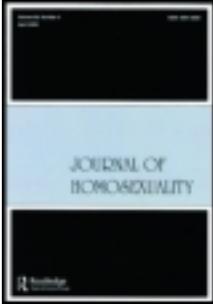


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# Comparing Sexual Behavioral Patterns Between Two Bathhouses: Implications for HIV Prevention Intervention Policy

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**SUMMARY.** There is a glaring lack of data to inform culturally appropriate HIV prevention interventions targeting environments such as bathhouses where men who have sex with men (MSM) practice sexual risk behaviors. This study compares sexual behavioral patterns across two bathhouse sites in order to identify important themes to address when tailoring HIV prevention interventions to bathhouse environments. We analyzed semi-structured interviews with workers and patrons at two bathhouses to explore similarities and differences. A coding scheme was established and data were organized according to conceptual themes. We found that differences between the two sites emerged in six key areas: bathhouse clientele, attraction to particular sites, sexual practices and condom use, communication about sex and HIV status, bathhouse rules, and substance use. Implications for HIV prevention intervention policy are discussed. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2003 by The Haworth Press, Inc. All rights reserved.]

**KEYWORDS.** Gay men, MSM, HIV/AIDS, sexual risk behaviors, HIV prevention intervention policy, bathhouse, public sex venues

### INTRODUCTION

Over twenty years have passed since the first HIV/AIDS cases were diagnosed in Los Angeles. In the mid-1990s, new treatments known as highly active antiretroviral therapy (HAART) brought some hope for people living with HIV and led to dramatic declines in AIDS incidence rates and HIV-related mortality (*HIV/AIDS Surveillance Report*, 1999). Recent research suggests that HIV incidence rates once stable among men who have sex with men (MSM) may be increasing for particular populations such as African American and Latino MSM (*HIV/AIDS Surveillance Report*, 2000). Continued HIV transmission combined with decreased mortality for those on improved treatment regimens translates into more people living with HIV and AIDS.

Recent investigations have suggested that HIV risk behavior and transmission have been increasing among MSM populations nationally (Stall et al., 2000; Wolitski et al., 2001). As the epidemic enters its third decade, there are over 16,000 people living with AIDS in Los Angeles County. The most common mode of transmission in Los Angeles

County continues to be male-to-male sexual contact, representing 71% of the cumulative AIDS cases. In Los Angeles, outbreaks of syphilis among MSM have recently been reported (CDC, 2001). In response to the evidence of increasing HIV risk among MSM, there are efforts to take research and prevention activities closer to the social environments where MSM congregate and to better understand these environments. Bathhouses provide a potentially important setting for this kind of research and intervention for reasons discussed below.

For more than one hundred years, bathhouses have been an important part of gay sexual cultures in the United States; from bathhouses where men occasionally had sex in the late 1890s to the modern bathhouses that exclusively cater to social and sexual needs of gay men (Bérubé, 1996). There have been recurring public health debates over the role of bathhouses in the proliferation of STDs such as HIV (Alexander, 1996; Bérubé, 1996). In the mid-1980s, San Francisco experienced a controversy over closing bathhouses that is not atypical of other debates (see Disman, this volume). During the San Francisco debate, some argued bathhouses should be shut because they encouraged activity that drove the HIV epidemic. Others promoted them as unique venues that facilitated outreach to populations with high-risk behaviors. Still others made bathhouses symbols of gay and civil rights (Shilts, 1987). Given their niche in gay sexual history, surprisingly little research has been conducted with respect to sexual risk behaviors within bathhouses.

Clearly, sexual behaviors that may transmit HIV do occur in bathhouses. For instance, Richwald (1988) interviewed 807 men as they left seven bathhouses in Los Angeles County; 10% reported having had unprotected anal intercourse (UAI) in bathhouses. The men who were having UAI were more likely to report 5 or more male partners in the past month than those who did not have UAI. Elwood et al. (1998) found that while many bathhouse patrons reported knowledge of HIV and safer sex practices and avoided penetrative sex or used condoms, a minority of this sample also reported complete disregard of risks of HIV infection or sexual prevention. Sey and Harawa (2001) found that 63% of HIV seropositive (+) MSM diagnosed with acute/primary or recent HIV infection had sex in public sex environments; at 12-month follow-up, 36% reported sex at bathhouses (personal communication with Harawa, 3/25/02). Binson and colleagues (2001) found that people using bathhouses are more likely to be HIV positive compared to men who cruised for sex only in cruising areas such as parks, tearooms, beaches, or bookstores.

Recent studies have begun to illustrate that differences may exist among bathhouse patrons. For example, Elwood and Williams (1998) found that men who frequent bathhouses were not a homogeneous group; attendees varied in terms of sexual identities and sexual behaviors. Another study found differences in the prevalence of sexually transmitted diseases, drug use, and risky sexual practices among men who frequent gay sex venues by type of venue (e.g., bathhouse, cruising areas, and multiple venues) (Binson et al., 2001). Previous bathhouse studies have not examined differences between patrons and their sexual activities across bathhouse sites (Richwald et al., 1988). Still, policy discussions regarding HIV prevention interventions targeting bathhouse settings continue to presume that one size fits all. If differential risk patterns exist across bathhouse sites, this nonspecific prevention policy model may be flawed and may inhibit efforts to intervene appropriately to reduce bathhouse sexual risk activities. Therefore, exploring whether or not differential behavioral patterns do exist between bathhouses is important for considering how to conceptualize HIV prevention policy and develop HIV interventions in these special settings.

We conducted a qualitative study of bathhouse sexual behavioral patterns and HIV risk behavior in two Los Angeles County bathhouses in order to identify themes that may be relevant for designing HIV prevention interventions targeting bathhouses. We found that differences as well as similarities emerged around the following themes that may be important to consider for assessing such efforts in other venues: perceptions of behavioral patterns and rules governing sexual and HIV risk behaviors such as clientele's attraction to particular bathhouses, condom use and sexual activities, the customary interpersonal processes involved in negotiating sex and condom use (communication about sex and HIV), and substance use. We also were interested in better understanding differences in clientele demographics and the formal and informal processes that were used by management and patrons to regulate sexual behavior and HIV risk.

The study included two bathhouses which, at the outset, were characterized by their management as having very different clientele: Bathhouse A clientele was seen as predominantly Caucasian, relatively young, affluent, and "out" with regard to sexuality. Bathhouse B was characterized as having a clientele that was predominantly ethnic/racial minority, more mixed in age and largely working class in economic background, with a greater proportion of closeted men (men who are not "out" or open about being gay or bisexual) than Bathhouse A. Though the number, location, and behavioral patterns of bathhouses

evolve constantly, there were eight bathhouses and two sex clubs operating in Los Angeles County at the time we started collecting these data (1999). The two participating bathhouses were chosen because of their differing clientele demographics and their managers' willingness to commit to this formative research as well as to a subsequent epidemiological study. The differences in location and clientele in these two settings provide a useful example for examining how the specific behavioral pattern that develops in a setting may be related to the patterns of risk behavior there and the considerations needed in developing setting-specific interventions to reduce HIV risk behavior in bathhouses.

### *METHOD*

Study staff conducted face-to-face, qualitative interviews (Goldbaum et al., 1996) with individuals who worked at the two bathhouses and, subsequently, with bathhouse patrons, or "key participants" between November 1999 and April 2000. Respondents were selected using a purposive nonprobability method (Kuzel, 1992; Patton, 1990). For both the bathhouse worker and patron samples, we attempted to obtain a broad cross-section of perspectives, experiences, ages, and racial/ethnic groups. Bathhouse workers were referred to study staff by the bathhouse management. Bathhouse patrons were recruited in a number of ways, including referrals from bathhouse management or outreach workers, promotional activities such as posting of flyers in the bathhouses, and by study staff directly approaching patrons during their visit.

#### *Participants*

The participants included 16 bathhouse workers and 24 bathhouse patrons. The 16 bathhouse workers included 2 managers, 8 staff (cashiers, cleaners, etc.), and 6 outreach workers who were employed by local community-based HIV prevention organizations. Seven workers from Bathhouse A were interviewed and 9 workers from Bathhouse B were interviewed. These interviews provided a staff perspective and an overview of bathhouse operations. The patrons included 13 from Bathhouse A, 10 from Bathhouse B, and 1 individual who did not identify with either bathhouse. This "unaffiliated" patron was excluded from further analysis of the data because of our interest in looking at possible differences between the two bathhouses. These interviews provided a

first-hand description of the behavioral patterns and functions of the two Los Angeles-area bathhouses.

### *Characteristics of Participants*

*Workers.* Sixteen bathhouse workers were interviewed. All of the bathhouse workers interviewed were male. Their average age was 34 (range = 21-52, s.d. = 8.2); 31.3% were white, 31.3% were Latino, 25% were African American, and 12.5% were unknown (missing data). The average education level was 12 years (high school equivalent). No data were collected on the sexual orientation of bathhouse worker respondents.

*Patrons.* Among the 23 bathhouse patrons interviewed, the majority at both bathhouses reported being primarily gay and the average age reported at both sites was in the upper-thirties. Of patron respondents at Bathhouse A, 84.7% were self-identified gay while 15.4% were self-identified as bisexual. The mean age of patron respondents at Bathhouse A was 36 (range = 22-45; s.d. = 8.6). Most of the patrons at Bathhouse A were Caucasian and reported having 4 or more years of college education. The racial/ethnic composition of patrons interviewed at Bathhouse A was 41.7% Caucasian, 33.3% Latino, 16.7% African American, 8.7% unknown, and 0% Asian/Pacific Islander.

Patrons interviewed from Bathhouse B were mostly African American or Latino, and reported having some college education. The racial/ethnic breakdown at Bathhouse B was 44.4% African American, 33.3% Latino, 11.1% Caucasian, and 11.1% Asian/Pacific Islander. At Bathhouse B, 88.9% self-identified as gay, 0% self-identified as bisexual, and 11.1% did not report a sexual identity. The mean age of patron respondents at Bathhouse B was 39 (range = 25-52, s.d. = 8.5).

### *Procedures*

All qualitative research participants were enrolled after giving written, informed consent. The research protocol and consent forms were approved by the Los Angeles County-University of Southern California Institutional Review Board (IRB) and the Centers for Disease Control and Prevention (CDC) IRB. Four interviewers collected the qualitative data after they attended a standardized three-day training workshop and completed a series of practice interviews. The workshop focused on methods for conducting face-to-face, semi-structured interviews. The interviewers were self-identified gay or bisexual men, ages 22 to 38,

who had prior work experience in clinical or community outreach settings.

Interviews were conducted at either of the bathhouses or at another mutually agreed-upon place that provided a quiet and private environment (e.g., community-based agencies, homes). The interviews were audio taped and transcribed verbatim into a computer database for analysis of qualitative data (CDC-EZ-Text, version 3.06C; Carey et al., 1998). The study coordinator performed quality assurance checks by comparing the transcribed interview documents with the tapes. The tapes were destroyed after quality assurance was completed. The interviews were confidential and no names or other identifying information were included in the transcripts. Respondents were compensated \$35 for travel or other out-of-pocket costs related to participation.

The respondents' beliefs, opinions, and behaviors described in the transcripts were assigned thematic codes by two CDC research staff in Atlanta who had not been involved in the collection of data. They defined codes in a codebook (MacQueen et al., 1998; Miles et al., 1994). Coding of the text passages was done using CDC EZ-Text, version 3.06C (Carey et al., 1998). To ensure consistent, thorough, and replicable coding between the two coders, a series of inter-coder reliability checks were undertaken, which used methods recommended for analysis of semi-structured qualitative data (Carey et al., 1996). Final intercoder reliability was excellent: 338 of the 396 codes (85.4 percent) defined in the final codebook used for the bathhouse patron database had Cohen's *kappas*  $\geq 0.90$ , and 283 of these 338 codes had a *kappa* = 1.00 indicating complete agreement between the two coders. Similar high inter-coder reliability was attained for the bathhouse workers (83.3% of the codes had a *kappa* > 0.90). After completing this process, remaining coding disagreements were resolved by the two coders discussing their divergences and arriving at a consensus for the final coding of the entire data set.

Coding was iterative and began with a content analysis of the qualitative interview questions and probes, with subsequent adjustments based on codes that emerged from subsequent content analysis of the interviews and reconciliation of these codes between the two raters (MacQueen et al., 1998). Themes were also allowed to emerge from the initial coding of the data (Buroway et al., 1991). Where visual inspection of the data suggested differences between the bathhouses, themes were identified and labeled. Axial coding was used to organize themes into concepts that clustered together around six major categories (Strauss, 1987). Illustrative quotes were obtained for each bathhouse

site to demonstrate differences and similarities across sites. No statistical tests for significance were conducted because the “n” for participants (patrons and workers) was very small (23 and 16, respectively). Bathhouses were coded as A and B to protect the confidentiality of these institutions. Interviewees were given pseudonyms to ensure confidentiality and these pseudonyms are used in the reporting of results here.

### *Measures*

The interviews used a semi-structured format, with a standard protocol of open-ended questions and probes. The worker and patron interviews were parallel in content and queried respondents regarding the clientele of the individual bathhouses (e.g., demographics; characteristics of popular patrons; popular times for patronage; the normal routine for bathhouse patrons; reasons for attending bathhouses; common sexual practices; verbal and nonverbal negotiation of sex; drug and alcohol use; condom use; disclosure of HIV status by patrons; and a number of questions regarding HIV counseling and testing). The results of the worker interviews informed development of specific items for the patron interview questionnaire, although topical areas of the two protocols were similar. The interviews were pretested with 4 gay-identified men working on different research projects.

## *RESULTS*

As stated previously, our purpose was to explore differences in the perceived and actual behavioral patterns of patrons at these two bathhouses in order to better understand how HIV prevention interventions may need to be targeted to specific bathhouse sites. We analyzed how the sexual norms, rules, and risk behaviors varied between Bathhouse A and Bathhouse B. In our analysis, we found that the patrons' proximity to fellow patrons and to the activities occurring behind closed doors at each bathhouse allowed for a richer characterization of the bathhouse clientele. For this reason, we have focused our presentation of results on the patron interviews with an occasional reference to the worker data set. Six categorical themes emerged that indicated differences: perceptions of bathhouse clientele, attraction to particular sites, bathhouse sexual practices (perceived and self-reported sexual activities and condom use), communication about sex and HIV status, bathhouse rules,

and perceived substance use practices among patrons. First, we will highlight the similarities across each site vis-à-vis these themes. We illustrate differences in how these categorical themes played out in our descriptions of each bathhouse site below in order to provide a sense of behavioral and demographic patterns reported at each bathhouse. A summary of similarities and differences between behavioral and demographic patterns reported at the two sites concludes this results section.

### *Similarities Between Bathhouse A and Bathhouse B*

The typical routines of patrons were consistent across sites. Such routines are characterized by patrons renting lockers or rooms, walking around to look for sex, and engaging in other secondary activities (e.g., socializing, taking showers, and using the spa or steam room). However, all patrons from both bathhouses perceived that they and other patrons were there primarily to have sex. Some patron respondents mentioned other motives such as “blowing off steam,” being in a “gay” environment and relaxing with acquaintances. Seeking multiple sexual partners, either successively or simultaneously, was believed to be very common in both bathhouses.

*Sexual and condom using behaviors.* Most patrons perceived that fellow patrons were less likely to use condoms for oral sex versus anal sex in both bathhouses (indeed, condoms were rarely reported to be used for oral sex). Patron interviewees also self-reported being more likely to use condoms for anal sex than oral sex. When asked how they decide to use condoms, the most common response among all patrons interviewed was that the participant let his partner decide whether or not condoms would be used.

*Communication about sex and HIV.* Patron respondents at each bathhouse were likely to state that indirect, nonverbal communication about sexual interests was more common than direct communication. Paul, a patron from Bathhouse B, said:

A lot of times, there is not a lot of verbal communications . . . it is common in my experience that people would try to start doing something . . . they would try to start penetrating you . . . or I will start licking a guy's anus . . . guys know what you are trying to do and if they don't like it they will just gently stop you . . . just put their hand on your head or on your penis or your hand . . .”

Many patrons interviewed shared their observation that men who like to receive anal sex will lie on their stomachs on their beds with the door open and wait for someone they like to enter the room; alternatively, men who prefer to be the insertive partner will lie on their backs and wait for a partner. At the same time, the majority of each group stated that direct verbal communication and eye contact were also common forms of communication. For instance, Phil from Bathhouse A shared how he communicates with potential sexual partners:

I usually say, um . . . Hi . . . my name is . . . and they will tell me their name and then I can tell if they are still interested . . . then I will . . . give them a compliment and they will usually like look at my body and then . . . do you have a room? . . . and we will go somewhere.

While a few patrons stated that some direct verbal communication about sex happens, their perceptions of how other patrons communicate at both bathhouses emphasized indirect communication.

The majority of patrons interviewed at both bathhouses stated that other patrons also tend to make assumptions about HIV status based on top/bottom roles (“top” refers to being the insertive partner in anal sex and “bottom” refers to being the receptive partner). For instance, George, a patron from Bathhouse A stated:

I don’t think either of them really think about it, but if anyone’s going to think about, especially not a top. Because if they’re going to be doing the fucking they’re going to think, you know, my chances of being infected are, are little. Bottoms, it might cross their mind more.

This “top/bottom” myth that tops are not HIV infected was consistent across sites.

*Bathhouse rules.* Patrons at each site perceived management’s enforcement of bathhouse rules similarly. For instance, both sites were perceived by most patrons to include rules such as “No Public Sex” and “Use Condoms and Lube (encouragement of safer sex)”; these rules were perceived by some at each site to be enforced by signs and by employees who patrolled public areas. At both sites, a smaller proportion of patrons also perceived that there were no rules. Interviews with workers at both bathhouses reveal very similar perceptions of the rules compared with interviews with patrons (no public sex, encouragement

of safer sex, and no substance use), with the exception that the majority of workers at both sites also stated that bathhouse management enforced rules by providing information such as posters about safe sex and testing information (whereas only one patron mentioned these posted materials).

*Substance use.* Patrons at both sites indicated that other patrons use poppers (inhalants such as amyl or butyl nitrate) and many also indicated that substances were used to relax and enjoy sex more. Patron respondents also perceived that fellow bathhouse patrons sometimes came to the bathhouse already intoxicated either from a party or the bars. Almost all patrons at each bathhouse said that substance use contributes to unsafe sexual behaviors.

### **Bathhouse A**

*Perceptions of bathhouse clientele demographics.* Our descriptions of Bathhouse A and Bathhouse B reveal unique characteristics of each site regarding clientele and behavioral patterns that cluster around the six categorical themes. Workers at Bathhouse A most frequently said that their patrons were openly gay or bisexual. Bathhouse A workers also described their clientele as white or representing a variety of racial/ethnic backgrounds. Patrons at Bathhouse A were also most likely to state that other patrons were from diverse racial/ethnic backgrounds (without one race/ethnicity being predominant). Chris, a patron respondent, described other patrons at Bathhouse A:

R: Well, like I came here on a Tuesday on a Latin-night and it was mostly Latinos, so it usually fits the bill pretty well. Sometimes there's a mix and sometimes there's more Caucasians than not.

I: And do you think most of these guys would describe themselves as gay, or either like straight guys, closeted guys?

R: Mostly gay, I've met a couple of bi ones, I've met like one that just came here before he came home from work to his wife.

This assessment of patrons at Bathhouse A typifies perceptions at this site.

*Communication about sex and HIV.* As stated above, patrons reported similar patterns of indirect (nonverbal) communication about sex at both sites. HIV status is also never or rarely directly discussed at either site as reported by most patron respondents, but patrons from Bathhouse A and B reported different assumptions about how other pa-

trons perceive the HIV status of sexual partners. Among patrons interviewed from Bathhouse A, the most common perceived assumptions regarding HIV status of sexual partners were: (1) other patrons are all HIV+ and (2) other patrons are HIV-negative. Some Bathhouse A patrons perceived that other patrons either make no assumptions about HIV status or make assumptions about HIV status based on criteria other than reported HIV status.

*Patrons' attraction to site.* Patrons at Bathhouse A most often mentioned being drawn to that site by good-looking, muscular patrons. For instance, one Bathhouse A patron, David, stated that he liked, "Attractive, butt, no fat people, or my frame, or nice looking (men)." Some of the patrons at Bathhouse A also said that they were in the frame of mind to party (use recreational substances) when they came to the bathhouse.

*Sexual and condom using behaviors.* Patrons at Bathhouse A perceived that both oral sex and anal sex were very common practices on site. While the practice of using condoms more frequently for anal sex compared to oral sex was consistent across bathhouses, we found that patrons at Bathhouse A were perceived to be very likely to be seeking anal sex at that site. Some of the patrons interviewed there said that they did not like using condoms. For instance, Rick, a patron from Bathhouse A, said that, "Having to fucking deal with them (condoms) right in the middle of a passionate moment, and everything is (discouraging)." Most patron respondents at Bathhouse A also reported that other patrons there use substances in order to lower inhibitions and to enjoy sex.

*Substance use.* Rafael, a patron interviewed from Bathhouse A, shared his perception of why patrons use substances such as crystal, ecstasy, and poppers in order to be uninhibited and enjoy sex at Bathhouse A:

I: Approximately what percent of people would you say have sex here at the bathhouse while under the influence of drugs or alcohol?

R: I'd say eighty-five to ninety.

I: Okay, why do you think they use that, the drugs or the alcohol? . . .

R: Uninhibited.

I: Like less, like they feel more open?

R: They're just more relaxed and they're not so conscious of, how can I put it, they're not in cue with what's really important, it just comes as a fantasy thing here, and it's just for fun and to let, you know.

Patron respondents reported substance use at both bathhouses; yet the use of ecstasy, cocaine, GHB, and crystal methamphetamine was frequently reported by patron interviewees at Bathhouse A. At the same time, when probed, most patrons interviewed at Bathhouse A cited rules about not using drugs and alcohol; many also stated that patrons at Bathhouse A were kicked out if they did not follow rules. If the perceptions of patron interviewees at Bathhouse A are true, clientele (predominantly from diverse racial/ethnic backgrounds and gay) there may be engaging in high risk anal sex activities under the influence of multiple substances.

### ***Bathhouse B***

*Bathhouse clientele demographics.* When asked to describe their patrons, some workers at Bathhouse B stated that their clientele were alternatively married, straight, gay, bisexual or closeted. Workers at Bathhouse B were most likely to state that black and Latino MSM patronize their establishment. The Bathhouse B patrons' perceptions of the race/ethnicity of other patrons were similar to the workers' perceptions, i.e., they were also most likely to state that patrons there were Latino or black. Many patrons at Bathhouse B also mentioned that some portion of fellow patrons there were married or closeted. For example, consider Mario's response, a patron interviewed at Bathhouse B, when asked about the typical patrons there:

I: Okay. And race, how would you describe the customer's race here?

R: I'd say a high percentage of them are Black, next would be probably Latinos, and probably less white people . . .

I: Okay. How would you describe the customer's degree of outness, you know, in terms of are they gay identified or are they more closeted, or is it a mix?

R: It's a mix, I would say it's a mix . . . I would say maybe at least seventy percent are totally gay, and probably out and the rest are probably like closeted.

The behavior of the closeted men at Bathhouse B is perceived by a comment by Jose, also a patron at Bathhouse B, "Closet case men, they feel they're at risk if they're going to give their name or their telephone number. They want to forget, they want to remain anonymous."

*Communication about sex and HIV.* As mentioned above, HIV status is never or rarely discussed at either site as reported by most patrons at Bathhouse A and B. Bathhouse B patrons were most likely to report that their fellow patrons make no assumptions about HIV status or that other patrons are HIV+. Some perceived that patrons make assumptions based on other criteria of potential sexual partners, whereas assuming that other patrons were HIV-negative was not a common theme among patrons interviewed from Bathhouse B.

*Patrons' attraction to the bathhouse.* Patrons at Bathhouse B mentioned multiple reasons (e.g., convenient location, erotic videos, or other sexual scenes such as exhibitionism) as the primary feature that attracted them to that bathhouse. For instance, Paul shared the following reasons for being attracted to Bathhouse B:

I: Are there particular scenes or kinds of partners here that make the bathhouse attractive to you?

R: Yes . . . um going back to how the men are more real . . . they are not the West Hollywood young boys with the perfect bodies . . . but they ah . . . they don't even have to be overweight . . . they just have to have a regular body where they don't go to the gym much or at all . . . um . . . now and then I like a big portly guy to have sex with . . . maybe a taller guy.

The interviews with Bathhouse B patrons revealed a sense that patrons go there for a variety of reasons including to meet "regular" types of guys.

*Sexual and condom using behaviors.* Most patrons did not say that anal sex was common at Bathhouse B among other patrons. When asked when they use condoms, patrons at Bathhouse B most frequently stated that they always use condoms for anal intercourse. For instance, one patron of Bathhouse B named Jeff shared his condom using behaviors there:

I: How do you decide when to use them (condoms) for particular acts or partners? And you say you always use them.

R: Yea . . . I always use them for anal sex.

Bathhouse B patrons tended to state that they always use condoms for anal sex and none said that they hated condoms or never used them.

*Substance use.* Bathhouse patron respondents reported that substances were used at both bathhouse locations. However, the type of

substances used varied by site. Marijuana and poppers were the most frequently reported substances used at Bathhouse B. James, a patron interviewed at Bathhouse B, shared this perspective of substance use behaviors there:

R: What I think? I mean like I know like some people in here use poppers and I'm not sure . . .

I: Okay, like the percentage, what would you guess?

R: Yea. I'd probably use the poppers, thirty percent, thirty percent, but maybe forty . . .

I: Okay. And what about other drugs? How about alcohol? What percentage of people . . .

R: They do, I've seen people bring like beer or whatever, or mixed drinks in like juice bottles. And I'd probably say maybe twenty percent of them that come here . . .

I: What about other drugs like crystal meth, marijuana . . .

R: I've never seen, I've seen like marijuana, like on the roof on occasions. I've seen guys when they smoke a little weed. I'd probably say probably twenty, twenty percent of some the guys that come here . . .

R: Well a lot of guys say the poppers; you know, turn them on and get their dick harder. And they say it makes them go longer, so they, you know, get the little bottle of poppers and they sniff that.

If patrons and workers interviewed at Bathhouse B are correct, the clientele there is primarily Latino and black and quite diverse in terms of sexual orientation and body type; some may also be closeted or married men. According to patrons interviewed, anal sex does happen at Bathhouse B, but oral sex is more common.

### *Summary of Behavioral and Demographic Similarities and Differences*

Similarities and differences were apparent between the behavioral patterns of the patrons from the two bathhouses. Similarities included the perception that patrons were more likely to use condoms for anal sex compared to oral sex; the perception that nonverbal communication about sex is the most common method for showing sexual interest and negotiating sex; the perception that HIV status was mostly not discussed with sexual partners; and perceptions that both bathhouses had rules prohibiting sex in public places and substance use in the bathhouses, that were inconsistently enforced. Patrons at both bathhouses

described a top/bottom typology for making assumptions about the HIV status of their sexual partners in which tops were perceived as being less likely to contract HIV during unprotected sex. When asked how they decide to use condoms (if at all), the most common response of patrons at both sites was they allowed their partners to make that decision. Minimal verbal communication tends to be the rule in initiating sexual activities at both bathhouses and all decision-making about what happens during a sexual encounter may be determined by non-verbal cues.

Differences were noted regarding reports of bathhouse rules. Although the patrons and workers interviewed stated that rules regarding safer sex and substance use were present at each location, the degree to which such rules were noticed and enforced varied within and across the bathhouses examined. For instance, bathhouse workers claimed that safer sex information in the form of posters and other promotional materials were prevalent, but patrons did not identify these materials. While some patrons did state that management expelled offenders of the "no substance use" rules at one site (Bathhouse A), the efficacy and consistency of bathhouse "rule" enforcement across bathhouses remains unclear. Some patrons even stated that no rules existed. Overall, there is varying awareness of the bathhouses' efforts to regulate sexual behavior and substance use and these efforts have unknown degrees of success.

Important differences in norms and rules guiding sexual practices at each site were also identified. Bathhouse B patrons and workers were likely to state that patrons were straight, bisexual, closeted, or married; patrons at Bathhouse B were commonly perceived as being primarily Latino and African American. Patrons at Bathhouse A perceived their fellow patrons to be very interested in anal sex and were likely to state a dislike for condoms as the reason for not using them. Patrons at Bathhouse B were commonly perceived to make no assumptions about the HIV status of their sexual partners, while patrons at Bathhouse A were likely to assume that their partners were HIV-negative. Substance use was prevalent at both bathhouses. However, different substances were used at each site and patrons described more extensive substance use at Bathhouse A. Perhaps, as a consequence, patrons at Bathhouse A commonly cited both the rules and the enforcement of rules about substance use. The use of substances to lower inhibitions and enjoy sex was also a major theme reported by patrons at Bathhouse A.

## DISCUSSION

This analysis suggests that differences exist between bathhouse behavioral risk patterns located within the same city. The differences between the sites examined here suggest that bathhouses are quite varied by a number of dimensions that may apply to such analyses of other bathhouses. Each site may promote a self-selection among patrons who organize around domains like race and ethnicity, body type of clientele (muscular or “regular”), the type of sex practiced by patrons, assumptions about HIV status, bathhouse rules and enforcement of rules, and the recreational drugs of choice used therein. Efforts to develop prevention strategies at bathhouses must take into account these differences. Due to these variations, approaches that work at one bathhouse may not be successful at another. The differences in substance use between Bathhouse A and Bathhouse B are one example. For example, interventions that address the on-site use of poppers and marijuana at Bathhouse B may not address Bathhouse A patrons’ use of crystal methamphetamine and ecstasy.

These results reveal key considerations for developing prevention and harm reduction strategies responsive to specific HIV risk factors at particular bathhouse sites. The patrons describe patterns of sexual risk taking, lack of verbal communication, nondisclosure of HIV status, and frequent substance use among patrons regardless of the specific bathhouse location or racial/ethnic composition of its patrons. For instance, the top/bottom belief regarding HIV status of sexual partners described by patrons from both bathhouses suggests that bathhouse patrons may be making erroneous judgments about partner risk. The idea that men who are willing to engage in insertive anal sex with them are less at risk for HIV infection and are HIV-negative may be used as a rationale to practice unprotected sex without talking about HIV. The attribution of HIV status (rather than communication about it) may further increase opportunities for HIV transmission, particularly if patrons perceive their sexual partners to be HIV-negative when they are not. Such opportunities for HIV transmission may be more prevalent in bathhouses where patrons make more erroneous assumptions about HIV status.

These findings suggest that some bathhouses may be more risk-conducive than others. For instance, interviewees reported more perceived sexual risk behaviors (noncondom use, assumptions about HIV status, and substance use activities) at one of the sites. Such varied perceptions of norms regarding sexual practices, communication about sex and

HIV, substance use, and safer sex rules across bathhouses suggests that HIV transmission risks exist at varying levels and that patrons naïve to the norms driving sexual behavioral patterns at particular bathhouses may be at particular risk of HIV infection.

Patrons at both bathhouses observed sexual risk behaviors that are known to transmit HIV and other STDs among MSMs. Some patrons were perceived to be married, closeted, or bisexual at both sites; such perceptions were more evident in the perceptions of patrons at one of the sites. The implications for the female sexual partners of patrons from some sites may be more pressing than for other sites. If condoms are not being used for oral sex, as perceived by patron respondents at both bathhouses, then the opportunities for transmission of sexually transmitted diseases (STDs) are evident at both sites. Since communication about HIV status does not happen, it may also be true that communication about STDs does not happen. These themes highlight the importance of understanding the bathhouse environments and the roles they may play in the spread of sexually transmitted infections (such as the syphilis outbreak in Los Angeles County) to partners outside the bathhouse.

The assumption that bathhouses attract many MSM who do not identify as being gay and, therefore, offer unique access to hard-to-reach populations should be continually examined. Even among racial minorities interviewed, the majority of patrons identified as being gay. Patrons and workers interviewed stated that straight and bisexual men were active at both bathhouses, yet one of the sites appears to draw a larger proportion of clientele from such populations. These findings provide a starting point to better understand the nexus of sexual orientation, sexual behavior, and sexual risk activities among men who attend bathhouses and who do not identify as gay. These data also suggest further research questions regarding how, if at all, sexual risk behaviors are associated with race/ethnicity and class status.

The image of the good-looking, muscular type appeals to the patrons of Bathhouse A, while homoerotic videos and “regular” guys are important components of the erotic draw of Bathhouse B. Both features suggest potential means of reinforcing safer sex practices with patrons such as prevention strategies that incorporate idioms, themes and images from the repertoire of gay behavioral patterns. The explicit gay self-consciousness of these clubs might be the optimal basis for planning and implementing interventions. Still, little is known about what attracts closeted or bisexual men to particular bathhouses for sex with men. It is possible that they cluster themselves into sites that are less ex-

PLICITLY gay-identified where they can seek sexual fantasies with other men without associating themselves with an explicitly gay experience.

The use of recreational drugs by a substantial number of the men interviewed remains a perplexing challenge to encouraging sexual behaviors that promote enjoyment and maintain health. The differences between the recreational drugs of choice of patrons at the two sites suggest another example of self-selection that may be helpful in narrowing casting interventions to promote harm reduction. If patrons use choice of drugs to cluster themselves into specific sites, then prevention strategies can be developed around particular patterns of drug use and related risky sexual behaviors. For example, if one bathhouse is characterized by patrons who use ecstasy, cocaine, GHB and crystal methamphetamine, then a combination of strongly enforced rules prohibiting use of these drugs, staff training in the symptoms of drug intoxication, and tailored marketing messages may impact unsafe behaviors driven by substance misuse. Given the unique odors associated with marijuana and poppers, a more aggressive and visible staff presence may positively impact these behaviors and how they interact with sexual risk activities in another bathhouse site. More research is needed to learn how substance use choices are associated with sexual risk behaviors within the context of bathhouses in order to further understand how sexual risk is differentiated by bathhouse sites.

The use of drugs and alcohol by patrons before entering both bathhouses remains a significant prevention challenge with no easy or apparent solution. The patrons' perceptions that their fellow patrons use substances, albeit different ones, at each site also highlight the potential for HIV risk behaviors across bathhouses. The finding that some patrons may be arriving at the bathhouses already intoxicated further supports the need to explore associations among sexual risk behaviors and the effects of alcohol and drugs on bathhouse patrons' sexual decision-making processes.

Bathhouses remain important sites for sexual exploration for significant numbers of men. Patrons may be perceived or actually be more likely to be straight, married, closeted, bisexual, or gay depending on the particular bathhouse being considered. However, all patrons seek to fulfill male-to-male sexual fantasies in settings that bill themselves as gay establishments. These data suggest that HIV interventions should seek to make use of the fantasy element by incorporating safer sex imagery into specific sexual scenes. Drawing on Kelly's work (Kelly et al., 1992), using popular patrons at Bathhouse A to diffuse safer sex messages into erotic scenes might be useful at Bathhouse A, while in-

corporating such messages in other sexual scenes (e.g., videos, sex shows, etc.) through the diffusion of innovations (Rogers, 2000) might be more useful at Bathhouse B.

This project demonstrates that qualitative studies of bathhouse sexual behavioral patterns are possible. However, there are limitations to this study. For instance, these data are based on self-reported sexual risk behaviors among a small sample that was not randomly selected. This study of bathhouse sexual behavioral patterns differs from those conducted in public sex environments because bathhouses are private businesses. As such, gatekeepers at particular bathhouses may limit access to participants. In the bathhouses we studied, public sex is not officially allowed. Although the rules at both establishments require that patrons have sex in rented rooms that are private, ethnographic research involving participant observation methodologies may yield more detailed information regarding the sexual and social structures of bathhouse sexual behavioral patterns. Such research may provide more information to determine if and where social diffusion interventions like Kelly's popular opinion leader model may work and which other interventions may be warranted for particular bathhouse sites.

The heuristic value of these findings is that HIV prevention programs targeting bathhouses must be tailored to unique sexual risk behavioral patterns. Differences may be detected among other bathhouses in the sexual behavioral pattern domains identified here. In all cases, these findings suggest that formative research should be conducted in each to inform targeted HIV prevention programs for individual bathhouse intervention sites. Given the solid position that bathhouses hold within gay sexual cultures, there is a compelling obligation to understand them and to use these unique environments to promote health and safety among their patrons.

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