reads "Michael Kaltenbach, LCSW". The signature is written in a cursive style and is positioned above a horizontal line.

Michael Kaltenbach, DSW Student, LCSW
mkalt@sp2.upenn.edu
(323) 646-1139

Version - 31 May 2016

July 14, 2016

THE THRIVE TRIBE
<https://www.thethrivetribe.org>
West Hollywood, CA 90069

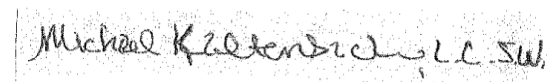
Re: Research study on PrEP

Dear Orren Michael Plaut, Board of Director:

Hope you are doing well. I would like to start off by introducing myself. I am a doctoral student at the School of Social Policy and Practice at the University of Pennsylvania. I am planning to conduct a qualitative research study on PrEP, as a preventive method for the spread of HIV, for my dissertation research. I will obtain the approval of the study from the IRB through the University. I am requesting your permission to post the attached recruitment flyer on your organization's website or Facebook page. I will be conducting interviews for the study with the participants in my private practice office located in Philadelphia and/or Los Angeles if feasible. Otherwise, I will be conducting the interviews in a closed office space where privacy and confidentiality can be respected.

I previously obtained the permission of Kevin James when he was the Board of Director; however, since he is no longer the Director I wanted to get your permission to post the flyer. Thank you for allowing your patients/clients/members the opportunity to be a part of my research. I look forward to meeting with you once the study has been completed to share the research results.

Sincerely yours,

A handwritten signature in black ink that reads "Michael Kaltenbach, LCSW". The signature is written in a cursive style and is positioned above a horizontal line.

Michael Kaltenbach, DSW Student, LCSW
mkalt@sp2.upenn.edu
(323) 646-1139

Michael Kaltenbach, DSW Student, LCSW
University of Pennsylvania
The Philadelphia Building
1315 Walnut Street, Suite 1003 **566 S. San Vicente, Suite 103**
Philadelphia, PA 19107 **Los Angeles, CA 90048**

June 1, 2016

www.PrEP Facts: Rethinking HIV Prevention and Sex

New York City, NY

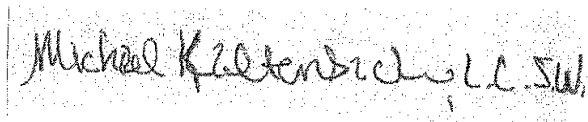
Re: Research study on PrEP

Dear Damon L. Jacobs, Creator:

Hope you are doing well. I would like to start off by introducing myself. I am a doctoral student at the School of Social Policy and Practice at the University of Pennsylvania. I am planning to conduct a qualitative research study on PrEP, as a preventive method for the spread of HIV, for my dissertation research. I will obtain the approval of the study from the IRB through the University. I am requesting your permission to post the attached recruitment flyer on your organization's website or Facebook page. I will be conducting interviews for the study with the participants in my private practice office located in Philadelphia and/or Los Angeles if feasible. Otherwise, I will be conducting the interviews in a closed office space where privacy and confidentiality can be respected.

Thank you for allowing your patients/clients the opportunity to be a part of my research. I look forward to meeting with you once the study has been completed to share the research results.

Sincerely yours,

A handwritten signature in black ink that reads "Michael Kaltenbach, LCSW". The signature is written in a cursive style and is positioned above a horizontal line.

Michael Kaltenbach, DSW Student, LCSW
mkalt@sp2.upenn.edu
(323) 646-1139

APPENDIX B

University of Pennsylvania IRB Approval Letter

University of Pennsylvania
Office of Regulatory Affairs
3624 Market St., Suite 301 S
Philadelphia, PA 19104-6006
Ph: 215-573-2540/ Fax: 215-573-9438
INSTITUTIONAL REVIEW BOARD
(Federalwide Assurance # 00004028)

13-Dec-2016

Toorjo Ghose
toorjo@sp2.upenn.edu

Attn: Michael Kaltenbach
mkalb@sp2.upenn.edu

PRINCIPAL INVESTIGATOR : Toorjo Ghose
TITLE : Qualitative Research Study: Changes In Sexual Behaviors Due To The Utilization Of PrEP
As A Preventive Method For The Transmission OF HIV
SPONSORING AGENCY : No Sponsor Number
PROTOCOL # : 826453
REVIEW BOARD : IRB #8

Dear Dr. Ghose:

The above referenced protocol was reviewed and approved using the expedited procedure set forth in 45 CFR 46.110, category 7, on 12-Dec-2016. This study will be due for continuing review on or before 11-Dec-2017.

Approval by the IRB does not necessarily constitute authorization to initiate the conduct of a human subject research study. Principal investigators are responsible for assuring final approval from other applicable school, department, center or institute review committee(s) or boards has been obtained. If any of these committees require changes to the IRB-approved protocol and informed consent/assent document(s), the changes must be submitted to and approved by the IRB prior to beginning the research study.

If this protocol involves cancer research with human subjects, biospecimens, or data, you may not begin the research until you have obtained approval or proof of exemption from the Cancer Center's Clinical Trials Review and Monitoring Committee.

The following documents were included in this review:

- HS-ERA Initial Application (confirmation code ccgbjgba), submitted 12/09/16
- Cover Letter, dated 11/02/16
- Informed Consent Document, version dated 05/31/16
- Semi-structured Qualitative Interview Questions on PrEP, uploaded 11/01/16
- Community Center Recruitment Letters, uploaded 10/11/16
- Recruitment Flyer, uploaded 12/02/16

The IRB reviewed and approved a waiver of written documentation of consent as per HHS 45 CFR 46.117(c)(2) or FDA 21 CFR 56.109(c)(1): That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context (e.g. Telephone survey).

When enrolling subjects at a site covered by the University of Pennsylvania's IRB, a copy of the IRB approved informed consent form with the IRB approved from/to stamp must be used unless a waiver of written documentation of consent has been granted.

If you have any questions about the information in this letter, please contact the IRB administrative staff. Contact information is available at our website: <http://www.upenn.edu/IRB/directory>

Thank you for your cooperation.

Sincerely,

Amanda
O'Hara

Digitally signed by Amanda
O'Hara
Reason: I attest to the accuracy
and integrity of this document
Date: 2016.12.13 13:18:15 -0500

IRB Administrator

APPENDIX C

University of Pennsylvania Informed Consent Form

University of Pennsylvania Informed Consent Form

Title of the Research Study: Qualitative Research Study: Changes In Sexual Behaviors Due To The Utilization Of PrEP As A Preventive Method For The Transmission Of HIV Among 15 Participants In The Areas Of: Philadelphia, New York City, and Los Angeles. Protocol Number: 826453

Principal Investigator: Michael Kaltenbach, DSW Student, LCSW

The Philadelphia Building 1315 Walnut Street, Suite 1003

Philadelphia, PA 19107

(323) 6461139

mkalt@sp2.upenn.edu

Co-investigator: Dr. Toorjo Ghose

School of Social Policy & Practice, University of Pennsylvania

(310) 902-7277

toorjo@sp2.upenn.edu / tighose@gmail.com

Emergency Contact: Dr. Lina Hartocollis

School of Social Policy & Practice, Univ. of Pennsylvania

(215) 898-5503

lhartoco@sp2.upenn.edu

You are being asked to take part in a research study. This is not a form of treatment or therapy. It is not supposed to detect a disease or find something wrong. Your participation is voluntary which means you can choose whether or not to participate. If you decide to participate or not to participate there will be no loss of benefits to which you are otherwise entitled. Before you make a decision, you will need to know the purpose of the study, the possible risks and benefits of being in the study and what you will have to do if decide to participate. The research team is going to talk with you about the study and give you this consent document to read. You do not have to make a decision now; you can take the consent document home and share it with friends, family doctor and family.

If you do not understand what you are reading, do not sign it. Please ask the researcher to explain anything you do not understand, including any language contained in this form. If you decide to participate, you will be asked to sign this form and a copy will be given to you. Keep this form, in it you will find contact information and answers to questions about the study. You may ask to have this form read to you.

What is the purpose of the study?

I plan to conduct a qualitative research study on PrEP (Pre-exposure Prophylaxis) for my dissertation research in pursuit of the Doctoral Social Work Degree through the School of Social

Policy & Practice at the University of Pennsylvania. The purpose of the study is to learn more about how sexual behaviors have changed due to PrEP usage as a preventive method for HIV.

Why was I asked to participate in the study?

You are being asked to join this study because from your response to the study participation inquiry you currently have been prescribed PrEP as a HIV preventive method, and have been taking the medication (Truvada) for at least the past thirty days. The researcher is interested in conducting a qualitative research study to learn about the sexual behaviors of the participants after being prescribed PrEP.

How long will I be in the study?

The study will take place over a period of approximately three months. This means for some time during the next three months we will ask you to spend one day for approximately 60 to 90 minutes participating in this study. The actual time will be determined by how long it takes for you, the participant, to verbally respond to the interview questions provided.

There will be at least a total of 15 participants enrolled into the study from the following geographical areas: Philadelphia, New York City, and Los Angeles.

Where will the study take place?

You will be asked at the scheduled time to come to the closest private practice office listed below, located at:

The Philadelphia Building
1315 Walnut Street, Suite 1003
Philadelphia, PA 19107

566 S. San Vicente, Suite 103
Los Angeles, CA 90048

* A conveniently located private practice office space in New York City will be determined once participants start to schedule an interview time with the researcher.

What will I be asked to do?

Participants are required to verbally respond to around thirty mostly open-ended questions that are communicated by the researcher during the interview process. The interview will be held during a one-time scheduled appointment in a secluded private practice office. The interview responses to the questions asked will be audiotaped and erased once the information has been transcribed verbatim by the researcher or research team.

What are the risks?

The safety and confidentiality of human subjects is extremely important, and their rights as participants needs to be addressed. Prior to participation in the study, the researcher will obtain written consent from participants stating that their participation is voluntary and not coerced in any manner. The participant will be informed that they can withdraw from the study at any time. The researcher will provide the following information to the participant: a clear statement of the study and the purpose of the study, any risks or potential risks that is anticipated, and describes

any benefits for participating in the study. The participants in this study are at a potential low risk for physical, psychological, social, legal, or other harm since their only participation requirement is to respond to questions provided by the researcher in an interview format. A research facilitator will be available to debrief and provide brief counseling if the participant had been even the slightest bit affected psychologically while completing the qualitative interview.

How will I benefit from the study?

There is no benefit to you. However, your participation could help us understand how sexual behaviors have changed due to PrEP usage, which can benefit you indirectly. In the future, this may help other people to learn how to practice preventive methods from the transmission of HIV and other sexually transmitted infections. Perhaps this study will help to improve the sexual health of a larger population.

What other choices do I have?

Your alternative to being in the study is to not be in the study.

Participants will be informed by the researcher of any acknowledgement of any additional alternative treatments are made available. There really is not any alternative treatment other than PrEP at this time, except other safe sex practices such as condom usage. Literature on condom usage and safe sex practices will be available to the participants if needed.

What happens if I do not choose to join the research study?

You may choose to join the study or you may choose not to join the study. Your participation is voluntary.

There is no penalty if you choose not to join the research study. You will lose no benefits or advantages that are now coming to you, or would come to you in the future. Your therapist, social worker, nurse, doctor or will not be upset with your decision.

If you are currently receiving services and you choose not to volunteer in the research study, your services will continue.

When is the study over? Can I leave the study before it ends?

The study is expected to end after all participants have completed all interviews and all the information has been collected. The study may be stopped without your consent for the following reasons:

- The PI feels it is best for your safety and/or health-you will be informed of the reasons why.
- You have not followed the study instructions
- The PI, the sponsor or the Office of Regulatory Affairs at the University of Pennsylvania can stop the study anytime

You have the right to drop out of the research study at any time during your participation. There is no penalty or loss of benefits to which you are otherwise entitled if you decide to do so. Withdrawal will not interfere with your future care.

If you no longer wish to be in the research study, please contact Michael Kaltenbach, at (323) 646-1139 to inform him of your decision.

How will confidentiality be maintained and my privacy be protected?

We will do our best to make sure that the personal information obtained during the course of this research study will be kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

Breach of confidentiality is the biggest legal risk involved in the study, and the research team will do everything in his or her power to protect each participant's confidentiality in the study. The participant will be given a number to identify them while they participate in the qualitative interview with the researcher. The participants will be informed of the confidentiality of the study and how their actual personal responses from the interview will only be seen by the researcher and involved parties. Once the participant is assigned a participant number their contact information such as first name and contact phone number will be deleted from the researcher's subject list. This information was previously gathered for the sole purpose of recruitment and to schedule the interview time for participation in the research study. Besides the actual researcher, the IRB at the University of Pennsylvania will have access to the records.

Electronic Medical Records and Research Results

What is an Electronic Medical Record?

An Electronic Medical Record (EMR) is an electronic version of the record of your care within a health system. An EMR is simply a computerized version of a paper medical record.

If you are receiving care or have received care within the University of Pennsylvania Health System (UPHS) (outpatient or inpatient) and are participating in a University of Pennsylvania research study, results of research-related procedures (i.e. laboratory tests, imaging studies and clinical procedures) may be placed in your existing EMR maintained by UPHS.

If you have never received care within UPHS and are participating in a University of Pennsylvania research study that uses UPHS services, an EMR will be created for you for the purpose of maintaining any results of procedures performed as part of this research study. The creation of this EMR is required for your participation in this study. In order to create your EMR, the study team will need to obtain basic information about you that would be similar to the information you would provide the first time you visit a hospital or medical facility (i.e. your name, the name of your primary doctor, the type of insurance you have). Results of research procedures performed as part of your participation in the study (i.e. laboratory tests, imaging studies and clinical procedures) may be placed in this EMR.

Once placed in your EMR, these results are accessible to appropriate UPHS workforce members that are not part of the research team. Information within your EMR may also be shared with others who are determined by UPHS to be appropriate to have access to your EMR (e.g. health insurance company, disability provider, etc).

What happens if I am injured from being in the study?

We will offer you the care needed to treat injuries directly resulting from taking part in this research. We may bill your insurance company or other third parties, if appropriate, for the costs of the care you get for the injury, but you may also be responsible for some of them.

There are no plans for the University of Pennsylvania to pay you or give you other compensation for the injury. You do not give up your legal rights by signing this form.

If you think you have been injured as a result of taking part in this research study, tell the person in charge of the research study as soon as possible. The researcher's name and phone number are listed in the consent form.

Will I have to pay for anything?

There is no monetary cost to participate in the study. For your participation, \$5.00 dollars will be provided for you to cover any transportation costs you may have occurred to get to the interview appointment.

Will I be paid for being in this study?

The researcher will inform the participants that the money earned from their participation is strictly a benefit and not an incentive for their participation.

Once the participant completely responds to all of the questions asked by the researcher, the participant will be given \$10.00 for compensation for their time and their participation in the study. Transportation costs in the amount of \$5.00 will also be provided for the participants. So, the total compensation amount for participation will be \$15.00.

Who can I call with questions, complaints or if I'm concerned about my rights as a research subject?

If you have questions, concerns or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you should speak with the Principal Investigator listed on page one of this form. If a member of the research team cannot be reached or you want to talk to someone other than those working on the study, you may contact the Office of Regulatory Affairs with any question, concerns or complaints at the University of Pennsylvania by calling (215) 898-2614.

When you sign this document, you are agreeing to take part in this research study. If you have any questions or there is something you do not understand, please ask. You will receive a copy of this consent document.

Signature of Subject _____

Print Name of Subject _____

Date _____

APPENDIX D

Informed Consent and HIPAA Authorization Form

Informed Consent and HIPAA Authorization Form

What information about me may be collected, used, or shared with others?

You will be assigned a subject number to protect your confidentiality. The following demographic information will be collected from you such as:

- Gender
- City of Residence, Age
- Educational Level
- Race or Ethnicity
- Relationship Status (*If in a relationship, the HIV status of your partner?*)

Along with the demographic information, your responses to the qualitative interview questions will be audio recorded and then transcribed in written form. The audio tape will be erased and deleted once your responses have been completely transcribed by the researcher. This will further provide the confidentiality of your voice. Your written transcribed responses will serve as part of the data that will be analyzed in the research study.

Why is my information being used?

Your information is used by the research team to contact you during the study. Your information and results of tests and procedures are used to:

- do the research
- oversee the research
- to see if the research was done right.

Who may use and share information about me?

The following individuals may use or share your information for this research study at the University of Pennsylvania.

- Michael Kaltenbach, DSW Student, LCSW --- The investigator for the study and the study team
- Dr. Toorjo (T.J.) Ghose, Associate Professor, School of Social Policy & Practice, University of Pennsylvania --- Dissertations Chair and the dissertation committee
- Dr. Lina Hartocollis, Dean of Students / Director of DSW Program at University of Pennsylvania

Who, outside of the School of Medicine and the School of Social Policy & Practice at the University of Pennsylvania, might receive my information?

- * Staff at Transcribe Me will be part of the research team used to transcribe the information collected from the interviews. However, they will not receive any identifying information except for the actual audio recording of the interview.

Oversight organizations

- University of Pennsylvania IRB Committee
- The Office of Human Research Protections

Once your personal health information is disclosed to others outside the School of Medicine, it may no longer be covered by federal privacy protection regulations.

Version - 31 May 2016

Version - 31 May 2016

The Principal Investigator or study staff will inform you if there are any additions to the list above during your active participation in the trial. Any additions will be subject to University of Pennsylvania procedures developed to protect your privacy.

How long may the School of Medicine use or disclose my personal health information?

Your authorization for use of your personal health information for this specific study does not expire.

Your information may be held in a research database. However, the School of Medicine may not re-use or re-disclose information collected in this study for a purpose other than this study unless:

- You have given written authorization
- The University of Pennsylvania's Institutional Review Board grants permission
- As permitted by law

Can I change my mind about giving permission for use of my information?

Yes. You may withdraw or take away your permission to use and disclose your health information at any time. You do this by sending written notice to the investigator for the study. If you withdraw your permission, you will not be able to stay in this study.

What if I decide not to give permission to use and give out my health information?

Then you will not be able to be in this research study.

You will be given a copy of this Research Subject HIPAA Authorization describing your confidentiality and privacy rights for this study.

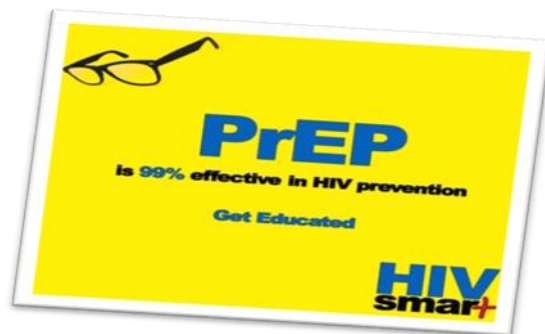
By signing this document, you are permitting the School of Medicine to use and disclose personal health information collected about you for research purposes as described above.

APPENDIX E

Participant Recruitment Flyer

Requesting participants in a research study on PrEP. Are you or someone you know currently prescribed PrEP?

If so, please contact me if you know of someone who is interested in participating in a one-time, approximately 60- to 90-minute interview about their thoughts and experiences of being on PrEP. The purpose of the research study is to gain insight on PrEP as a method of HIV prevention. The qualitative study is in conjunction with the University of Pennsylvania's DSW program at the School of Social Policy and Practice.



For more information contact:
Michael Kaltenbach, LCSW
mkalt@sp2.upenn.edu
(323) 646-1139

Your time and participation are greatly appreciated. Your participation will require that you be available within the Los Angeles, New York City, or Philadelphia areas. Compensation in the total amount of \$15.00 will be given for your time and participation.

APPENDIX F

Face-Sheet Data

Qualitative In-Depth Interview

Face-Sheet Data

Gathered the demographic information from each participant and explained the information in English as the common language in layperson terms.

1. Given subject number
2. Gender (as identified by the participant)

Sexual preference / orientation

3. City of Residence
4. Age
5. Educational Level
6. Race or Ethnicity (in the participant's own words)
7. Relationship Status

If in a relationship, the HIV status of your partner?

8. Substance Use

How often and at what amount(s) do you use the following substances?

Cigarettes, Alcohol, Marijuana, Cocaine, Methamphetamine, Heroin, and/or any other substances that have not been mentioned.

9. Annual Income

Qualitative In-depth Interview

1. Tell me about your attitudes towards PrEP.
2. Why did you personally decide to start taking PrEP?
3. How did you first hear of PrEP?
4. How long have you been taking PrEP?

5. Has being on PrEP improved your relationship and faith in the healthcare system?
How difficult is it for you to obtain PrEP? Please explain?
6. What are your attitudes towards PrEP? For example, how effective do you think PrEP is from stopping the spread of HIV?
Without PrEP do you think you were at risk for contracting HIV due to your sexual behaviors? Explain?
7. How has access to the internet and social media apps. changed or impacted your social interactions or sexual behaviors?
8. What are some of the reasons why you think people are taking PrEP? Or in your opinion, what are some of the benefits of taking PrEP?
9. How do you think your sexual behaviors have changed comparing your sexual behaviors prior to being prescribed PrEP and afterwards while you are on PrEP?
Please explain.
10. Tell me about how you have sex now that you are using PrEP?
How often do you engage in sexual activity?
11. Do you think you engage in sexual activity more frequently now that you are taking PrEP?
12. Tell me about how and when you use condoms and other methods of protection.
Before and after starting PrEP?
Do you still use these methods of protection now that you are on PrEP?
What percentage of the time do you use condoms? Has that percentage changed since you have been taking PrEP?

13. Tell me about how PrEP has affected the way you have sex. What about decisions around safety?

Do you ever engage in “raw”/”condomless”/”bareback” sex? Vaginal sex? Anal sex? If anal sex, do you receive (receptive “bottom”) or give (insertive “top”)? Versatile?

If you do engage in “condomless” sex, do you or your partner ever ejaculate inside the other person’s / persons’ anus or vagina during a sexual encounter? Has this behavior changed due to the use of PrEP? Why or why not?

Do you have a fear of catching HIV?

Have you ever had an STD / infection prior to being on PrEP? What type of disease if so? Have you ever been diagnosed with an STD / infection after being prescribed PrEP?

Since you have been prescribed PrEP, do you think you engage in more risky sexual behaviors? If so in what ways? Do you discuss your sexual history with each partner prior to engaging in a sexual encounter?

Do you think people taking PrEP are having group sex more frequently and/or having multiple partners as a result? In the past 30 days, what is the frequency and the amount of use of each of the following substances: erectile dysfunction medication (Viagra), psychotropic medication, alcohol, marijuana, methamphetamine, cocaine, PCP, ecstasy, heroin, pain medications, and / or any other substance not mentioned. Has your use of substances changed since you have been prescribed PrEP?

How many sex partners have you had in the past week? Past 30 days? Past 6 months?

Prior to being on PrEP, on an average how many people did you have sex with during a year time span?

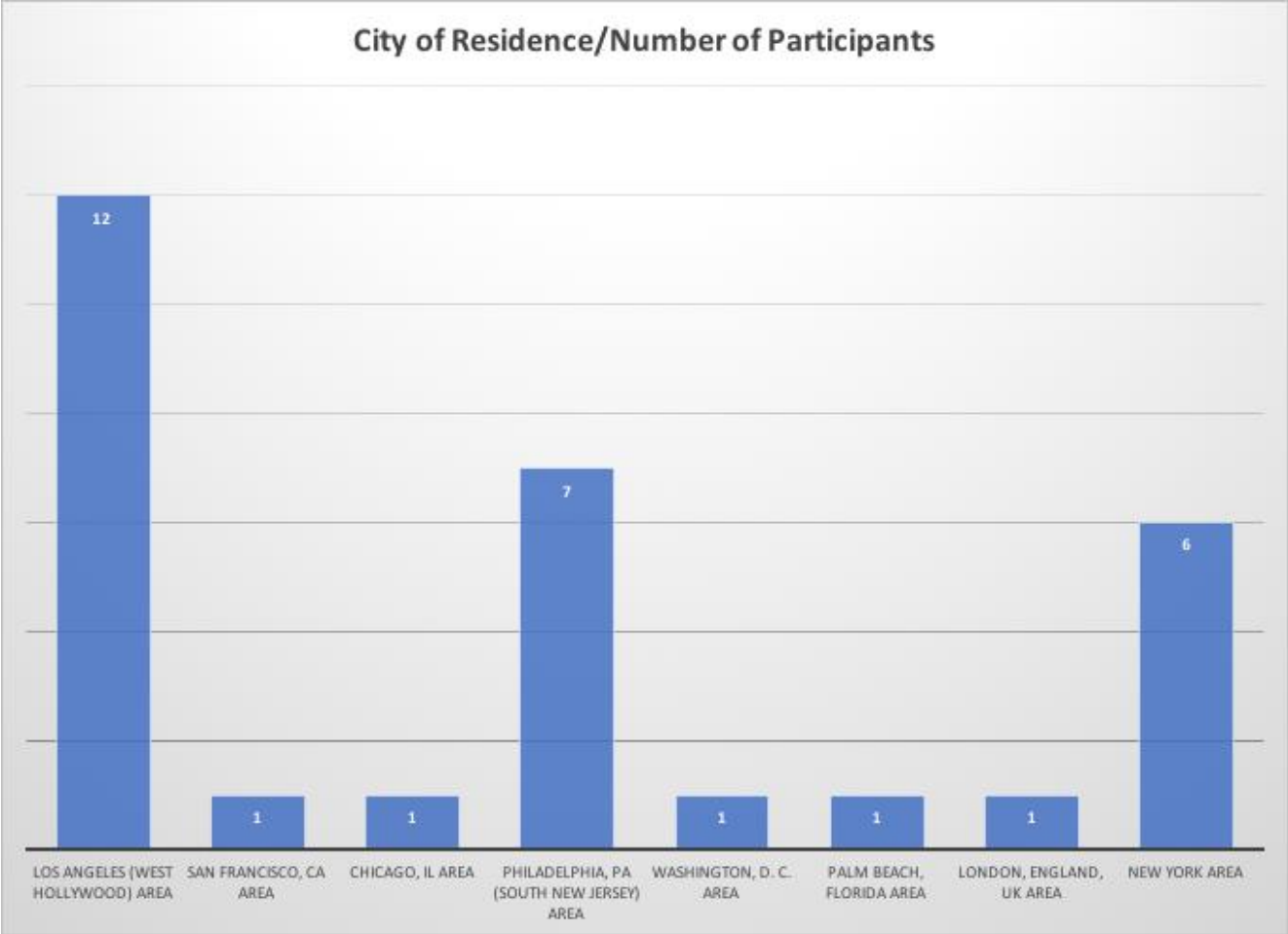
How many individuals have you engaged in anal sex with in the past three months?

What is the number of sexual encounters with in the past 3 months that you or your sexual partner has been under the influence of drugs or alcohol? What substances were used?

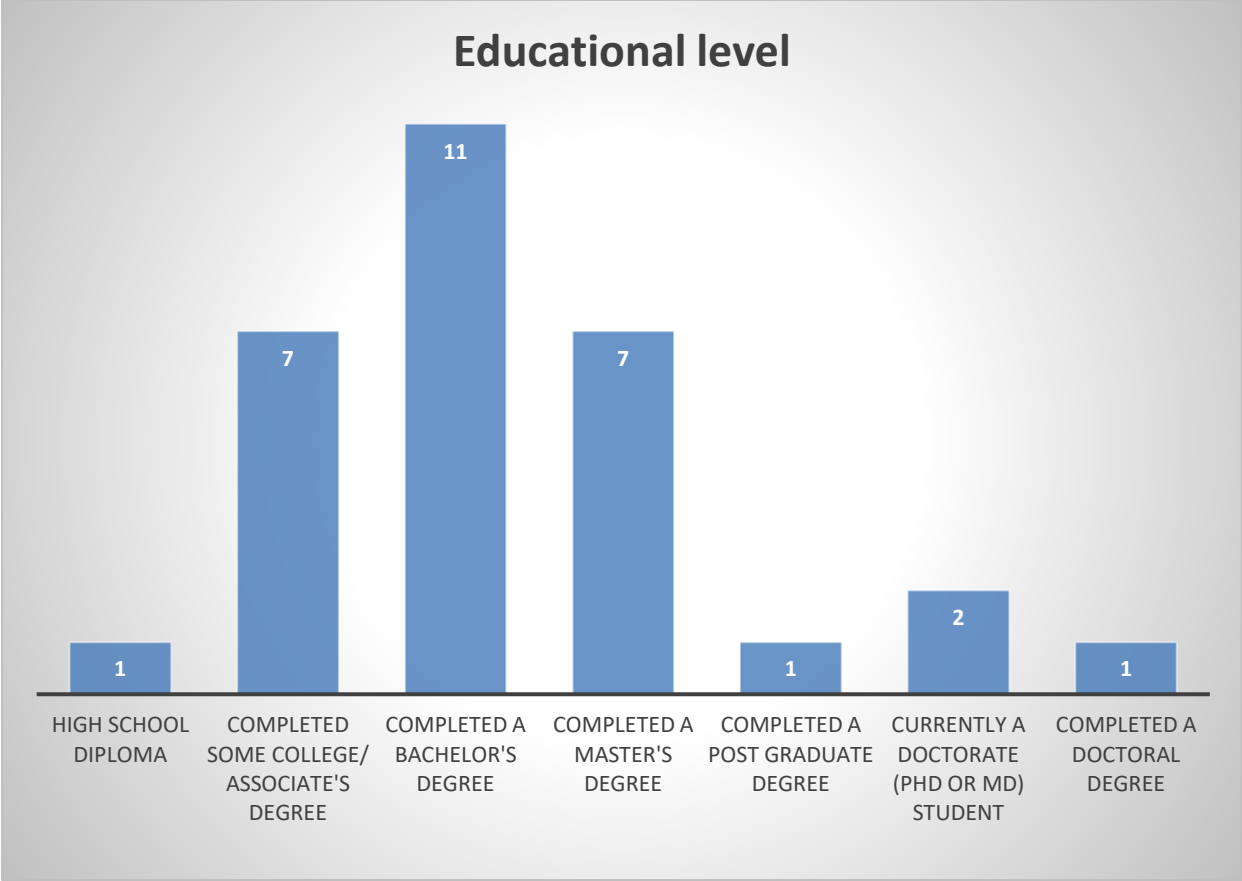
What was the HIV status of your sexual partners in the past three months (i.e., HIV+, HIV-, or unknown)? Do you think these numbers would be similar if you were not on PrEP? Why or why not?

14. Tell me about how satisfied you are with current sex life? What would you want to change about your sex life? Do you think being prescribed PrEP has contributed to the way you feel about the satisfaction of your sex life?
15. Do you think your communication and/or your relationship / connection with your sexual partner(s) improved as a result of PrEP usage?
16. Have you ever received any discrimination or negative feedback from others when you informed them that you are taking PrEP? Please explain?
17. (Wrap-up) Is there anything else about your experiences using PrEP that you would like to share that has not been previously discussed?

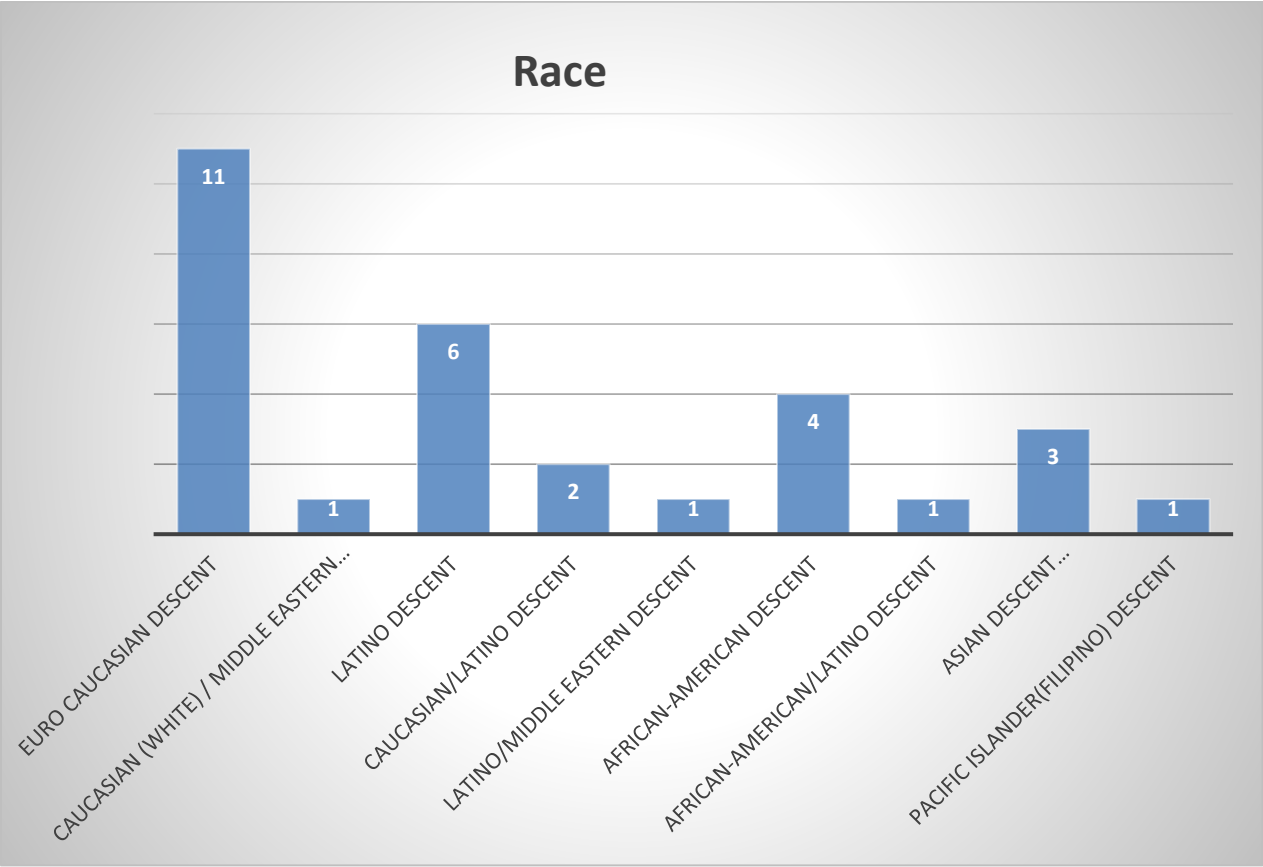
APPENDIX G
Charts / Graphs



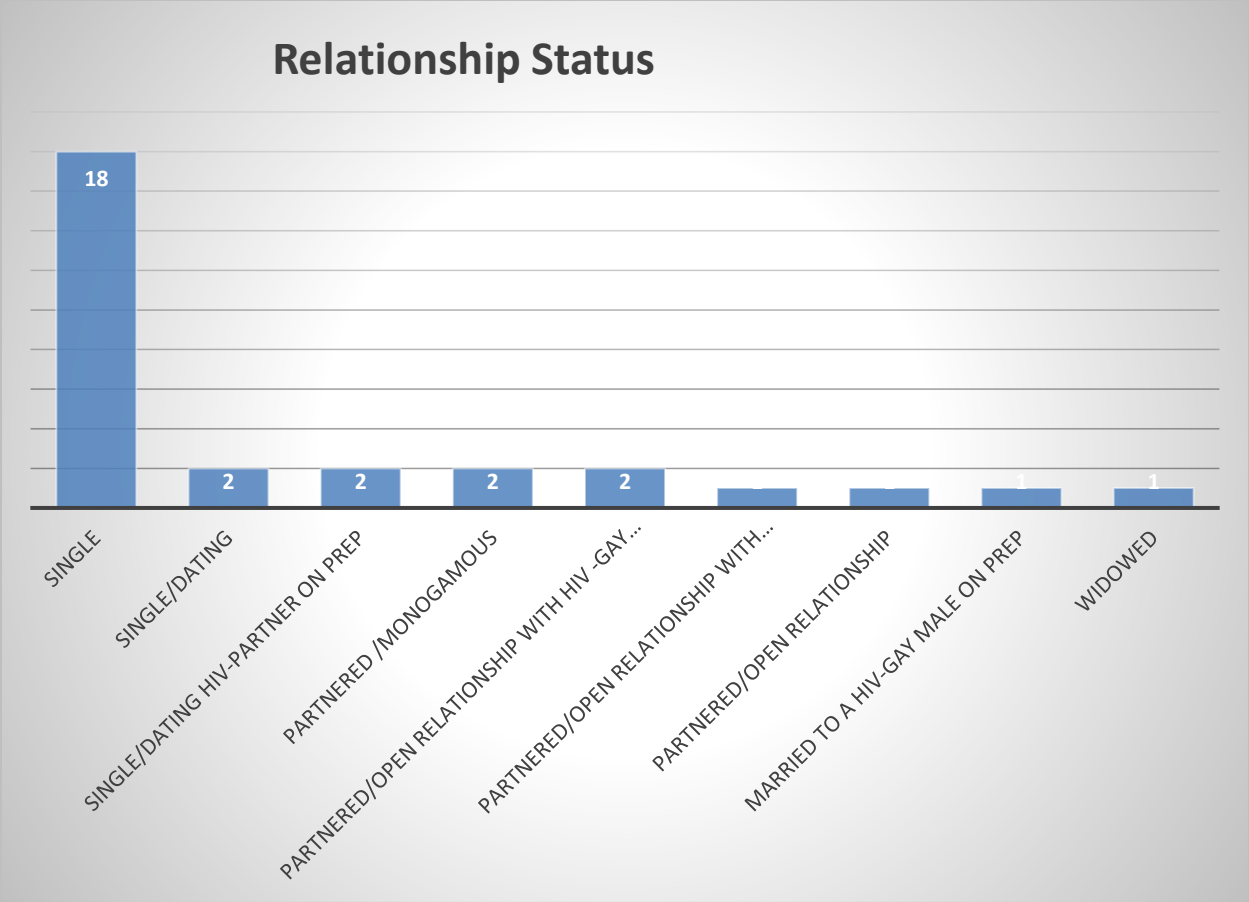
This graph depicts the location of the participants' city of residence.



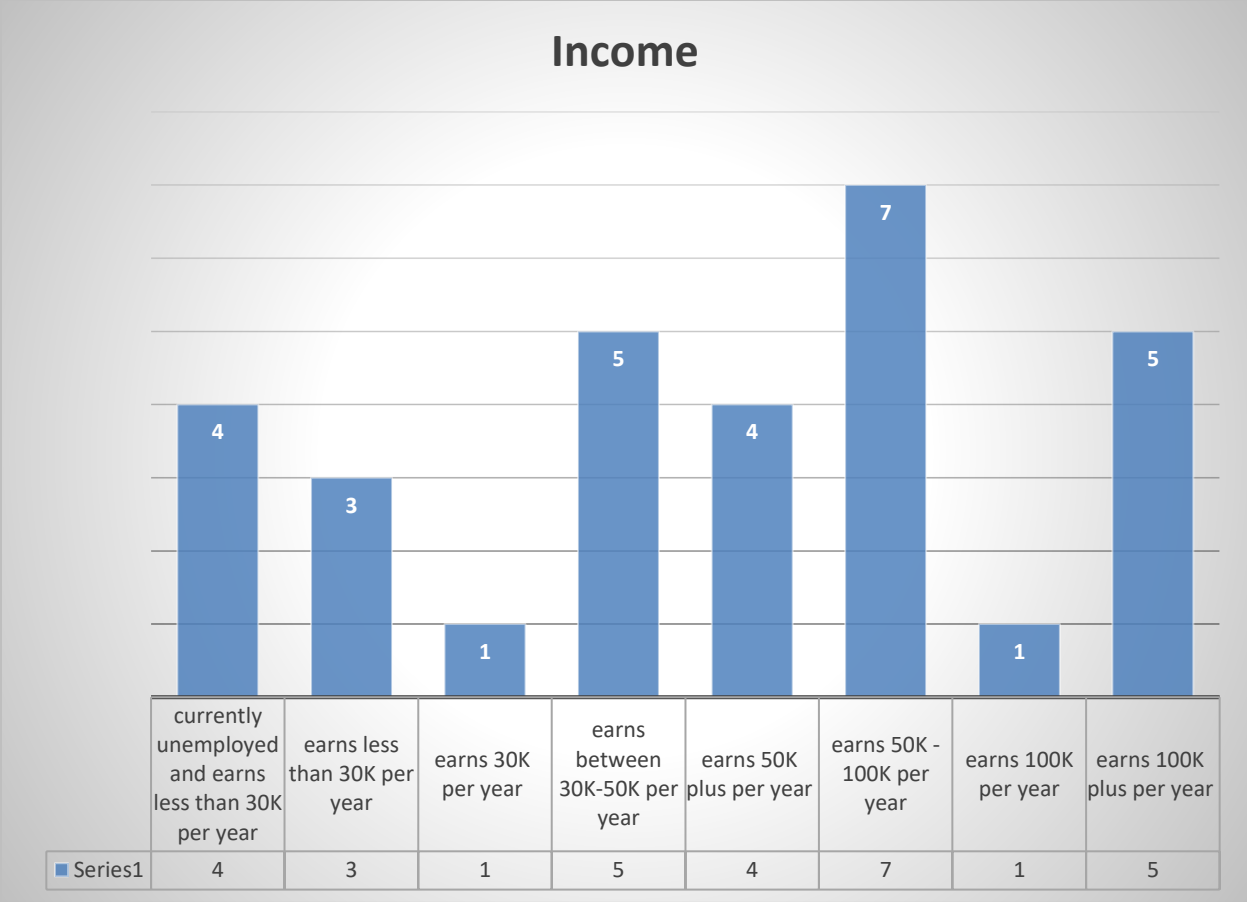
This graph depicts the level of education of each of the participants currently taking PrEP.



This graph depicts the race of the participants currently taking PrEP.



This graph depicts the relationship status of each of the participants currently taking PrEP.



This graph depicts the amount of income of each of the participants currently taking PrEP.

REFERENCES

- Associated Press. (2014, April 6). Divide over HIV prevention drug Truvada persists. *USA TODAY*. Retrieved from <https://www.usatoday.com/story/news/nation/2014/04/06/gay-men-divided-over-use-of-hiv-prevention-drug/7390879/>
- Beadnell, B., Morrison, D. M., Wilsdon, A., Wells, E. A., Murowchick, E., Hoppe, M., Gillmore, M.R., & Nahom, D. (2005). Condom use, frequency of sex, and number of partners: Multidimensional characterization of adolescent sexual risk-taking. *The Journal of Sex Research, 42*(3), 192-202.
- Beck, J. S. (2011). *Cognitive behavior therapy basics and beyond*. (2nd ed.). New York, NY: Guilford Press.
- Blackwell, C. W. (2008). Men who have sex with men and recruit bareback sex partners on the Internet: Implications for STI and HIV prevention and client education. *American Journal of Men's Health, 2*(4), 306-313.
- Bonacquisti, A. & Geller, P. A. (2013). Condom-use intentions and the influence of partner-related barriers among women at risk for HIV. *Journal of Clinical Nursing, 22*, 3328-3336. doi: 10.1111/jocn.12101
- Buehler, S. (2014). *What every mental health professional needs to know about sex*. New York, NY: Springer Publishing Company, LLC.
- California Department of Public Health. (2015). *Fact sheet: What health care providers need to know about pre-exposure prophylaxis (PrEP)*. Retrieved from <https://archive.cdph.ca.gov/programs/aids/Documents/Healthcare%20provider%20PrEP%20Fact%20Sheet.pdf>

- Critchlow Leigh, B. (1990). The relationship of substance use during sex to high-risk sexual behavior. *The Journal of Sex Research*, 27(2), 190-213.
- Dehart, D. D. & Birkimer, J. C. (1997). Trying to practice safer sex: Development of the sexual risks scale. *The Journal of Sex Research*, 34(1), 11-25.
- DiIorio, C. (2009). *Safe Sex Behavior Questionnaire (SSBQ)* Routledge. Retrieved from http://cw.routledge.com/textbooks.9780415801751/resources/DiIorio_SSBQ_Exhibit.doc
- Dilley, J. W., Woods, W. J., Loeb, L., Nelson, K., Sheon, N., Mullan, J. Adler, B., Chen, S., & McFarland, W. (2007, April). Brief cognitive counseling with HIV testing to reduce sexual risk among men who have sex with men. *Journal of Acquired Immune Deficiency Syndrome*, 44(5), 569-577.
- Feagin, J. R., & Feagin, C. B. (1996). *Racial and ethnic relations* (5th ed.). Upper Saddle River, NJ: Prentice-Hall, Inc.
- Fisher, T. D., Davis, C. M., Yarber, W. L., & Davis, S. L. (2010). *Handbook of sexuality-related measures*. New York, NY: Routledge.
- Gold, R. S., & Skinner, M. J. (1992). Situational factors and thought processes associated with unprotected intercourse in young gay men. *AIDS*, 6, 1021–1030.
- Golub, S. A., Kowalczyk, W., Weinberger, C. L., & Parsons, J. T., (2010). Preexposure prophylaxis and predicted condom use among high-risk men who have sex with men. *Journal of Acquired Immune Deficiency Syndrome*, 54(5), 548-555.
- doi: 10.1097/QAI. 0b013e3181e19a54

- Grant Smith, N., Hart, T. A., Moody, C., Willis, A. C., Faaborg Anderson, M., Blais, M., & Adam, B. (2016). Project PRIDE: A cognitive-behavioral group intervention to reduce HIV risk behaviors among HIV-negative young gay and bisexual men. *Cognitive and Behavioral Practice, 23*, 398-411.
- Grossman, H. (2014, November). Do HIV-negative gay men need condoms if they're on PrEP? Here's what I tell my patients. *The Body The Complete HIV/AIDS Resource*. Retrieved from <http://www.thebody.com/content/75205/do-hiv-negative-gay-men-need-condoms-if-theyre-on-.html?ts=pf>
- Guest, G., Shattuck, D., Johnson, L., Akumatey, B., Kekawo Clarke, E. E., Chen, P., & MacQueen, K. M. (2008). Changes in sexual risk behavior among participants in a PrEP HIV prevention trial. *Sexually Transmitted Diseases, 35*(12), 1002-1008.
doi: 10.1097/OLQ.0b013e3181812939
- Hart, T. A., Tulloch, T. G., & O'Cleirigh, C. (2014). Integrated cognitive behavioral therapy for social anxiety and HIV prevention for gay and bisexual men. *Cognitive and Behavioral Practice, 21*(2), 149-160.
- Hershberger, S. L., Wood, M. M., & Fisher, D. G. (2003). A cognitive-behavioral intervention to reduce HIV risk behaviors in crack and injection drug users. *AIDS and Behavior, 7*(3), 229- 243.
- Horvath, K. J., Oakes, J. M., & Simon Rosser, B. R. (2008). Sexual negotiation and HIV serodisclosure among men who have sex with men with their online and offline partners. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 85*(5), 744-758.
doi: 10.1007/s11524-008-9299-2

- Jordan, J. V. (2010). *Relational-cultural therapy*. Washington, DC: American Psychological Association.
- Jordan, J. V., Walker, M., & Hartling, L. M. (2004). *The complexity of connection*. New York, NY: Guilford Press.
- Madrid, R. (2007). Harm reduction or barebacking. *The Body The Complete HIV/AIDS Resource*. Retrieved from <http://www.thebody.com/content/art42462.html>
- Matthews, L. T., Baeten, J. M., Celum, C. & Bangsberg, D. R. (2010) Periconception pre-exposure prophylaxis to prevent HIV transmission: Benefits, risks, and challenges to implementation. *AIDS*, 24(13), 1975-1982.
- McDavitt, B. & Mutchler, M. G. (2014). “Dude, you’re such a Slut!” Barriers and facilitators of sexual communication among young gay men and their best friends. *Journal of Adolescent Research*, 29(4), 464-498.
- Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation* (4th ed.). San Francisco, CA: Josey-Bass A. Wiley Brand.
- Nagaraj, S., Segura, E. R., Peinado, J., Konda, K. A., Segura, P., Casapia, M., Ortiz, A., Montano, S.M., Clark, J.L., Lama, J.R., & for the Peruvian HIV Sentinel Surveillance Working Group. (2013). A cross-sectional study of knowledge of sex partner serostatus among high-risk Peruvian men who have sex with men and transgender women: implications for HIV prevention. *BMC Public Health*, 13(181), 1-7.
doi: 10.1186/1471-2458-13-181

- Noar, S. M., Crosby, R., Benac, C., Snow, G., & Troutman, A., (2011). Application of the attitude-social influence-efficacy model to condom use among African-American STD clinic patients: implications for tailored health communication. *AIDS & Behavior, 15*, 1045-1057.
- Pachankis, J. E., Hatzenbuehler, M. L., Rendina, H. J., Safren, S. A., & Parsons, J. T. (2015). LGB-affirmative cognitive-behavioral therapy for young adult gay and bisexual men: A randomized controlled trial of a transdiagnostic minority stress approach. *Journal of Consulting and Clinical Psychology, 83*(5), 875-879.
- Pachankis, J. E., Rendina, H. J., Ventuneac, A., Grov, C., & Parsons, J. T. (2014). The role of maladaptive cognitions in hypersexuality among highly sexually active gay and bisexual men. *Archives of Sexual Behavior, 43*, 669-683.
doi: 10.1007/s10508-014-0261-y
- Paul, J. P., Ayala, G., & Choi, K. Y. (2010). Internet sex ads for MSM and partner selection criteria: The potency of race / ethnicity online. *Journal of Sex Research, 47*(6), 528-538.
doi: 10.1080/00224490903244575
- Perez-Figueroa, R., Kapadia, F., Barton, S.C., Eddy, J.A., & Halkitis, P.N., (2015). Acceptability of PrEP uptake among racially/ethnically diverse young men who have sex with men: the P18 study, *AIDS Education and Prevention, 27*(2), 112-125. The Guilford Press.
- Rosario, M., Schrimshaw, E. W., & Hunter, J. (2006). A model of sexual risk behaviors among young gay and bisexual men: Longitudinal associations of mental health, substance abuse, sexual abuse, and the coming-out process. *AIDS Education and Prevention, 18*(5), 444-460. doi: 10.1521/aeap.2006.18.5.444.

- Saldana, J. (2016). *The coding manual for qualitative researchers* (3rd ed.). London: Sage Publications.
- Semple, S. J., Strathdee, S. A., Gallardo Cruz, M., Robertson, A., Goldenberg, S., & Patterson, T. L. (2010). Psychosexual and social-cognitive correlates of sexual risk behavior among male clients of female sex workers in Tijuana, Mexico. *AIDS Care*, 22(12), 1473-1480. doi: 10.1080/09540121003758648
- Shernoff, M. (2006). Condomless sex: Gay men, barebacking, and harm reduction. *Social Work*, 51(2), 106-113.
- Spieldenner, A. (2016). PrEP whores and HIV prevention: The queer communication of HIV pre-exposure prophylaxis (PrEP). *Journal of Homosexuality*, 63(12), 1685-1697.
- Thomas, F., Mience, M. C., Masson, J., & Bernoussi, A. (2014). Unprotected sex and internalized homophobia. *The Journal of Men's Studies*, 22(2), 155-162.
- Underhill, K. (2013). Risk-taking and rulemaking: Address risk compensation behavior through FDA regulation of prescription drugs. *Yale Journal on Regulation*, 30(2), 377-437.
- Weis, R. (2014). *Introduction to abnormal child and adolescent psychology* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Yep, G. A., Lovaas, K. E., & Pagonis, A.V. (2002). The case of "riding bareback": Sexual practices and the paradoxes of identity in the era of AIDS. *Journal of Homosexuality*, 42(4), 1-14.
- Yi, H. & Sandfort, T. G. M. (2010). Effects of disengagement coping with HIV risk on unprotected sex among HIV-negative gay men in New York City. *American Psychological Association*, 29(2), 205-214. doi: 10.1037/a00117786