STIGMA AND DISCLOSURE: THE HEALTH COMMUNICATION OF GAY AND BISEXUAL COLLEGE MALES.

by

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This thesis examines what it means to be a self-identified gay or bisexual male college student, and how stigma and disclosure relate to health. Qualitative research was conducted to explore the reasons some patients withhold disclosure of sexual orientation. A considerable amount of research has been done on disclosure of gay and bisexual males. Yet studies examining the combination of gay and bisexual college-age males, and communication as it pertain to stigma, disclosure, and health is lacking in the field of communication. This analysis attempts to address common reasons gay and bisexual males do not disclose their sexual orientation, how stigma affects that decision and how it relates to health.

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by

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…to be “feminist” in any authentic sense of the term is to want for all people, female and male, liberation from sexist role patterns, domination, and oppression.”

— Bell Hooks

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CHAPTER 1

Introduction

I remember when I first became interested in the study of male sexual orientation and disclosure. I was a junior at a small liberal arts college in Ohio and had started making many gay friends. While I myself am not gay (although very feminine) I understood many of the struggles of being victimized as the "gay boy" in high school, whether you were out of the closet, gay or not. The point was I was feminine and was not supposed to be, so I must be gay.

One night I was sitting in my room with a freshman who had recently come out of the closet. We were discussing how his parents had reacted to the news of their oldest son being gay and comparing it to others' stories. At the time I had just begun studying health communication and had been assigned a research project on a topic of my choice. The confluence of events raised a question in my mind. I promptly turned to him and asked if his doctor knew he was gay. He thought about it for a minute and replied with a simple and concise "no."

A string of thoughts and research questions ran through my head, but he seemed apprehensive about why I thought this was such an important decision as part of the coming out process. Shortly thereafter I undertook a literature search that revealed only a small amount of research had been conducted in the area. Why the lack of research? I came across a quantitative study that concluded that many gay men do not disclose their sexual orientation to their healthcare provider, but the article failed to explain why. Was it fear, stigma, isolation, guilt, oppression, privacy, or was their sexual orientation trivial information that seemed to be irrelevant when it came to their healthcare? At that instant I knew what my research project would be, what it could be, and what I wanted it to become. This thesis is the evolution of that

research project. Through countless drafts, hundreds of irrelevant article searches and what I am sure is now thousands of cups of coffee, I have continued to try to answer the question: Why?

One reason we do not have a definitive answer as to why gay men do not disclose their sexual orientation to their healthcare providers is that the answer seems "obvious." It is easy to assume the reason for apprehension is stigma, but might there be other reasons? And if stigma is the primary culprit, then we need to know for sure so that we can empower this marginalized group and provide them with better access to non-discriminatory healthcare.

The remainder of this chapter will discuss how gendered communication affects disclosure of sexual orientation and how disclosure of sexual orientation affects health. Scope, significance, and method sections follow the literature review. Chapter one concludes with a preview of the forthcoming chapters.

Review of Literature

The following literature review explores previous research within the field of communication as it relates to communication differences within gender communication and disclosure. The gaps in the aforementioned research have subsequently limited the alternatives available for consideration for improving patient-provider communication. Thus, the analysis section attempts to expand upon previous work in order to supply new qualitative data that could potentially improve channels of communication and the practice of medicine.

Gender Communication

Though there has been extensive research in the field of communication as it relates to gender, many researchers overlook the importance of distinguishing the differences between "gender" and "sex." While the boundaries can become somewhat blurred - due to the dominant gender roles pushed by American culture - they are vastly different and exist as exclusive

categories. Gender is a socially constructed way of producing and repeating one's actions to form an identity that others perceive as masculine or feminine, and sex is the biological and anatomical differences between males and females. Due to the widespread confusion about these terms many people think of gender as being male or female, instead of masculine or feminine.

Gender is a socially constructed system wherein individuals must follow the norms of society in order to gain acceptance as "normal." While this sounds very stereotypical, a vast majority of the population conforms to these norms subconsciously during social interactions as a method of diffusing cognitive dissonance. Previous studies have shown that men and boys experience a greater social pressure to conform to these stereotypical behaviors, which can range from verbal messages to physical actions (Courtenay, 2000). The men and boys who choose to divert from these norms stand a higher risk of isolation and segregation because of their defiance and resistance against the gender status quo.

The two main groups of males that risk facing the most ostracism and segregation are feminine homosexual males and feminine bisexual males. This societal rejection emerges out of a concept known as hegemonic masculinity, a dominant form of socially constructed masculinity that holds precedence over all forms of femininity and other forms of less dominant masculinity (Courtenay, 2000).

How Gender Communication Leads to Risk Taking Behaviors

Common behaviors related to domestic beliefs, language, sports, sex, and even health related beliefs, just to name a few, also fall under these restraints of what is normative for masculine males. Therefore, one could claim that "doing health is a form of doing gender" and, as a result, it can be assumed that "health actions are social acts" (Saltonstall, 1993, p. 12). Gendered communication establishes the norms for gendered acts. Gay and bisexual males are at

the crux of gendered expectations. Are they to behave more feminine or masculine, and how do these roles impact health? It is common for masculine individuals (previous research conducted on male's healthcare-seeking behavior) to not seek care, but it becomes complicated for feminine gay and bisexual males. Negotiating between what the norms of gendered health would determine, and what the feminine identifying gender role would assume, are two very different actions. This constant negotiation, dissonance, and flux between societal established gender roles and identifying gender only become more taxing with added stigma.

Constructions of masculinity become especially complex when working with gay and bisexual males. The perception that all gay males are feminine is highly inaccurate and does not account for the fact that it is quite possible to be a masculine gay male. Silence as a masculine characteristic is often observed in barebacking behavior (Haig, 2006). It establishes and reinforces the impression that "talk ruins the mood" and lowers the desirability of the "talkative" male. The concern for emotions and satisfaction of the talkative male is a feminine communicative action that functions as an aversive characteristic. Because masculinity (and in turn, silence) have become desirable traits of gay male sexuality, conversing about the need for condom usage has become somewhat taboo.

Some men believe that if they are not insistent on using condoms that their sexual "currency" will be increased, meaning they will be able to participate in sex with men whom they perceive to be more attractive than themselves (Shernoff, 2006). Furthermore, the lascivious exaggeration of oiled male torsos exhibited in gay pop culture has distorted the perception of male attraction, further rationalizing silence (Haig, 2006). Silence has also become more prevalent through the convenience of meeting other gay males online who are interested in barebacking. There are entire chat rooms and websites dedicated to personal ads in relation to

barebacking. Since the richness of computer-mediated communication is less than face-to-face communication, the amount of silence increases. Daft and Lengel (1984) argue that, "Information richness is defined as the ability of information to change understanding within a time interval…. Communications that require a long time to enable understanding or that cannot overcome different perspectives are lower in richness. In a sense, richness pertains to the learning capacity of a communication" (p. 560). Daft and Wiginton (1979) further this explanation by contending that the differences in richness result from the medium's capacity for immediate feedback, number of cues and channels utilized, personalization, and variety of language.

Major Findings Regarding Gay and Bisexual Men's Health Communication

Eight of the most significant findings about gay and bisexual men's health communication are highlighted in the following section. These findings help to address communicative behaviors such as lack of disclosure, high-risk sexual behavior, and access to healthcare. Prior research has indicated a lack of disclosure of sexual orientation to healthcare providers based on select factors, motives behind high-risk sexual behavior, and perceptions toward access to gay-friendly healthcare. However, this data has primarily been created through quantitative research methods. Therefore, these earlier studies (while valuable) do not provide the rich description of the lived experiences of gay and bisexual males that this thesis provides.

There are several factors that influence the amount of information gay and bisexual patients choose to disclose to their healthcare providers, but the most prevalent factors are fear of rejection, isolation, and stigmatization. Cant (2005) explored doctors' reactions and the experiences of gay patients when they disclosed their sexual orientation to their physicians. The study showed that the most common reaction was silence. On the other hand, there was often an

increase in communication when physicians supported patients. The study examined 38 gay men and 12 healthcare providers. The participants were selected through gay voluntary organizations and selected through the use of snowballing recruitment methods. Interviews were conducted with the participants, and a general analysis was concluded from the data.

One reason gay and bisexual male patients don't disclose their sexual orientation is because they do not perceive the benefits outweigh the risks. The stigmatization associated with being a gay or bisexual male is overwhelming for many men and is especially difficult for adolescents/young adults who may be in the process of coming out and/or creating a sexual identity. It is an assumption that many gay and bisexual males may not see the relevance in disclosing their sexual orientation to their healthcare provider, especially if they have a minimal sexual education experience as it pertains to homosexual relations (as is common in North Carolina). Sex education is often not gay friendly in North Carolina because if homosexual "acts" are discussed in sex education courses, they must be followed up by the (previous) "legal status on those homosexual acts that pertain to the transmission of HIV/AIDS" (Bach, 2006).

Participants in the Rhodes et al study reported that not using condoms is not always about risk and that there are other factors such as love and trust that play an important role in this decision. These participants also conveyed that sex is about having fun and that sex without condoms is "hotter," that condoms reduced sensation and pleasure, and that sometimes not everyone prepares for sex (Rhodes et al., 2011). The authors concluded that men who have sex with men "continue to need targeted sexual health and HIV and STD prevention education to increase knowledge and reduce misconceptions" (Rhodes et al., 2011, p. 149).

du Pre (2005) discussed sexual orientation and the consequences of coming out to a physician (e.g., the fear of social rejection by an authority figure). This can be especially

threatening when one's health is at risk and a patient fears he will receive substandard care because of his sexual orientation. du Pre also talks about the risk of not disclosing information, mainly in the form of preventive measures such as the hepatitis vaccine. Stigma also plays a large role in whether or not individuals disclosure information about sexual orientation. du Pre describes stigma as a type of social rejection stemming from not complying with norms defined by society. According to her research, people can actually die from embarrassment because they are too afraid to seek medical care for their conditions for fear of being isolated (du Pre, 2005, p. 217). This fear paired with the pressures of coming out likely prevents many young men from disclosing their sexual orientation to their healthcare providers.

The intricacies within the patient-provider dynamic/relationship can make the communication process difficult, especially from the patient's perspective. Patients often feel muted by the superior-subordinate relationship due to several factors such as status differences, education, and gender roles. This poses a major concern for the welfare of the patient. If doctors and patients do not have open relationships then treatment options and diagnostic measures become restricted to the limited quantity of information provided by the patient. Therefore, it is the role of both the patient and the healthcare provider to ask questions in order to receive as much information so that informed decisions can be made and discussed. Effective healthcare necessitates that in order to make informed and shared decisions it is the patient's responsibility to provide any and all relevant medical information. Similarly, it also requires that the healthcare provider use probing questions in an attempt to uncover all information that plays a key role in the health and wellbeing of the patient, such as the patient's medical history and related environmental and social factors. This becomes even more important when consulting patients with different sexual orientations and gender roles.

Gendered communication has also affected the way we refer to these marginalized groups in clinical settings. The evolution of once offensive slang has now become the standard accepted linguistic. Modern usage of the term "gay" has a positive connotation and may be used in a clinical setting to signal recognition and acceptance of men with same-sex orientation. Likewise healthcare providers can be reasonably confident with the term bisexual (Cornelson, 1998). However, the term lifestyle should be avoided because it implies that being gay is a lifestyle choice. "It is hard to imagine why anyone would 'choose' a 'lifestyle' that is subjected to social approbation, moral condemnation and sanctioned discrimination" (Cornelson, 1998, p. 263). If physicians are apprehensive about directly asking patients about their sexual orientation, it is advised that they implore gender-neutral questions such as; "Are you in a relationship?" and "Are you sexually active with men, women, or both?" (Cornelson, 1998).

Floyd and Bakeman (2006) discussed how life course factors influenced coming-out by evaluating maturity and historical context using seven common coming-out experiences often associated with the coming-out process. The results showed that the mean average of self-identification was 19.7 years and the mean year was 1986; it was primarily an adult sample. Fifty-one percent of the participants reported an identity-centered pattern rather than a sex-centered pattern. A partial reason for this was because the younger participants had less heterosexual experience before identifying as gay, lesbian, or bisexual. Historical changes are also an important factor in disclosure due the increasing openness among adolescents (Floyd and Bakeman, 2006).

The importance of finding "gay friendly" physicians is ranked as being a deciding factor for many gays and bisexuals when it comes to disclosing their sexual identity. Statistics from a self-report survey of 66 gay men and 28 lesbians at a gay and lesbian community center

indicated that fewer than half of the participants felt that their insurance plans gave them the opportunity to find a suitable physician they were comfortable with (Klitzman and Greenberg, 2002). The study also showed that men were more open to discussing sexuality with their physician and that if participants were given more options for physician selection it would facilitate communication, and discussion about high risk sexual behavior.

Warner (1995), in an essay that discusses why gay men are having risky sex, sheds light on another side of "barebacking." He argues that most gay men are not using condoms because they either believe they love the person they are with, trust the person, are willing to live on the edge and take the risk, or don't want to be labeled as promiscuous because they insist on using condoms. This last claim asserts that the stigma of AIDS is twofold. The first stigma is that (as a gay man) one should always use a condom to prevent the likelihood of contracting HIV. The second stigma is that (from a gay man's perspective), "Yes, using a condom is safe, but you must be very promiscuous if you feel that you need to use one." This second stigma is the more dangerous of the two. Now we are not only concerned about preventing HIV, but we must reshape the belief that a concern for safety is not a red flag that indicates the person is promiscuous.

Barebacking first evolved as a way for gay men to rebel against the pressures of HIV prevention and the heterosexist stigma of gay men being labeled public health enemies. This behavior was originally defined as intentional anal sex without the use of a condom (Shernoff, 2006). Now, barebacking has become a highly desired category on gay porn sites, spawned its own chat groups, personal ads, and bareback parties (Haig, 2006). The denotation of the term has been altered to "casual, unprotected anal sex among gay and bisexual men who, while aware of the risks of HIV transmission, deliberately choose not to use condoms" (Haig, 2006, p. 860).

This once feared action of having unprotected anal sex has evolved, over time through the actions of activists and media, into a highly desired homoerotic fantasy that many gay and bisexual men seek to enact.

Shernoff (2006) argues that the rise of barebacking may stem from sociocultural stressors such as racism, homophobia, and internalized homophobia (the psychological phenomenon that results from internal dissonance of being gay that is associated with the social stigma). These stressors contribute to the ideas that gay men and the men they have sex with are unimportant, expendable, and undervalued.

The cultural stereotype that gay men are hypersexual may also contribute to the rise in barebacking behavior (Wilkerson, Brooks & Ross, 2010). As it becomes more socially expected for gay men to be hypersexual, this notion transcends into gay culture (especially to the younger generation) as normal sexual behavior. This social stressor combined with the glamorization of this high-risk behavior only augments the condition. When the culture is overly focused on sex, young gay men may feel pressured to conform to those expectations (Isacco, Yallum & Chromik, 2011).

Scope

While the scope of this study is relatively small and not generalizable to the greater population, I contend that the results of this study prove to be a valuable asset for the care of gay and bisexual college males in the sample. The strength of this study is the use of narratives and the rich descriptions. No other study has supported the aforementioned claims with the use of qualitative data. This study makes real the quantitative data and represents people that were formally just viewed as a series of numbers and statistics. I have selected a relatively small sample of gay and bisexual males from a state school located in rural North Carolina. I have

selected this group because I believe it is particularly marginalized by the rural, conservative community. Conducting a qualitative study on a sample that is at such a high risk can reveal problems within doctor-patient communication specific to this group. The southeastern U.S. experiences a disproportionate rate of HIV infection, because many individuals in the region have little knowledge about the HIV epidemic and healthcare providers tend to know almost as little about intervention approaches that have been successful in other regions of the country (Rhodes et al, 2011).

As I contemplated questions to ask during the in-depth interviews, I was mindful to create questions that would neither be too vague, nor too invasive. This careful balance between building rapport and gaining relevant information will be crucial to revealing the meaning behind the shared experiences of the sample population. Ultimately, there were a host of questions that could be asked in the interviews, but I elected to pose questions about high-risk sexual behavior and patient experiences. It was my goal to understand (1) why patients engage in these behaviors and (2) why they rarely disclose this information to their healthcare providers. These specific questions are highlighted in the methods section.

One possible threat to the study would be researcher attributes due to the content of the discussion. For example, participants may experience evaluation apprehension produced by their fear of being ridiculed based upon their responses. This threat is very possible due to the size of the sample and the possible lack of disclosure that might result from the age similarity between the researcher and participants. The majority of the information gained is highly personal and ownership of the information was shared in order for the study to reach its full potential.

Further research will need to be conducted in order to appropriately dissect the complex nature of homosexuality and bisexuality among males as it pertains to health. Because both

health and gender are multifaceted systems, and because so little research has been conducted about this population, there are many possible research questions that cannot be answered given the scope of this thesis.

Significance

Little research has been done in the area of gay and bisexual health communication. This study could prove to be a valuable resource within the area of health communication and gender. My goal as a feminist/critical researcher is to initiate change and progress on various levels for marginalized and oppressed groups within society. The minimal goal of this study is to increase awareness of gay and bisexual male health in regards to stigma and disclosure. That awareness can be used to support further research for gendered health communication. If this complexity of this population continues to be disregarded by research, the health of this population will continue to decline as HIV rates and other sexually transmitted diseases increase. Our healthcare system cannot ignore the well being of any group (especially groups that are marginalized) if it is to promote social justice and truly serve the community. If conversations between healthcare professionals and patients can result in lower HIV transmission rates through the exercise of safe sex and prevention, should we not attempt to understand this particular patient-provider interaction? As the state of healthcare evolves, so must the processes of care. This study can be beneficial for the gay/bisexual population, healthcare providers, and gender/health communication scholars. The use of narratives means the study has the potential to speak to scholars across a variety of disciplines as well as healthcare professionals and even the interested lay audience.

Methodology

I gathered data through the use of semi-structured primarily qualitative interviews with 13 gay or bisexual male college students ages 18 to 24. My goal was to provide a rich description about stigma and disclosure and how it relates to health.

The research interview was comprised of open-ended questions designed to entice participants into sharing evoking narratives about their personal experiences. It entails what phenomenologists call "imaginative variation," a process by which a researcher establishes "inter-subjectivity with participants" and "step[s] into their experiential shoes" (Husserl, 1970; Moustakas, 1994, pp. 67-68). The researcher uses probing questions to co-construct the meaning of the phenomenon with the participants (Becker, 1992). These stories are then recast as impressionist tales (or imaginative variations, as cited in Moustakas, 1986) that retell the participant's narratives of how the phenomenon was experienced (Creswell, 2013).

The textual description, in this case, consists of what Van Maanen (2011) calls an "impressionist tale" in order to provide a rich description of my participant's experience and hopefully invest readers in the narrative. "Social scientists' descriptions of interpersonal life are stories that interpret, construct, and assign meaning or value to the patterns of relating they have observed" (Bochner and Ellis, 1992, p. 167). This unique method of obtaining and recreating rich descriptions of experiences is different from other types of ethnography in the sense that it attempts to directly place the audience in the same environment as the field researcher. This type of ethnography was selected due to its ability to evoke strong emotion and to help readers better empathize with the study's participants (Van Mannen, 2011). Impressionist tales tell striking stories. They are not about the story that usually happens, but what rarely happens. It is not the

goal to retell the already told story, but to recreate an untold story in a manner that helps readers to gain a critical view of the experience.

A comprehensive description was formed from the individual descriptions (stories shared by the 13 participants) and synthesized to provide a textual description using dramatic recall of what was experienced and how it was experienced. As Van Mannen writes,

> Impressionist tales present the doing of fieldwork rather than simply the doer or the done. They reconstruct in dramatic form those periods that the author regards as especially notable and hence reportable…impressionist writing tries to keep both subject and object in constant view. The epistemological aim is then to braid the knower with the known. (p. 102)

These comprehensive descriptions or impressionist tales require the researcher to engage and write in a self-reflexive voice. The stories emerge out of reflexivity and portray the impression left on the researcher. Goodall (2000) posits the question of trust in storytelling. He writes, "Whom do you trust – the person who never discloses her or his feelings, who has no interesting life stories to offer…or do you trust the person who emerges in the talk of someone living a passionate and reflective life…" (p. 23)? The pains and ambiguities in the stories shared by the participants in this study represent the type of people Goodall is referring to. Qualitative researchers strive to capture the experiences of participants with passion in their storytelling. Recreating the stories shared by the participants relies on that passion and thrives off of it.

Participants were selected through a modified snowball sample to refer other gay and bisexual men through personal contact, LGBT campus organizations, and campus email recruiting. Participants scheduled an interview appointment in a private conference room on

campus. Rapport was established by explaining the purpose of the study and why I became involved in the study.

I began each interview by asking participants to tell their coming out story as a way to defuse the tension before introducing probing questions regarding doctor-patient communication and their amount of disclosure. Topical questions included items such as:

"At what age did you identify as being gay or bisexual?"

"At what age did you become sexually active with other individuals?

"Have you ever participated in a high-risk sexual behavior?

"And, if so, what were your motivations behind those actions?"

The primary issue questions were:

"What does it mean to be a gay or bisexual male patient?"

"How does that meaning affect the disclosure of your sexual orientation to your healthcare provider?"

Probing questions were established as needed to further the interview and delve more deeply into reoccurring statements.

All interviews were audio recorded and hand written field notes were taken during the interview. Data from the multiple interviews were transcribed and compiled into narrations that illustrate the comprehensive description.

This data was then compared against the eight most significant findings of previous quantitative research in gay men's health communication. Using narratives to support claims made by quantitative research further validates the need for change measures in the healthcare of gay and bisexual men. Using qualitative data to support quantitative data not only corroborates findings; it generates more complete data, and creates a more comprehensive understanding of

problems that arise in gay and bisexual men's health. In addition, it creates insights that cannot be produced by quantitative data alone (Creswell & Plano, 2007).

Forthcoming Chapters

Chapter two consists of the impressionist tales created through comprehensive descriptions that support claims made in previous research. These narratives provide a rich description of the gay/bisexual male experience, high-risk sex behaviors, and the motivations behind them. The tales seek to evoke the emotion of the reader to empathize with the patient. I attempt to paint a colorful portrait of the experience: each layer of paint tinted with more detail, more emotion, and more description until the portrait is complete.

Chapter three reviews the claims that emerged, offers a critique of the negative experiences, and provides prescriptive measures for change (either at a social or organizational level). Chapter four consists of a conclusion of the thesis and directions for future studies.

There are a series of misconceptions surrounding gay/bisexual males, sex, and health, all of which can be alleviated through effective communication. The reality of the matter, though it may be complex, is that homosexual behavior is no less comprehensible than heterosexual behavior. The problem is when heteronormative assumptions thwart open and rational dialog about homosexual acts. Avoidance, for example, is a serious concern. Too many healthcare practitioners cope with "non-normal" acts by simply never broaching the subject with their clients. Gay sex happens, and in fact, it has been occurring for centuries. Yet, many in society still struggle with the notion of sex for the purpose of not reproducing. Many gay men engage in high-risk sexual acts as a means of rebellion. While highly pleasurable, these acts are dangerous for non-committed sex partners. As sex becomes less monogamous the spread of disease is much

more likely, and thus HIV rates will increase as has occurred amongst gay men in North Carolina.

Many gay men in rural communities see their sexual orientation as private information that can be used to discriminate, isolate, and segregate them from society. They are fearful of stigma and of becoming falling victim to a variety of forms of violence. The boundaries surrounding sexual orientation need to be disassembled within the healthcare setting and society at large if progress is to be achieved for this group. This study sought to identify some of the issues and motivations associated with gay health and the care provided to young gay men.

Through hours of interviewing, questioning, transcribing, reflecting and writing I delved deeper into this study to answer the question: Why do young gay men so rarely disclose information about their sex lives to their healthcare providers? Is the reluctance to disclose a secondary effect of fear, stigma, isolation, guilt, oppression, or privacy? I continue to seek proof that this disclosure is important for better healthcare and that conversations about safe sex are a necessity. I detest stigma and aspire to articulate the oppressive nature of its essence, in hopes of exposing the problems within gay healthcare.

As I moved from merely thinking about my methodology to actually employing it, I thought, “In-depth interviews; that will be fun!” I was prepared for whatever could be thrown at me. I had “finished” my literature review, defended my proposal, and even convinced ECU IRB to let me ask our students about gay sex – these forms are located in appendices A and B. The battle was won, or at least so I thought. I was not prepared for the stories that were about to be shared with me.

CHAPTER 2:

From the literature review in Chapter 1, I have distilled eight main reasons why gay and bisexual males do not disclose their orientation and how it relates to health. This chapter explains how these claims are reflected in the narratives of gay and bisexual college-age males:

Claim 1: The perceived benefits of disclosure don't outweigh the risk.

Claim 2: Sex education in North Carolina is not gay friendly.

Claim 3: Not using condoms is not always about risk, but instead focuses on love and trust.

Claim 4: Sex is about having fun and sex without condoms is "hotter."

Claim 5: Not everyone prepares for sex.

Claim 6: Reluctance to disclose is due to fear of rejection by an authority figure.

Claim 7: Gay and bisexual males lack access to gay-friendly healthcare providers.

Claim 8: Men don't want to be labeled as promiscuous because they insist on using condoms.

The use of narratives to reaffirm claims issued in previous research can strengthen and add nuance and understanding to those claims, and perhaps serve as a catalyst for change in healthcare institutions. These eight reoccurring claims drawn from previous studies emphasize the need for inclusivity among healthcare providers. While the limitations of the study include scope, the narratives provide a rich description of how the phenomenon was experienced. The attempt is to place the audience, as much as possible, into the lived experience of gay and bisexual college-age males. My hope is that by doing so the full measure of the difficulties faced by gay and bisexual males who attempt to receive quality healthcare will be both better felt and, therefore, understood.

Scott

"Coming out in a Southern Baptist home was more than painful," says Scott, a 23-year-old graduate student. He revisits his sophomore year when he realized he was gay. He had started watching gay porn when he was in high school, but was confused about his sexual orientation. Actually, he really didn't know what gay meant. He associated gay with a flamboyant male. So when it came to watching gay porn it was especially confusing as to what motivated the men to have sex. He wasn't even sure if it was called sex because in his mind sex was what happened between a man and a woman. Regardless, he knew that porn was bad, but he also liked what he saw. In Scott's words, "I knew why porn was so attractive to other individuals. This was HOT!"

The emotional stress associated with this confused sexual identity and the pressure of telling his parents manifested in the form of panic attacks. Scott went to the student health center to be seen by a doctor. Confused by whether the woman in the room was a doctor or a nurse, Scott was reluctant to disclose (Claim 6). But this overwhelming emotion flooded out of Scott with tears and hysteric sobbing. In the midst of all other the other stressors surrounding his everyday life he screamed out "and I think I like boys." The woman told him to wait while she went to speak with a doctor. She returned with a nurse who escorted him to student counseling services. After a session with a counselor and the fiasco at the student health center, he was emotionally numb and exhausted. Confused and seeking comfort Scott called his parents. His mom (on the other end of the phone) screamed to his father that their poor baby boy was sick and they needed to go get him.

When his parents arrived at school, his mom got out of the car to greet her little boy. Crying and exclaiming that she was here for him, she placed Scott in the back seat of the car with

her, his head on her shoulder. Scott told them "I am gay and I am going to fix it." Mom burst into tears as dad clenched the steering wheel and stared through the windshield.

Scott tells me, I spent that summer in Colorado at a "pray the gay away" camp (mostly because my cousin, the minister, had told me that I had been possessed by a demon). The psychologist I saw disclosed to me that he was bisexual and he had a daughter that was a lesbian. The first thought that ran through my head was "how could someone who also likes men be trying to fix me?" Then he told me that he was not bisexual anymore. He was an "ex-gay." That conversation led to many sessions in support groups with other ex-gays. The men there were both young and old. Some had just come out to their wives and others had been "struggling" with their gayness for most of their lives. I started to realize I didn't necessarily buy into this idea that my gayness could be "fixed" any longer.

I knew that I had a raw attraction to men and that there was only one way to satisfy this temptation. I decided to have my first gay sexual experience—Craigslist. Looking back this could have been a horrible decision, but I don't regret it. I went to the section of men-seeking-men. I knew that I wanted to try this, but I really didn't ever want to see this guy again. I didn't want to go all the way, you know…real sex, I just wanted to mess around a little.

I drove 45 minutes away to his house. He was sitting outside on the porch as I pulled up to the house. His profile picture had indicated that he was only a few years older than me, but he was actually double my age. I thought that maybe I should just leave, but his house was really nice so we sat down on the couch and attempted to make small talk. He was sweet and could tell that I was incredibly nervous. Not only had I never done this before, but I was in a stranger's house 45 minutes away from anything. I told him that this was my first time and that I was more than

nervous. He said that we could go as slow as I wanted. That reassured me and gave me enough confidence to at least try it.

He told me to sit back on the couch and started giving me head. By now I was more excited than nervous. It felt so good. I could feel this tingling sensation welling up inside me. Suddenly it released and I have the most intense orgasm ever. Then we switched places. I went down on him as I thought… this is cool. I really like this! This is so HOT! He wants to kiss me, but kissing is just too intimate for me. So instead, he gives me oral a second time. I cum so hard the second time, I feel like I have lost entire control of my body. By this point my body is covered in cum (Claim 4) so I asked him if I could use his shower. In the shower I began to feel incredibly awkward. I mean I had just had oral sex with a complete stranger. "I thought, what have I done?"

I exit the shower, dry off, and get dressed. I start to walk to the door. He is sitting in the living room waiting for me. He approaches me and I thank him and extend my arm for a handshake. He says "a hand shake, really?" So I gave him a hug. He whispers into my ear "don't be a stranger," as I think to myself "I don't ever plan on seeing you again." On the drive home I am overwhelmed with emotion. I feel so stupid for being so risky, but I don't know if I truly regret it. In fact, I think I am glad that I did.

Eight months and two partners later, I find out I have herpes. The diagnosis is cut and dry. Use protection and take your medication is what the doctor tells me. Luckily, I have found a herpes hotline on Google. The woman on the other end of the phone is so polite. She recommends protection to me, but also advises me of the risks if I don't. Finally, someone is being objective about this! Maybe it was easier to disclose over the phone to a woman far away. I don't know, but somehow I feel like she understands me (Claim 6 and 7).

Claims 6, 4, and 7 were displayed in Scott's narrative. Claim 6: Reluctance to disclose due to fear of rejection by an authority figure was found twice in this story—once in the doctor's office and again while on the phone with the hotline counselor. Each account was different as the latter assured more anonymity. Claim 7: Gay and bisexual males lack access to gay-friendly healthcare providers, was also echoed within the same account. Scott indicated that he was not sure as to whether the woman in the room was a doctor or a nurse. The reality of the situation is that it could have been a nurse, nurse practitioner, physician assistant, or doctor. The lack of introduction by the provider only inhibited Scott's disclosure. If he was to risk disclosing he would only intend to do so one time as to lessen the risk of disproval of an authority figure. This begs the question as to whether a simple introduction would have alleviated much of Scott's anxiety and could have led to a conversation with the provider instead of an escort across campus to speak with a counselor. I think it can be assumed that Scott did not see the provider as a gay friendly doctor. Was that the reason for the escort to counseling services? Did the provider feel uncomfortable with having a conversation about Scott being gay? And even more terrifying, did the provider feel that she would not know how to answer Scott's questions?

Claim 4: Sex is about having fun and sex without condoms is "hotter," was indicated during Scott's first gay sexual experience and subsequent others which later led to his diagnosis of herpes. Scott had no intention of anal intercourse upon his first gay sexual experience, but his continued lack of condom use ultimately led to his contraction of herpes. Scott was not sure which partner he had contracted herpes from, but he seemed to assume it was one of his last two partners. Since Scott did not use condoms during his first sexual experience it was easy to rationalize continued lack of use. For many gay males like Scott, the thrill of the risk of condomless sex only intensifies the pleasure.

Dalton

Dalton reflects back to middle school in his sex education class in the seventh grade. The boys, of course, were separated from the girls during the lecture. The school nurse was an older woman, gray-haired, with large plastic framed glasses, and blush that looked as if it had been applied with a paintbrush.

Dalton says to me, “Imagine trying to listen to your grandma tell you about the birds and the bees. That's what it was called because a lady would never use such vulgar words as penis or vagina. Gay wasn’t mentioned, except when she mentioned AIDS. She said, ‘You kids don't need to worry about AIDS unless you are black or gay.’ Protection wasn’t even addressed until high school, probably because all of my sex education was abstinence only. That was really effective; considering 10 of the girls in my high school class either had a baby or were pregnant when they received their diploma (if they even made it that far).”

Gay sex was NEVER mentioned, at least not by the school nurse or teachers (Claim 2). I found out about porn from one of my friends. I remember the first time I saw porn. We were in his bedroom on the computer. He told me I had to see this. Nakedness appeared on the screen. I don't even think I was turned on by the porn as much as I was by watching his excitement. I did, after all, have a crush on him. I don’t think he ever knew.

I have known I was gay since the 8th grade. It took me six years to actually admit it. The first four of the six years were the hardest. It took me that long to cope with it. Maybe it was that my mom kept telling me that God would grant me heterosexuality. She told me that she was supportive, but worried how society would treat me. Then she would start up with the God thing again. This happens every time we try to talk about it.

For the past two years I have been slowly coming out to friends. My dad still doesn't know, but I don't think I will ever tell him. I always thought mom would, but I guess she just hasn't. They have been separated since I was really young. Maybe she feels like I should tell him? I think deep down I don't want him to know. I am afraid of what he might say. Especially if he knows all the stuff I have done (Claim 6).

I am bringing a boy home for Christmas at mom's house. She thinks he is just my friend. I don't know how she could possibly think that after he stays in my bed, but I will play along if it makes her feel better. He and I have been together for a while now. Our relationship started as an intoxicated one-night stand that lasted through the night until 7:00 a.m. After that first night, we realized how much we really had in common. I mean the sex was really hot, but I think it is more than that. We connect on an emotional level. I love bottoming for that reason, especially when he doesn't wear a condom (Claim 3). We both don't have anything and we are exclusive, so I think it is okay. I am not saying that condoms bother me, but it just feels better so why not? STDs worry me, but I trust him. I mean, I have never been tested, but I am pretty healthy. Even when I go to the doctor they ask about sex, but I just say I am good. I really don't think I should have to announce to the doctor that I am gay. If he thought it was important wouldn't he ask? I suppose it probably wouldn't bother me. It is, after all, covered by doctor-patient confidentiality. I just don't like the idea of being like "Hi, my name is Dalton and I am gay." I just feel like it is such a label.

Claims 2, 6, and 3 are exhibited in Dalton's story. Claim 2: Sex education in North Carolina is not gay friendly, is affirmed by the statements about the school nurse. This narrative is similar to many of the other stories shared by my participants. Sex in N.C. education is taboo and gay sex is unmentionable. Abstinence only education has a poor success rate, yet was the

only method utilized for the males in this study. Research shows that 9% of N.C. high school aged teens have had sex before the age of thirteen, 17% of N.C. teens have had sex with four or more partners before high school graduation (U.S. Department of Health and Human Services, 2013). Instead of educating youth about safe sex and protection, the state encourages a blind eye by pretending the problem does not exist. Many of the same conservative advocates who were responsible for the strict sex education laws are the same individuals that have introduced N.C. House Bill 693. If this bill passes the house and senate, North Carolina will become the first state in the country to require "notarized parental consent for a physician to prevent, diagnose, or treat any venereal diseases, abuse of controlled substances or alcohol, emotional disturbances, or pregnancy for an unemancipated minor" (General Assembly of North Carolina, 2013). The continuation of suppressing teenagers' right to education and medical care is only perpetuating an ongoing epidemic of sexually transmitted diseases in this state.

Claim 6: Reluctance to disclose is due to fear of rejection by an authority figure is visible in Dalton's unwillingness to disclose to his father. Many of the participants, like Dalton, were unwilling to come out to their fathers. Many, if not all, had come out to their mothers and either expected their mothers to tell their fathers or their mothers to continue to keep their son's sexual orientation a secret. This is likely the result of feelings of uncertainty and fear of the father's reaction. I had heard horror stories of fathers becoming physically abusive when their sons came out of the closet, but this was not the anticipated reaction shared by my participants. They were more concerned that they would disappoint or upset their fathers, or, in the "worst case scenario" that they would be rejected by their fathers.

Claim 3: Not using condoms is not always about risk, but instead focuses on love and trust, was evidenced when Dalton discussed bottoming without condoms. Dalton's choice not to

use condoms with his partner is not included as part of bareback culture as described by Shernoff in previously mentioned literature, but instead closely aligns with research conducted by the Rhodes et al. (2011) study. This condomless sex is driven by interpartner trust and a monogamous relationship in which both partners should undergo regular testing.

Sam

Sam was the only participant to have not had intercourse prior to the time of the study. His perspective was unique because of this. Not only had he never had anal sex, but he had never been in a relationship for an extended period of time. Due to his lack of experience, he had not solidified many of his opinions surrounding sexual health, yet his answers were still constant with the other "seasoned" participants. "I knew I was gay when I was 13 years old," says Sam. "I questioned it for quite a while as to why I did not like girls, and maybe that was the reason I never really 'came out.' I mean, I changed it on MySpace. After that, my sister told my mom and my mom talked to me about it. Well, she sort of talked to me about it. She basically said 'I really don't like it' and that was the end of it. I am not one to hide my sexual orientation, but I also don't go around showing it off. It's not like I wear a t-shirt around saying 'Hey, I'm Gay!'

The few dates that Sam has had with men were all during college. He disclosed to me that the furthest he had ever been with a guy was oral sex. I was curious to hear his story about disclosing to healthcare providers. I began with his opinion of the sex education he had received. "My mom had had the talk with me when I was a teenager, but it wasn't much of a talk. When I got to college and took Health 1000 was the first time we had ever talked about AIDS or HIV. In high school they had mentions STDs, but it was more about using condoms, so that you don't get pregnant (Claim 2). Which now that I think about it, it is ironic that pregnancy was the focus, but the pill was never mentioned."

I asked Sam how concerned he was about contracting STDs and if he would disclose his orientation to a physician. “Disclosure depends on what I am being seen for. If I go in for a headache, I would be offended if my orientation was questioned.” As far as STDs, you can still get a disease even if you use condoms (Claim 1). I just think for the most part every interaction with a doctor is very different and it depends on the situation (Claim 7).”

Claims 2, 1, and 7 are revealed in Sam’s narrative. Claim 2: Sex education in North Carolina is not gay friendly, is clearly indicated by the fact that Sam did not learn about AIDS/HIV until college. The average freshman is 18 years old when she or he enters college. By this point in their lives many students have had sex with at least four different partners, yet STD prevention was not a part of Sam’s education. Many young people in North Carolina do not learn about the different types of venereal diseases and how to prevent them. Until they are in college, many students still don’t understand exactly how the pill works, nor are they aware of other forms of birth control such as IUDs or injections. In sum, they remain ignorant about the health risks associated with sex; they know they enjoy it, but don’t understand the consequences associated with irresponsible sexual practices.

Claim 1: The perceived benefits of disclosure don’t outweigh the risk, is presented with the perception that the use of condoms not outweighing the risks of venereal diseases. Sam believed that the benefits of condoms did not outweigh the risk of not using them. His statement, “you can still get a disease even if you use condoms,” while true, only accounts for a very, very small percentage of cases. The Centers for Disease Control has issued the following statement regarding condom usage:

> Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS. In addition, consistent and

> correct use of latex condoms reduces the risk of other sexually transmitted diseases (STDs), including diseases transmitted by genital secretions, and to a lesser degree, genital ulcer diseases. Condom use may reduce the risk for genital human papillomavirus (HPV) infection and HPV-associated diseases, e.g., genital warts and cervical cancer (Centers for Disease Control, 2013).

While this research is readily available to educators and health practitioners, it is not consistently being shared with the populations most at risk for STI/STD transmission. Not until North Carolina teens enroll in their first year of college, if they attend college, do they learn about safe sex practices. Not only is the information not readily available to these teens, most of it is not targeted toward teen readers. Therefore it is up to health educators to condense the information and deliver it to N.C. teens.

Claim 7: Gay and bisexual males lack access to gay-friendly healthcare providers, is seen in Sam's statement that every doctor interaction is different and depends on the situation. Sam was not specific in his statement, but it is understandable that managing privacy is contextual. Petronio (2002) asserts that humans are choice makers, humans are rule makers and rule followers, and humans' choices and rules are based on a consideration of others as well as the self, as stated in (West and Turner, 2010, p. 223). This internal negotiation is what is used to establish whether or not disclosure can occur in a given situation. Sam's rules and choices are determined via the provider's attitude, length of stay, talk time, and Sam's reason for the visit. As many of the participants indicated, if they are being seen for a cold they are not likely to disclose their sexual orientation because they have determined it not to be relevant to the visit.

Jonathon

"I consider myself bisexual. I very much like women; not the women down here, they are too high-maintenance for my liking. They also act very dumb; even if they are smart they act like bimbos. I can't stand that fake-ass 'Like, Oh My God' shit. You're not from the valley; you live in Eastern North Carolina, I mean let's be real," says Jonathon, a displaced northerner who was forced to move when his parents' jobs relocated. "The men down here are not usually my type either. I typically prefer men from the north. There are two polar opposites here. Either they are backwoods rednecks that recently came out of the closet, or flamboyant bitches that are just too much to tolerate. I want someone sophisticated. I want someone who is intelligent that you can actually hold a conversation with. I would prefer a tall, well-built Italian man or maybe even a Japanese man; you know, something a little more exotic."

Jonathon then proceeds to share with me his sexual fantasies. "I am very sadistic. What I mean by that is that I enjoy mentally breaking people. I like to humiliate them; I like to be able to manipulate them and maybe keep them in a dungeon for a couple years only to let them out every now and then to play with them. It would be something very Marquis de Sade."

I have to admit, as a researcher this threw me a little bit. I thought to myself, "Is he serious? Or, is this all an elaborate, made-up story to spark a reaction?" My facial expressions! Oh god, am I controlling them? I try so hard to keep my "therapist face." No, I am good. There were no explicit reactions. I must remember to just keep taking notes and listen.

I inquire about his healthcare experiences. He tells me that he only goes to a doctor in Charlotte, N.C. (more than a 4 hour drive) just to receive his yearly checkup. I ask why he travels so far to seek medical care. He tells me that the doctors there are a little more liberal and accepting. He says, "It is the only place I feel that I can freely talk about my sex life, or my

personal life for that matter (Claim 7).” I probe further; I feel that there must be more to this story.

I ask about his earliest sexual memories. He continues, “My mom took me to a sex therapist when I was around three or four years old. She thought I had gender identity disorder. That was clearly not the case; I just liked cross-dressing. I mean several years later I was experimenting with my male cousins. You know, I think men are more resilient to experimentation because it is not as emotional as it is for women.” I ask what he means when he says he messed around with his cousins. “Well there was no penetration, but we did have make-out sessions and there was frequent fondling. I mean I didn’t make it this far without pulling the incest card at least once!”

I was seriously confused by this point in the interview. What is happening? Is this real life? It could be…I mean these things do happen and I suppose it is more than plausible that all of these life events took place. But then it became worse. There were stories about him attending a conservatory and his drug-using, pedophilic dance teachers; or the 13 women and 4 men with whom he had sex/relationships within a five year period (also possible, but they just weren’t adding up); or his mentioning that he would change his diet and conduct at least two enemas prior to having anal sex (a rather odd practice that I have never heard of in relation to “prep-work” for sex). At this point, I was no longer buying it. I asked myself: Is any part of this story real? Is this his story?

Claim 7: Gay and bisexual males lack access to gay-friendly healthcare providers, is very much the primary theme of this narrative. After much reflection, I realize that maybe his story is not so unusual. It is possible that he tells these stories often. These statements may not seem so unusual to a doctor in Charlotte who sees him on a yearly basis, someone who has seen him for

several years. If finding a gay-friendly provider is one of his primary considerations for disclosure (as claim 7 suggests), then it makes sense to travel so far. Here he is restricted from accessing gay friendly care. What student health is not able to provide (either through lack of services or heteronormative staff); gay and bisexual male students are subjected to the care of the local health department if they wish to maintain low to minimal cost on a college budget. Regardless, there is always a certain amount of risk involved with disclosing to a local provider. The gay community is small here and stories of contemptuous care from providers are frequently shared among its members. Many of the gay male students don't trust local doctors and will travel to seek appropriate care.

Hunter

Hunter reflects back to the first time he had sex with a guy. "I had met him online. He only lived about an hour away, so I traveled to meet him at the mall. I didn't know anyone there, so it was nice to walk around and hold hands." He had never held hands with a guy until this moment. "He asked me if I was ready. I was nervous, but I was so curious to experiment. He took me into the bathroom at Belk."

The guy pressed Hunter up against the wall and touching led to the removal of clothes. "He turned me around and kissed down my back, then put it inside of me. I had never bottomed; well I had never had sex with a guy. I had never experienced such an emotional feeling like this one. Then he finished inside of me. We didn't use a condom. I was in the moment and never even thought to ask (Claims 5 and 8). I felt horrible afterward, like maybe I could catch something from him. At that time I didn't even know what AIDS was, but I knew that you could get an STD. Thinking about it now, I am not even sure I knew there were different types of STDs, I just knew that you didn't want one."

I went to get tested at Student Health. I scheduled an appointment, checked in, and waited for what seemed like an hour. Of course, I was beyond nervous. Not only did I think that I had some sort of disease, but no one wants to have that conversation with a doctor (Claim 7). Finally the nurse called my name. I walked back to the scale and then to have my blood pressure taken. She asked me why I had come, and I told her to get tested for an STD. She asked me if I had any symptoms. I thought about it for a couple seconds and then asked her: What kind of symptoms? She rattled off a few like, rashes, discharge, bumps, sores, itching. I thought about it and said, "No, I don't think so." She looked at me blankly, as if I didn't even answer. Then she said, "If there is really nothing wrong, then there is no need for a test." I was confused by her statement. I left feeling like maybe I had misunderstood her, but I usually feel like I don't get what I need from doctors (Claim 7).

Claims 5, 8, and 7 are prominent in Hunter's story. Claim 5: Not everyone prepares for sex was evidenced by the fact that even though Hunter knew he was going to meet the guy for sex, he had not prepared for it. Was part of his reasoning that he didn't want to be labeled as promiscuous if he insisted on using condoms, or was it that he simply thought the guy would bring a condom instead? In any case, he did not disclose the reason. And, in fact, had it occurred to me to ask, I believe he might not have known the reason. It was his first encounter and his education was lacking to say the least, so it is plausible that it may have slipped his mind all together.

Claim 7: Gay and bisexual males lack access to gay-friendly healthcare providers. Hunter stated, "I usually feel like I don't get what I need from doctors." This is a feeling shared by many gay males. du Pre (2005) argues that stigma from providers can be especially threatening when one's health is at risk and a patient fears he will receive substandard care because of his sexual

orientation. Researchers agree that men who have sex with men "continue to need targeted sexual health and HIV and STD prevention education to increase knowledge and reduce misconceptions" (Rhodes et al 2011, p. 149). The importance of finding gay friendly providers is again echoed in a study of men that showed that "men were more open to discussing sexuality with their physician and that if participants were given more options for physician selection it would facilitate communication, and discussion about high risk sexual behavior" (Klitzman and Greenberg, 2002).

Andy

They had been dating for a year and a half when Andy decided to end it because Chase had become verbally abusive. "I just couldn't handle the emotional toll it was taking on me, said Andy." Six months later Chase texted him demanding that Andy return his Nintendo DS. Andy had forgotten he still had the game system; it had been thoughtlessly stored away in his closet. Andy offered to walk the DS down the block to Chase's house.

Andy knocked on the door. Chase opened it and walked into the kitchen. Andy, confused about why Chase had walked away, assumed he was invited inside. As soon as Andy was inside the kitchen, Chase began to scream at him about keeping his possessions. Andy explained that he had forgotten he still had the DS and never meant to keep it. Chase slapped Andy and called him a little bitch. Andy backed away as Chase charged toward him, thrusting his fist into Andy's chest. Andy turned to the door to try to leave. With a quick blow to the head, Chase knocked Andy to the floor. Andy looked up at Chase from the floor. Chase's eyes were filled with rage. Chase tore at Andy's clothes, ripping them to get them off. Andy cried out, begging him to stop.

Andy told me, "I remember trying to struggle, but I knew the more that I struggled the worse it would be. He pulled down my pants and underwear to my ankles and thrust my legs

toward my torso. With no lube or protection he shoved himself inside of me. Intense pain overwhelmed my body as I lay there motionless and crying. With each agonizing push, I felt as if I wanted to die. I lay there, motionless, and waited until he was through.

When he finished, he walked out of the room. I pulled my pants up on my waist and ran out of the house. As I began my walk home, my legs felt increasingly warm. I looked down to see my ankles stained with blood. I was trailing droplets of blood down the sidewalk. I stuffed my pant legs into my socks, went up to my room and cleaned myself up. The rest is a blur. I did not tell anyone.

Not my parents.

Not my friends.

Not anyone.

Not until now."

Andy's story is one that was not specifically supported by any of the claims made by the research regarding disclosure of sexual orientation to healthcare providers, but it was a story that I could not leave out. This story, I believe, speaks to the bigger problem of stigma as seen in all the other narratives. Because of stigma, Andy felt that he could not tell anyone about what had happened to him until several years later. This would not necessarily be the case if the two categories that Andy fell into were not as highly stigmatized. Being raped as a gay male is something that continues to go unreported and wasn't recognized by the FBI until 2012 (U.S. Department of Justice, Office of Public Affairs, 2012). In a study of 121 gay men, 53% experienced unwanted intercourse as a result of force by other men. The study also found that men with a history of unwanted sexual intercourse were more likely to have been physically assaulted by a male partner and were significantly more likely to report being afraid to request

that male partners use condoms (Kalichman et al., 2001). Andy continues to see a psychiatrist regarding the rape and assures me that he is making a lot of progress.

CHAPTER 3

Don't Let Me Down Son.

The fear of negative reactions from individuals in positions of authority is a dominant theme in many of the stories. Most of these fears stem from being afraid of a parent's reaction to "coming out" or even expressing same sex feelings. Waldner and Magrader (1999) offer that, "adolescents often choose not to reveal concerns about their sexual orientation, opting instead to withdraw. This withdrawal is based on fear of parental rejection (Hersch, 1991), abuse (Savin-Williams, 1994), and a desire to avoid hurting or disappointing parents" (Cramer & Roach, 1988). However, if we dissect the notion of disappointing one's parents even further, it is obvious that most young feel their being gay WILL be a disappointment. At this point it becomes evident that this is a societal norm that has been engrained into children at a very early age. Males have been socialized to believe that any display of non-typical masculine behavior is bad.

If a male realizes that he has same sex feelings around age 12 and is afraid of telling his parents, then we can assume the fear must have originated before middle school. The next phase backward would be elementary aged peers. Is this the origination of homosexual stigma? No! School aged children have been socialized with the assumption that gay=bad, but where have elementary school children learned this equation? Parents, media, and society are the answer. Stigma is a multifaceted social system that has its roots in fear-based dissonance. Simply put, people are afraid of what they don't (or refuse) to understand.

How this stigma affects gay males later in life is even more complex, and as I have found out through this research, quite unpredictable. Many of the males in this study explained that they were reluctant to disclose not only to healthcare providers, but to their parents, siblings, and friends. It is more than just social stigma that plagues many of these males. Internalized stigma,

or as it is known in gay research, internalized homophobia, still affects many if not most of the participants to some degree. For these males, how the notion of internalized homophobia manifests is just as unique as the stories they shared with me.

Common themes included the reluctance to announce one's gayness upon meeting new people; the idea that if it mattered to others, people would inquire about orientation; orientation as private information; announcing regret as a side note during the telling of a story ("maybe I shouldn't have done it"); and feelings of remorse toward the initial phase of their coming out process. It is ironic that even some of the most flamboyantly gay males I interviewed still feel remorse about how they came out to their parents. This theme of disappointing one's parents continues to echo through each of the stories to some degree. A study conducted by Allen et al (1998) showed that out of 79 adolescent gay, lesbian, or bisexual teen patients 74.7% of them indicated that they did not want to discuss sexual orientation in front of a parent while being seen by a healthcare provider, 58.6% were afraid that the healthcare provider would tell their parents, and 49.4% did not want to discuss their sexual orientation with their provider.

Stigmatized Language Engenders Unreasonable Expectations

If you examine the disproportional number of gay men infected by HIV it is easy to label unprotected anal intercourse as high risk, unsafe, or destructive behavior. However, what society fails to recognize is the difference between "unsafe" and "unprotected" sex. Shernoff (2006) defines unsafe sex as when a HIV negative man has condomless anal sex with another man of unknown HIV status or known HIV positive status. Unprotected anal sex occurs when two HIV negative men engage in sex without a condom. Situations of unprotected anal sex were described by many of the participants in this study and were based on interpartner trust. In all of these cases both partners received regular testing and were in monogamous relationships.

What continues to amaze me is that these males remain resilient and regularly seek testing despite the fact that they have so often received patronizing medical care by disdainful healthcare professionals. The unreasonable belief that all gay men must have protected anal sex is an irrational conjecture. This is all propagated by "hegemonic centrism of heterosexism" that is practiced and taught throughout most of academia (Whittle, 1996, p. 202). North Carolina's sexual education continues to be heteronormative, and for the most part relies on comprehensive sex education with preference towards abstinence. Despite numerous statistical reports that support the need for inclusive comprehensive sex education, the state continues to promote and rationalize its current method of sex education. The most current report shows that teen pregnancy is down 12% in North Carolina from last year, but the state still remains as one of the lowest in the nation for pregnancy prevention.

North Carolina is a state that not only makes up 3.35% of births to women under age twenty in the nation. 9% of N.C. high school aged teens have had sex before the age of thirteen, almost 1 out of every 5 N.C. teens have had sex with four or more partners before high school graduation, and 14% of N.C. teens have experienced some form of physical abuse by a partner compared to the national average of 9%. The U.S. average maintains that 84% of high school students were taught about AIDS or HIV infection, but in N.C. no data was available because it was not included as part of the curriculum (U.S. Department of Health and Human Services, 2013).

All of these statistics are 2-5 percentage points above the national average. As a health communication scholar, this terrifies me. Not only is the state not providing students with adequate sexual education, but it is also not providing them with the tools essential to raise their children in safe homes.

Many of these statistics are due in part to the 1995 legislation introduced by U.S. Representative Robin Hayes (R-N.C.). His argument for the abstinence-only sex education was that "we are teaching comprehensive sex education. We have condoms, dental dams, role-playing, all of this going down into 7th grade. This is not something we need to be doing to the exclusion of sexual abstinence until marriage" (Miller 1994). However, this law was overridden by the Healthy Youth Act of 2009. Now, schools are required to teach students about contraceptives and sexually transmitted diseases in addition to their traditional abstinence-until-marriage curriculum (Mann, 2010). While the Healthy Youth Act of 2009 is a progressive leap in the right direction, it still leaves those now college-aged at a disadvantage. Moreover, the law allows teachers to be culturally insensitive and biased (even allowing them to promote religion) and does not require that they provide instruction about sexual orientation or the negative outcomes of teen sex (Guttmacher Insitute, 2013). In other words, North Carolina is moving forward, but at a snail's pace.

We still have not overcome the problem of heternormativity in the great state of North Carolina as displayed by N.C.G.S. 14-177. This law reads "If any person shall commit the crime against nature, with mankind or beast, he shall be punished as a Class I felon." This vague description only leads to additional confusion about what the law really means. To help define this standard one must access precedential cases in N.C. Below are a list of cases that hold true for crimes against nature.

- the receiving, by a male or a female, of the sexual organ of a male into his or her mouth or anus, State v. Griffin, 175 N.C. 767 (1876); State v. Chance, 3 N.C. App. 459 (1969),
- fellatio, State v. Poe, 40 N.C. App. 385 (1979),
- cunnilingus, State v. Joyner, 295 N.C. 55 (1978),

- analingus, and
- the inserting of an object into a person's genital opening, State v. Stiller, 162 N.C. App. 138 (2004).

There are many problems surrounding these cases and their implications. All of these "violations" fall well within the standard range of sexual behavior displayed by humans across the globe and date back thousands of years (Smalls, 2010). It is obvious given the previously cited statistics that sex is very much prevalent amongst teenagers in North Carolina and avoiding discussions about sex and sexuality education is clearly not preventing intercourse. Trying to prevent teens from having sex is almost as impractical as denying its existence. This is as true for gay teens as it is for straight teens. Denying that gay sex happens doesn't make it go away.

Sex Education and Porn

Traditionally, young males were often exposed to pornographic magazines, but as technology has evolved Internet porn has become a more accessible medium. Most children, on average, are exposed to porn around age 11 and continue to view porn to satisfy childhood needs (Maltz and Maltz, 2010). Those needs include: 1) Learning about sex, 2) Belonging to a group, 3) Sexual permission and pleasure, and 4) Coping with emotional stress (p. 33). When taking the sexual history of the participants all of the males said that they had viewed Internet porn at an early age. All of the participants who shared stories of porn viewing originally used porn to satisfy the needs of learning about sex (specifically, gay sex) or sexual permission and pleasure.

So how are a gay male's needs different from those of heterosexual males? While childhood friends originally exposed some gay males to porn, heterosexual males typically continue to view or discuss porn amongst their friends. For gay males (after initial exposure) porn becomes private and a way to make sense of not only learning about sex (including gay

sex), but a way to grant self permission and pleasure that would be denied by others. As David Steinberg, erotic art photographer and writer, explains, "Pornography is still the medium that most vociferously advocates free and diverse sexual expressiveness, a radical stance in a culture which is still essentially puritanical and sex-negative" (as cited in Maltz and Maltz, 2010, p. 37).

For all of the participants porn viewing was described as a secretive act. Most were caught by their parents in their early teens and were subsequently punished. Not only were their little boys watching porn, but they were consuming GAY porn. The boys were chastised, sent to therapy, forbidden from ever using the computer again, but not one participant described having a conversation with his parents surrounding his choice in porn. It was always a punishment, never a discussion. For most of the men I interviewed, Internet porn was the only method at their disposal when it came to learning about gay sex. It was illegal to discuss gay sex in schools and for a period of time illegal to even discuss the mechanics of sex as most of these men were raised in a time and in places that provided abstinence only education. All of the males received "the talk," (the heterosexual talk) from their mothers and most of them were just given a pamphlet. Safe sex was almost never mentioned, and when it was mentioned it was in a context such as "you only need to worry about AIDS if you are black or gay."

These males were set up for failure, and are still being socially ridiculed, excommunicated, oppressed and stigmatized by the education system. The very system that should be informing and educating at the very least, all too often simply perpetuates ignorance and misinformation.

Religiosity Begets the "Religulous."

Scott's story prompted the discussion of this emergent theme. Because I grew up Baptist, it was not uncommon to hear stories about demons possessing "the Gays." However, I had never

heard this kind of story directly from a gay male. Before hearing the story, I had always heard the perspective of the preacher as he delivered his sermon or from the point of view of the women in the congregation gossiping about the topic over dinner after church. I had heard of pray the gay away camps, prayer meetings, interventions, healings (exorcisms in some churches), but I had never heard about these things from the perspective of the "demonized" Gay male.

How confusing it must have been for the gay males attending the camp. They were being asked to identify with the "reformed" gay men at the camp. However, the vast majority of the men I spoke with attended these camps against their will. Yes, there may have been some males trying to be "healed" by the grace of God through the process of praying for heterosexuality, but most of them were in a confused state of negotiating an identity that had been rejected by everyone around them.

Most of the males I spoke with didn't feel as though their sexuality was something that could be fixed. Even those who had originally thought they were broken maintained their identities as gay males. If anything, the attempted process of "fixing the gay" had the opposite effect. Many of these men lashed out against their parents, their therapists, and this has serious consequences today for their healthcare providers. This occurs primarily because healthcare providers play the role of authority figure over the patient's health. The patient in turn rejects this notion because it is similar to other authority figures not understanding, but wanting to control their lives.

Stigma

"There is a 'self-other, normal stigmatized unity': stigmatized and non-stigmatized alike are products of the same norms" (Goffman 1968). Ultimately, stigma is the primary overarching

theme of these narratives. Each participant is affected by stigma in at least one way. Stigma is created through the process of breaking norms. Norms are created by those with power in a society (usually the majority). Those who deviate from socially-created norms are labeled "deviants." They break the "rules" either implicitly or explicitly and are punished because of it. Whether it is through felt stigma, or internalized stigma, deviants suffer. They fear rejection, isolation, disproval, and worse, violence. Growing up gay is not an easy life for most males in the South as can clearly be seen in the stories shared in this thesis.

Coming out is a lifelong process. With every new healthcare provider gay males must weigh the benefits against the risk of disclosing to a stranger. The anxiety of predicting the provider's reaction is enough to discourage any patient. Will the reaction be silence, avoidance, disproval, or will it be compassion and acceptance? For most males it feels like a game of roulette and every provider interaction is somewhat different.

CHAPTER 4

Conclusion and Implications

The narratives presented in this thesis were much more revealing that I had originally anticipated. Their raw exposition of emotion and honesty still astounds me with every read. My thesis chair had warned me, "You will be amazed at what people will tell you!" He must have said that to me in at least 10 different conversations before I started interviews. Little did I understand how serious he was. I learned that when you ask the right questions, you receive amazing answers. Usually it is not the answer you had intended to receive. That was another obstacle I had originally faced. I thought I knew the answers I was going to get. "Poor research," that is what my committee members said. "If you go looking for something, you will find it, but you will miss the most important parts. Let the information come to you." That is what I did. I asked the questions, sat back, and listened. The information poured out. Not in long, detailed novels, but in rich little narratives that turned out to be priceless.

There was a lot of information that ultimately did not get used, but the themes that emerged out of those stories were all consistent with the claims that previous research had indicated. I continuously checked to make sure I was not leading or priming the data. But no, it is pure confirmation of what previous scholars had concluded. This thesis places those 8 emergent claims into one document. A document to validate through qualitative measures that the earlier work was relevant then, and continues to be just as important (if not more) now.

Implications

There is and always will be an inherent problem with speaking for others. Since I am not a member of the gay community, it is easy to make prescriptive measures from the outside looking in, but they are just that…measures. For change to occur at the necessary level there

must be a cultural shift. Stigma is not something that a thesis, a paper, or 10 papers can change. It takes an evolutionary process that requires years of persistent advocacy, change efforts, and enacted policy, before progress can be made. We have a start, but there is still a long road ahead.

What the stories I have shared in this thesis indicate is that our healthcare system is broken for college-aged gay and bisexual men. And while it will take years of advocacy and struggle to overcome all of the challenges faced by these men, I would like to conclude this thesis imaginatively. If we return to the eight claims (all of which were verified by the narratives in this thesis), it is possible to imagine a future where things might be otherwise.

Claim 1: The perceived benefits of disclosure don't outweigh the risk. If providers were more inclusive upon registration or in the initial examination uncertainty from the patient could easily be reduced. Some practices have established a sexual orientation check box on the registration form. This private information would be disclosed through written communication and would notify the provider before the interaction with the patient. Secondly, one of the participants indicated that when he went to his provider for his junior high physical the provider asked if he was dating girls, boys, or both. The nonchalant manner in which the provider obtained information as if it were part of a standard medical screening put the patient at ease when answering.

Claim 2: Sex education in North Carolina is not gay friendly. Providing comprehensive and inclusive sex education in middle school would better prepare N.C. teens for safe sex. Some would argue that middle school is too young to have conversations about sex, but 9% of N.C. teens have sex before the age of 13 (U.S. Department of Health and Human Services, 2013). Early conversations about sex better inform youth about responsible and safe sex practices.

Claim 3: Not using condoms is not always about risk, but instead often focuses on love and trust. The LOVE Condoms campaign is a great example of a public health campaign targeted at protection and acceptance of condom usage. This initiative was created by the AIDS Healthcare Foundation (AHF) to "promote widespread access, usage and acceptance of condoms as a vital component of the Global AIDS Control, through encouraging individuals to protect themselves and their partners by consistently using condoms" (AIDS Healthcare Foundation, 2012).

Claim 4: Sex without condoms is "hotter." This claim is directly related to claim 3. If the message is framed that condom usage is about love and protection of self and others, then the perception of sex without condoms can be modified.

Claim 5: Not everyone prepares for sex. Access to free condoms and contraceptives combined with comprehensive sex education and additional resources would provide the necessary knowledge and tools to equip young adults for safe unplanned sex.

Claim 6: Reluctance to disclose is due to fear of rejection by an authority figure. Many providers and staff (especially on college campuses) use the rainbow symbol as a signifier of a GLBT safe zone. This is a universally recognized symbol of inclusivity for GLBT individuals. This symbol placed on the door or interior wall of an examine room, would alleviate much anxiety about the reaction of the provider and staff.

Claim 7: Gay and bisexual males lack access to gay-friendly healthcare providers. Courses conducted on GLBT health combined with elements of sensitivity training should be provided to healthcare providers at no cost. LGBT advocates exist on most campuses across the state and posses the knowledge to deliver such training.

Claim 8: Men don't want to be labeled as promiscuous because they insist on using condoms. This is opposite of Claim 3, but recommendations are very similar. Education is the first step in transforming perceptions such as this. If condom usage is centered on responsibility and concern for self and other, then perceptions toward condom usage can be shifted. Secondly, patient education on vaccine regimens can also prevent many illnesses associated with gay men's health such as Hepatitis A and B, HPV, and Flu (Centers for Disease Control and Prevention, 2011).

The misconceptions surrounding gay/bisexual males, sex, and health are really no more complex than those of heterosexual males, all of which can be alleviated through effective communication. The reality of the matter is no more incomprehensible than heterosexual behaviors seen every day by healthcare providers and health educators. The problem continues to persist as heteronormative assumptions impede conversations with gay/bisexual males about sex. With the implementation of prescribed measures presented in this thesis, it is possible to imagine a better healthcare system that would be more supportive of gay and bisexual male patients.

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Appendix A

EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board Office
4N-70 Brody Medical Sciences Building· Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** ·
www.ecu.edu/irb

Notification of Initial Approval: Expedited

From:
Social/Behavioral IRB
To:
Branden Chambers
CC:

Eric Shouse
Date:
10/9/2012
Re:
UMCIRB 12-000907
Disclosure of Sexual Orientation Among Gay and Bisexual College Males

I am pleased to inform you that your Expedited Application was approved. Approval of the study and any consent form(s) is for the period of 10/3/2012 to 10/2/2013. The research study is eligible for review under expedited category #6, 7. The Chairperson (or designee) deemed this study no more than minimal risk.

Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The Investigator must adhere to all reporting requirements for this study.

The approval includes the following items:

Name	Description
Physician–Patient Communication: Disclosure of Sexual Orientation Among Gay and Bisexual College Males. | History	Study Protocol or Grant Application
Questions | History	Interview/Focus Group Scripts/Questions
Verbal Consent Doc | History	Consent Forms

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

Appendix B

East Carolina University

Informed Consent to Participate in Research

Information to consider before taking part in research that has no more than minimal risk.

Title of Research Study: Physician–Patient Communication: Disclosure of Sexual Orientation Among Gay and Bisexual College Males.
Principal Investigator: Branden Chambers
Institution/Department or Division: East Carolina University – School of Communication
Address: 102 Joyner East, Greenville, NC 27858
Telephone #: 252-328-4227

Researchers at East Carolina University (ECU) study problems in society, health problems, environmental problems, behavior problems and the human condition. Our goal is to try to find ways to improve the lives of you and others. To do this, we need the help of volunteers who are willing to take part in research.

Why is this research being done?
The purpose of this research is to examine what it means to be a self-identified gay or bisexual male patient. Secondly, it will help understand how that meaning affects their choice to disclose their sexual orientation to the healthcare provider. The decision to take part in this research is yours to make and your participation is voluntary**.**

Why am I being invited to take part in this research?

You are being invited to take part in this research because you have indicated that you are a self-identified gay or bisexual college male age 18 to 24. The amount of time it will take you to complete this study is dependent upon you as the participant, but not to exceed the length of the study (April 1, 2013). The estimated amount of time is 2 to 4, one-hour sessions. If you volunteer to take part in this research, you will be one of about 15 people to do so.

Are there reasons I should not take part in this research?

You should not volunteer for this study if you do not self-identify as a gay or bisexual college males age 18 to 24.

What other choices do I have if I do not take part in this research?
You can choose not to participate.

Where is the research going to take place and how long will it last?
The research procedures will be conducted at East Carolina University in Joyner East, room 205 A. You will need to schedule an appointment with me via email at chambersb11@students.ecu.edu prior to the day you would like to participate in the study. A follow-up meeting may be scheduled after the first session. The total amount of time you will be asked to volunteer for this study is a minimum of one hour over the next six months.

What will I be asked to do?
You are being asked to do the following: You are being asked to participate in one-on-one interviews. You will schedule an interview appointment in a private room on campus. Rapport will be established by explaining the purpose behind the study and the why I became involved in the study. The interview will begin with a look at their coming out story. Topical questions such as, "At what age did you identify as being gay or bisexual; at what age did you become sexually active with other individuals; have you ever participated in a high-risk sexual behavior and what was the motivation behind those actions?" The primary issue questions will be "What does it mean to be a gay or bisexual male patient?" and "How does that meaning affect the disclosure of your sexual orientation to your healthcare provider?" Probing questions will be established as needed to further the interview and question reoccurring themes. It is the goal that each subject participates in multiple interviews until saturation is reached. All interviews will be audio recorded, in addition to hand written notes. Data from the multiple interviews will then be transcribed and compiled according to similar reoccurring themes.

What possible harms or discomforts might I experience if I take part in the research?
You, as a self-identified gay or bisexual male should not feel any obligation to respond or participate in a portion of the research that would compromise your identity. The only minimal identified risk is that you may be seen leaving the interview location. In the event of emotional distress associated with the disclosure of an emotional experience in your life, information for The Center for Counseling and Student Development will be distributed.

What are the possible benefits I may experience from taking part in this research?
We do not know if you will get any benefits by taking part in this study. This research might help us learn more about what it means to be a gay or bisexual male patient. There may be no personal benefit from your participation but the information gained by doing this research may help others in the future.

Will I be paid for taking part in this research?
We will not be able to pay you for the time you volunteer while being in this study.

What will it cost me to take part in this research?
It will not cost you any money to be part of the research.

Who will know that I took part in this research and learn personal information about me?
To do this research, ECU and the people and organizations listed below may know that you took part in this research and may see information about you that is normally kept private. With your permission, these people may use your private information to do this research:

- The University & Medical Center Institutional Review Board (UMCIRB) and its staff, who have responsibility for overseeing your welfare during this research, and other ECU staff who oversee this research.

How will you keep the information you collect about me secure? How long will you keep it?

Information received during the interview will be audio recorded and will be transcribed upon the conclusion of the session. Once transcription is completed, the audio recorded will be erased. Electronic transcriptions will be free of identifying markers and all participants will be given pseudonyms to ensure confidentiality of your identity. Electronic transcriptions will be completed at East Carolina University in Joyner East 116, and will be stored on the secure East Carolina University server (Pirate Drive).

What if I decide I do not want to continue in this research?

If you decide you no longer want to be in this research after it has already started, you may stop at any time. You will not be penalized or criticized for stopping.

Who should I contact if I have questions?

The person conducting this study will be available to answer any questions concerning this research, now or in the future. You may contact the Principal Investigator at chambersb11@students.ecu.edu.

If you have questions about your rights as someone taking part in research, you may call the Office for Human Research Integrity (OHRI) at phone number 252-744-2914 (days, 8:00 am-5:00 pm). If you would like to report a complaint or concern about this research study, you may call the Director of the OHRI, at 252-744-1971

I have decided I want to take part in this research. What should I do now?

- I have read (or had read to me) all of the above information.
- I have had an opportunity to ask questions about things in this research I did not understand and have received satisfactory answers.
- I know that I can stop taking part in this study at any time.
- I have been given a copy of this consent document, and it is mine to keep.