Sexual risk behaviors of African American men who have sex with men: Implication of situational factors and partner dynamics

Lena Denise Saleh

Department of Social Policy and Intervention

St. Cross College

Michaelmas 2012

Thesis submitted in partial fulfillment of the requirements for the Degree of Doctorate of Philosophy in Evidence-Based Social Intervention in the Social Sciences Division at the University of Oxford

Word Count: 69 204

Abstract

HIV infection disproportionately burdens Black men who have sex with men (MSM) living in the United States. Qualitative research is able to richly contextualize the HIV risk factors of Black MSM, but to date limited qualitative evidence exists. This study set out to: (a) examine how participants perceived their childhood experiences to impact their adult sexual behaviors; (b) describe the situational context and the main perceived drivers of high and low risk behaviors, and contextualize these behaviors according to life circumstances at the time; and (c) explore participants' perceived sources of social support, and understand how the quality of this social support may influence participants' psychological well-being and HIV risk behaviors. Semi-structured in-depth interviews were conducted with 34 Black MSM in Providence, Rhode Island, USA. Thematic analysis sought to understand the factors contributing to an episode of protected sex and unprotected sex occurring within the previous 12 months. Narratives suggest that sexual risk behaviors are not isolated events, but instead the result of a lifetime of experiences that may influence attitudes and beliefs toward sexual safety, mental and emotional health, and self-efficacy for condom use. Participants perceived that: (a) interpersonal, internal/psychological, and episodic factors influenced their high risk and low risk sexual behaviors; (b) childhood socioeconomic status, family characteristics, and experiences of abuse were among the most important childhood factors implicated in their adult sexual behaviors; and (c) limited social support led to feelings of loneliness, isolation, and alienation, which may have led participants to seek intimacy through high-risk sexual episodes. This thesis suggests that complex interrelated factors underlie the sexual risk behaviors of Black MSM. Future HIV prevention efforts must extend beyond safer-sex approaches and address the social-ecological determinants of sexual behaviors. Further qualitative examination can deepen understanding of Black MSM's sexual behaviors, provide meaningful insight into the factors driving unprotected sexual behaviors, and uncover novel points for intervention.

Acknowledgements

First and foremost, thank you to the men who participated in this study and spoke with me about very personal, intimate, and often painful experiences.

Thank you to my academic supervisors Don Operario and Lucie Cluver for your invaluable guidance. Don, thank you for all your encouragement and support, I really appreciated it! Lucie, thank you for your insight and attention to detail.

Thank you to everyone that provided their expertise in recruiting participants, and referred potential participants to the study. Specifically, thank you to James Robinson from YPI, for brainstorming recruitment strategies with me; Bobby Ducharme from Miriam Hospital for posting recruitment flyers in MegaPlex bathhouse when I could not; Wydnyr Montervil for her recruitment help at the Urban League of Rhode Island; and Ray from AIDS Care Ocean State

Thank you to Jacob van den Berg for coaching me on appropriate debriefing and referral procedures, and generally being a super helpful person! Thank you to Christopher Chambers for your input on qualitative methodologies.

Thank you to all my friends who read numerous individual chapter and whole thesis drafts, and did so with great vigor. Thank you to all the friends who helped me with recruitment, ranging from printing off flyers to going to nightclubs and approaching random strangers, to sneaking into men's restrooms to post flyers. Thank you to all my friends with printers at work, who gladly printed off hundreds upon hundreds of pages for me. Thank you to all my friends in Oxford, who commiserated with me while providing constant encouragement, and helping me to see the light at the end of the tunnel. Thank you to Thomas for being my biggest cheerleader.

Lastly, thank you to my parents and sister for all the years of support. I can finally get a real job!

Publications and presentations arising from this thesis

The work in this thesis has resulted in the following peer-reviewed articles and publications:

Saleh LD & Operario D. (2009). Moving beyond "the down low": A critical analysis of terminology guiding HIV prevention efforts for African American men who have secretive sex with men. Social Science and Medicine; 68(2): 390-395.

Saleh LD, Operario D, Smith CD, Arnold E, & Kegeles S. (2011). We're going to have to cut loose some of our personal beliefs: Barriers and opportunities in providing HIV prevention to African American men who have sex with men and women. AIDS Education and Prevention; 23(6): 521-532.

Saleh LD, van den Berg J, & Operario D. Social support, psychological vulnerability, and HIV risk among African American men who have sex with men. AIDS Care, *in press*

The following papers arising from this thesis are currently under review:

Saleh LD & Operario D. Adverse childhood experiences and the sexual risk behaviors of Black men who have sex with men: A qualitative examination. *Submitted to Journal of HIV/AIDS and Social Services.*

The work in this thesis has been presented at the following international conferences:

Saleh LD & Operario D. When knowledge clashes with judgment: When Black men's subjective assessment of HIV risk in prospective male partners. Oral presentation at 2011 American Public Health Association Annual Meeting, Washington D.C., 29 October - 2 November.

Saleh LD & Operario D. A qualitative exploration of the personal and situational factors implicated in the sexual risk behaviors of Black men who have sex with men. Poster presentation at 2010 American Public Health Association Annual Meeting, Denver, Colorado. 6 November – 10 November.

Saleh LD & Operario D. Sexual risk assessment among African American men who have sex with men in Providence, Rhode Island. Poster presentation at The Forgotten Epidemic: HIV/AIDS crisis in Black America. Harvard University Center for AIDS Research and NAACP. 19 November 2010 – 20 November 2010.

Abstract ... 2
Acknowledgements ... 3
Publications and presentations arising from this thesis ... 4
List of Acronyms ... 8
List of Figures ... 9
List of Tables ... 10
List of Graphs ... 11
CHAPTER 1: HIV/AIDS IN BLACK AMERICA ... 12
1.1 Overview ... 12
1.2 Definitions ... 13
1.3 HIV epidemiology ... 14
1.4 Contextualizing HIV risk in the Black community ... 18
1.5 Structural contributors of HIV risk ... 22
1.6 Social/cultural contributors to HIV risk ... 24
1.7 Situational context of HIV risk: Significance and existing evidence ... 28
1.8 In summary: Why study HIV risk among Black MSM? ... 33
1.9 Research Questions ... 33
1.10 Overview of chapter contents ... 35
CHAPTER 2: THEORETICAL APPROACHES TO HIV RISK ... 37
2.1 Overview ... 37
2.2 Traditional theories in HIV prevention, and their limitations ... 38
2.3 General contextual theories to improve understanding of HIV risk ... 44
2.3a Socio-Epidemiological Model of HIV risk ... 46
2.3b Syndemic Production of Disease ... 51
2.3c Life course perspective ... 52
2.4 Specific contextual theories to understanding HIV risk in Black MSM ... 55
2.4a Minority Stress ... 55
2.4a.1 Internalized homophobia ... 59
2.4a.2 Perceived stigma ... 61
2.4a.3 Discrimination and violence ... 63
2.5 Resiliency Models ... 64
2.6 Summary ... 69
CHAPTER 3: STUDY METHODOLOGY ... 70
3.1 Research Objectives and Questions ... 70
3.2 Qualitative methods for the study of HIV risk among Black MSM ... 71
3.3 Research Ethics ... 72
3.4 Study Site ... 73
3.5 Recruitment and Sampling Strategy ... 74
3.6 Challenges to recruitment ... 77

3.7 Eligibility criteria **79**
3.8 Sample Group **80**
3.9 Data Collection **82**
3.9a Interviewer 82
3.9b Interview Process 82
3.9c Interview Guide 84
3.9c.1 Interview guide Part 1: Economic, social, and community life conditions 84
3.9c.2 Interview guide part 2: Unprotected sexual episode 87
3.9c.3 Interview guide part 3: Protected sexual episode 87
3.9c.4 Interview Guide Part 4: Participant debrief and referrals 88
3.10 Data quality and management **88**
3.11 Data storage **89**
3.12 Data analysis **89**
3.13 Methodological limitations **91**
3.14 Reflexivity **93**

CHAPTER 4: ADVERSE CHILDHOOD EXPERIENCES AND HIV RISK BEHAVIORS **95**
4.1 Overview **95**
4.2 Adverse childhood experiences and adult health **97**
4.3 Childhood experiences, development, and physiological responses **102**
4.4 Research Questions **103**
4.5 Factors of childhood experience implicated in sexual risk behaviors **105**
4.5a Socioeconomic circumstances 105
4.5b Socioeconomic status and sexual risk behaviors 107
4.5c Family characteristics 111
4.5d Alternative depictions of childhood family life. 119
4.5e Family characteristics and sexual risk behaviors 121
4.5f Occurrence of Abuse 123
4.5g Childhood abuse and sexual risk behaviors 125
4.5h Non-normative patterns 128
4.6 Discussion **132**

CHAPTER 5: CONTEXTUALIZED DRIVERS OF SEXUAL RISK BEHAVIORS **136**
5.1 Overview **136**
5.2 Background **137**
5.3 Research questions **140**
5.4 Situational context of sexual episodes **141**
5.4a Partner meeting 142
5.4b Location of Sexual Encounter 143
5.5 Drivers of unprotected sexual behaviors **149**
5.5a Transactional sex 150
5.5b Men's attitudes toward condom use 151
5.5c "Heat of the Moment" 160

5.5d Poor emotional health 162
5.5e Reliance on visual and behavioral cues 167
5.5f History of unprotected sex 170
5.6 Discussion **177**

CHAPTER 6: SOCIAL SUPPORT AND SEXUAL RISK BEHAVIORS **184**
6.1 Overview **184**
6.2 Background **184**
6.3 Research questions **188**
6.4 Social networks **189**
6.5 Family support and expectations **191**
6.5a Limited social support 191
6.5b Positive social support 194
6.6 Peer and sexual partner social support **198**
6.6a Peer social support 198
6.6b Sexual partner support 200
6.7 Psychological consequences of limited social support **202**
6.8 HIV risk and protective behaviors **205**
6.8a Limited support and sexual behaviors 205
6.8b Positive support and sexual behaviors 209
6.9 Discussion **212**

CHAPTER 7: DISCUSSION AND CONCLUSIONS **216**
7.1 Summary and interpretation of key study findings **216**
7.2 Theoretical implications of study findings **218**
7.3 Current effective evidence-based interventions **222**
7.4 Potential implications for future HIV intervention approaches **227**
7.5 Future research recommendations **233**
7.6 Methodological limitations of this study. **235**
7.7 Conclusion **237**

LIST OF REFERENCES **239**

APPENDICES **273**
Appendix 1: Participant consent form **273**
Appendix 2: Ethics approval letters **275**
Appendix 3: Interview guide **277**

List of Acronyms

3MV – Many Men, Many Voices

ACE – Adverse childhood experiences

AIDS – Acquired immunodeficiency syndrome

CAAS – Center for Alcohol and Addiction Studies.

CBO-– Community-based organization

d-UP! – Defend Yourself

HIV – human immunodeficiency virus

LGBT – Lesbian, gay, bisexual, transgendered

MSM – Men who have sex with men

PI – Principal Investigator

PRS – CDC's HIV/AIDS Prevention Research Synthesis project

RI – Rhode Island

STD – Sexually transmitted disease

UAI – Unprotected anal intercourse

List of Figures

1.1 Conceptual framework of Black MSM's construction of risk.

1.2 Overview of study design

2.1 Multiple levels of social epidemiological analysis for understanding HIV transmission

2.2 Potential pathways from structural violence to HIV/AIDS

2.3 Hypothesized life course models

4.1 Effect of different types of stress on bodily stress response systems

4.2 Impact of adverse childhood experiences

4.3 Childhood development basis for adult health and wellbeing

4.4 Relationship of neglect to self-esteem, condom-related attitudes, and HIV risk

5.1 Mechanisms by which poor emotional health led to unprotected sex among participants

List of Tables

1.1 Estimated HIV infection among persons aged ≥ 13 years

1.2 Levels of environmental influences on sexual behavior

2.1 Individual-level theories of health behavior commonly used in HIV prevention

2.2 General contextual theories for understanding HIV risk

3.1 Participant recruitment venues

3.2 Study inclusion criteria

3.3 Descriptive sociodemographic variables of study participants

5.1 Partner characteristics of most recent unprotected and most recent protected sexual episode

5.2 Environmental settings of participants most recent unprotected and protected sexual episode

List of Graphs

1.1 Estimated new infections by transmission category, 2009

1.2 Number of new HIV infections among most affected subpopulations.

CHAPTER 1: HIV/AIDS IN BLACK AMERICA

1.1 Overview

In the United States, Black men who have sex with men (MSM) have been more affected by HIV/AIDS than any other population (CDC 2011). HIV rates among African Americans are comparable to some developing African nations (Wilson et al. 2008), yet few interventions have been demonstrated to be effective at reducing HIV transmission in this population. This thesis was borne out of the need to reframe the nature of sexual risk among Black MSM, in the hopes of refreshing current HIV prevention strategies targeted to this population. Evidence suggests that for African Americans, understanding HIV risk will necessitate a greater appreciation of the wider sociocultural and structural forces in play (Mays et al. 2004). Accordingly, through qualitative interviews, this thesis examines situational and life course factors perceived as contributing to high and low HIV risk behaviors. Situational factors are those aspects of an individual's immediate physical, interpersonal, or psychosocial environment that impact their risk assessment processes or sexual behaviors, such as condom availability or partner characteristics. Life course factors refer to experiences over the course of a lifetime that may individually, interactively, or cumulatively increase or contribute to high or low risk sexual behaviors, such as childhood experiences, family characteristics, relationship dynamics, emotional wellbeing, and sources and quality of social support.

Narratives suggested several major distinct, yet interactive, themes that shaped participants' high and low risk sexual episodes: 1) structural and environmental characteristics, including *interpersonal, internal/psychological, and episodic factors* that inhibited condom negotiation led participants to de-prioritize sexual safety, or seek out self-harming behaviors, such as unprotected sex with high-risk partners; 2) the influence of *cumulative life trajectories* on risk behaviors: recollected childhood experiences—particularly, socioeconomic status, family characteristics, and experiences of abuse—may have influenced adult sexual behaviors by diminishing

emotional health, self-efficacy, coping skills, social networks, and perceived life prospects, in turn impacting approaches to sexual health; 3) perceived *limited social support networks* led to feelings of loneliness and desire for emotional connection; however, difficulties trusting others left participants unable to make these connections. Participants with little social support described higher risk sexual behaviors, and participants with stronger social support networks described lower risk behaviors

1.2 Definitions

Black/African American: The US Census Bureau adheres to the October 30, 1997, Federal Register Notice entitled, "Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity" issued by the Office of Management and Budget (OMB), in which the construct of race employed reflects self-identification of persons to the race with which they most closely identify. African American or Black is classified as a person having ancestral origins in any of the Black populations of Africa, and includes those who self-identify as Black, African American, or Negro. While the Census Bureau classification of Black/African American also includes national-origin groups, such as Nigerian or Ghanaian, the use of African American or Black in this thesis refers to those US citizens who are the direct descendents of captive Africans who survived slavery in the United States.

Men who have sex with men (MSM): For this study, MSM refers to any man who engages in sexual intercourse with another man. These men may also have sex with women and/or transgendered persons. Self-reported sexual identities (i.e. gay/homosexual, straight/heterosexual, bisexual) may differ from the sexual behaviors of this population, and is therefore not employed as an indication of behavior. Importantly, in many Black communities, homosexuality and same-sex behaviors are stigmatized and unaccepted; consequently, Black men who engage in same sex behaviors may be less likely to identify as ‘gay’ or respond to study

literature (e.g. recruitment materials) seeking gay males (Freimuth et al. 2001, Sengupta et al. 2000).

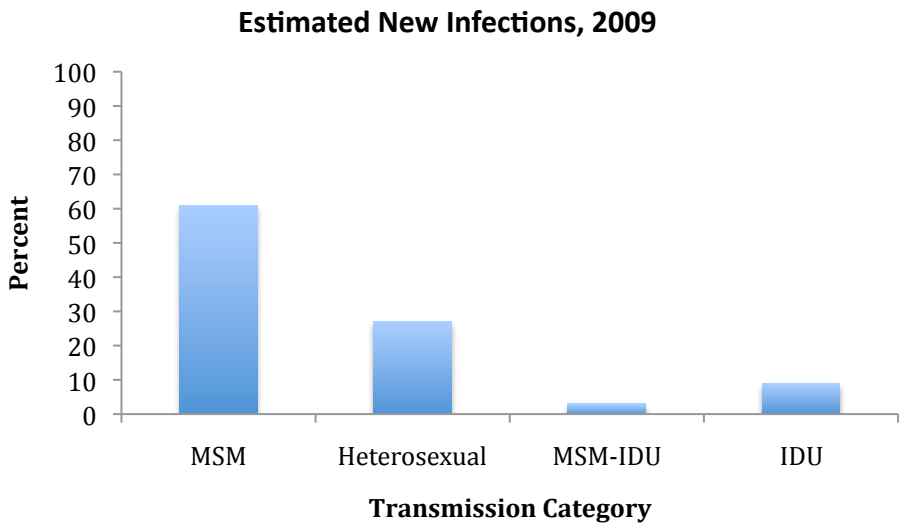
Contextual factors for HIV risk: In this study, contextual factors refer to characteristics of the physical and non-physical environment that directly or indirectly influence risk behaviors that may lead to HIV infection. These contextual factors may be from the social environment (e.g. peer or sexual networks, social support), cultural environment (e.g. African American beliefs on sexuality, religious beliefs), or structural environment (e.g. neighborhood characteristics, education, racism). In the lives of Black MSM, these factors oftentimes occur simultaneously and cannot be disentangled. Accordingly, this thesis juxtaposes these different contextual factors; for instance, this thesis uses the terms sociocultural to refer to social and cultural, or sociostructural to refer to social and structural factors.

1.3 HIV epidemiology

In the United States, the HIV/AIDS epidemic continues unabated in the Black community. Compared to all other ethnic groups, Black men and women are disproportionately burdened at all stages of the illness. Accurate estimates of HIV incidence has until recently been elusive. Since its emergence in the United States in 1981, AIDS surveillance was conducted through a standardized, confidential name-based system. However, on its own this surveillance data was unable to determine trends in HIV incidence across the country, and to meet federal, state, and local needs for the planning and provision of prevention and care programs. This led to a shift towards a more integrated national HIV/AIDS surveillance system which augmented the ability to track and characterize HIV-affected groups and provide data on all those living with HIV/AIDS. This enhanced monitoring system resulted in revision of previous surveillance data and now provides the most precise HIV/AIDS data available. HIV surveillance data—rather than AIDS surveillance data—allows for a more inclusive picture on the state of the epidemic in the United States;

however, it is still unable to accurately determine HIV incidence since some individuals will have been recently infected while others more distantly in the past. To address this, the CDC developed a serological assay able to differentiate recent from long-standing infections, and thereby provide a more accurate estimate of incidence of HIV infection (CDC 2008). Prevalence data reported in this thesis is derived from the 33 states employing confidential name-based HIV infection reporting since at least 2007. According to the number of AIDS cases reported, the 33 states included represent approximately 63% of the epidemic nationally (CDC 2008). Incidence data (and relevant extrapolations) reported here is calculated from the 22 states with confidential, name-based HIV surveillance and HIV incidence surveillance with sufficient data for the calculation of incidence estimates (CDC 2008, Hall et al. 2008). While the incidence data reported represent 73% of all U.S. AIDS diagnoses, the estimates may not be nationally representative as states with high AIDS morbidity, but without confidential, name-based HIV reporting in 2006 were excluded (such as the District of Columbia and California) (CDC 2008).

Data indicates that at the end of 2008 (the most recent year national prevalence data is available), an estimated 1,178,350 individuals in the United States were living with HIV/AIDS, including 20% with undiagnosed HIV infection (Torian et al. 2011). Three quarters of all individuals living with HIV infection were male, and 66% of those men were men who have sex with men. HIV prevalence among African Americans was eight times the rate of Caucasians. In 2009, the highest transmission category, accounting for 61% of new infections, occurred as a result of male-to-male sexual contact. This was followed by high risk heterosexual contact at 27%, injection drug use at 9%, and concurrent male-to-male sexual contact and injection drug use at 3% (Hall et al. 2008).



Graph 1.1 Estimated new infections by transmission category, 2009. Adapted from Prejean et al. 2011.

Though comprising just 14% of the total national population, as of 2009, 44% of new infections occurred among Blacks, followed by Whites at 36%, and Hispanics at 20%. When examined by gender, 40% of new infections occurred among Black males, 41% in Whites, and 19% in Hispanics (CDC 2011, CDC 2012). Among females, 61% of infections occurred in Blacks, 23% in Whites, and 16% in Hispanics. HIV incidence among Black males and females is 6.5 and 15 times the rate of White males and females, respectively (CDC 2012). Furthermore, HIV incidence among Black males aged 13-29 was 7.1 times the rate of White males similarly aged (CDC 2008).

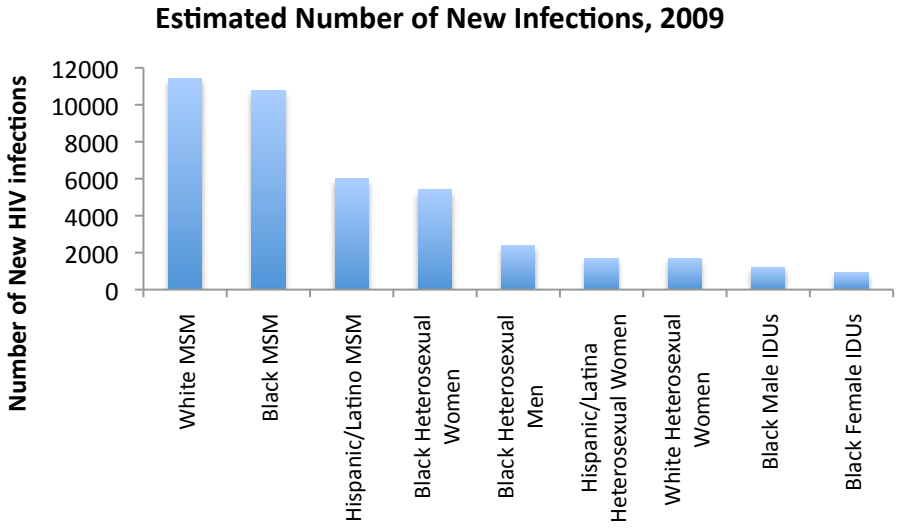
Characteristic	Number	Rate per 100 000 population
Total	*1 178 350*	*469.4*
Sex		
Male	883 450	719.5
Female	294 900	230.0
Age group (yrs)		
13-24	68 600	134.1
25-34	180 600	440.9
35-44	357 500	846.3
45-54	385 400	871.3
55-64	147 700	439.3
≥ 65	38 400	99.0
Race/Ethnicity		
American Indian/ Alaska Native	5000	268.8
Asian/Pacific Islander	16 750	174.0
Black/African American	545 000	1819.0
Hispanic/Latino	205 400	238.4
White	406 000	592.9
Transmission category		
MSM	580 000	NC
Intravenous drug use - male	131 600	NC
Intravenous drug use – female	73 900	NC
MSM and intravenous drug use	55 200	NC
Heterosexual contact – male*	110 900	NC
Heterosexual contact – female*	217 400	NC

Table 1.1 Estimated HIV infection among persons aged ≥ 13 years, 2008. Adapted from Torian et al. 2011.

*sexual contact with a person known to have, or to be at high risk, for HIV infection.

NC = not calculated because population denominators for transmission category subgroups were not available.

The demographic characteristics of the epidemic have significantly shifted from that of the early 1980s. Men who have sex with men still represent the majority of new infections in the United States, however Black MSM now account for 49% of the estimated HIV/AIDS diagnoses made through 2009, and more new infections occur in young Black MSM (aged 13-29) than any other age/racial group of MSM (CDC 2008.) HIV is the ninth leading cause of death for all Blacks and the third leading cause of death for Black men and women aged 35-44.



Graph 1.2: Number of new HIV Infections among most affected subpopulations, 2009. Adapted from Prejean et al. 2011

1.4 Contextualizing HIV risk in the Black community

Despite elevated HIV prevalence and incidence among Black MSM, evidence suggests that Black MSM are *not* more frequently engaging in behaviors considered to be high risk for HIV infection (Millet et al. 2006, Millet et al. 2007, Millet & Peterson, 2007). Three prominent behavioral hypotheses have been put forth to

explain the elevated HIV rates among Black MSM, however *evidence does not exist to support these hypotheses*:

Hypothesis 1: *Black MSM are more likely than non-Black MSM to engage in high-risk sexual behaviors.* A review by Millett et al. (2006) found 15 studies that showed no significant differences in rates of unprotected anal intercourse for MSM of different ethnicities (Denning & Campsmith 2005, Lemp et al. 1994, MacKellar et al. 2005, Mansergh et al. 2002, McKirnan et al. 1995, McKirnan et al. 2001, Purcell et al. 2005, Ruiz et al. 1998, Solorio et al. 2003, Stokes et al. 1996) and found Black MSM were less likely than non-Black MSM to engage in high-risk sexual practices (Bartholow et al. 2005, Bingham et al. 2003, Harawa et al. 2004, Peterson et al. 2001, Valleroy et al. 2002), have comparable, if not lower, rates of unprotected anal intercourse than other MSM groups (CDC 2005, LCWK2 2003, Mansergh et al. 2002, Solorio et al. 2003, Stokes et al. 1996), have fewer male sexual partners in their lifetime than other MSM groups (Johnson et al. 2003, Mays et al. 2004, Solorio et al. 2003) and are not more likely than other MSM to engage in sex for money (Heckham et al. 1999, Mays et al. 2004, Newman et al. 2004, Rietmeijer et al. 1998).

Hypothesis 2: *Black MSM are more likely to be injection drug users; this increases their risk for HIV infection*. Millett et al. (2006) demonstrated that crack cocaine is the only illicit drug that Black MSM report using more than non-Black MSM (Heckham et al. 1999, McKirnan et al. 2001). However, crack cocaine is generally not an injection drug and has not been shown to significantly contribute to the discrepancy of HIV rates between Black MSM and other groups, nor has evidence indicated that Black MSM are more likely to combine sexual intercourse with substance use.

Hypothesis 3: *Black MSM are less likely than other MSM to identify as gay or disclose their sexual identity; this may lead to increased HIV risk behavior*. While Black MSM *are* less likely than White MSM to be gay-identified (McKirnan et al. 1995, McKirnan et al. 2001), join gay-related organizations (Kennamer et al. 2000), and read gay-

related media (Purcell et al. 2005), this has not been shown to increase the HIV risk taking behaviors of Black MSM.

These findings have led researchers to conclude that behaviors alone do not account for the discrepancy observed in HIV rates between Black and other MSM groups, and that for Black MSM, HIV risk may instead be determined by the contextual factors associated with the behaviors rather than the behaviors *per se* (Mays et al. 2004, Millet et al. 2006). To date, much of the research on HIV within the Black MSM community has been epidemiological in nature, with a focus on infection rates, prevalence of risk behaviors, and attitudes/beliefs about HIV among gay men, categorized according to age, race and other demographic characteristics; however a stronger consideration of social factors and experiences unique to the Black community is needed. Contextual factors that can increase likelihood of HIV infection include sexual partner characteristics, dynamics within close and intimate relationships, rates of incarceration, social/sexual network characteristics, neighborhood and community ties, sexual partner concurrency, social support, family characteristics, childhood sexual abuse, and social inequalities (Adimora & Schoenbach 2005, Mays & Cochran 1998, Mays et al. 2000)—all of which remain under-examined in HIV prevention research for this population. Black MSM's decision-making processes and sexual-risk taking behaviors may also be framed by psychosocial and structural forces including racism, discrimination and stigma, internalized homophobia, poverty, and African American cultural norms (Malebranche 2003, Myers et al. 2003, Operario et al. 2008, Stokes & Peterson, 1998, Wyatt et al. 2008). Evidence suggests that multiple forms of social oppression operate as overarching forces shaping HIV risk for Blacks in general (Sanders-Philips 2002), and for Black men in particular (Treadwell & Ro 2003). These multiple forms of oppression are further described in Chapter 2.

In recent years, studies have suggested the significance of the Black community's beliefs of sexuality and masculinity in guiding Black men's sexual behaviors. Sociologists and Black history scholars argue that current idealized notions of Black

sexuality and masculinity are a consequence of the historical legacy of slavery and racism in the United States and the resulting economic and social dynamics (Bowleg 2004, Cazenave 1984, Collins 2005, Jackson 2006). These notions mold Black-White interaction and assumptions about gender roles and masculinity amongst Blacks (Whitehead 1997). During the early American post colonial era, masculinity was predominantly associated with the ability to economically provide for one's family, but since Black men lacked opportunities to achieve this form of economic control, images of masculinity associated with Black men tended to take the form of corporeal and sexual prowess (Hodes 1993, Hunter 1992, Whitehead 1997). Current cultural depictions of Black men—as evidenced through news media, fictional narratives, and popular music—may act to perpetuate and reinforce the historical perspective of the Black male body as a hyper-masculine, hyper-sexualized, and de-personalized entity (Ferber 2007). Theorists suggest that these beliefs of masculinity have been internalized and viewed as accepted standards of Black masculinity (Collins 2005, Ferber 2007).

For many Black men, sexual identity and behaviors exist along a continuum, and discrete categories of sexual identity (i.e. gay/homosexual, heterosexual, bisexual) employed in HIV prevention campaigns might not adequately capture the complex understandings that these men have of their sexuality (Ford et al. 2007). In fact, it has been shown that 14% of Black MSM report sex with a female partner in the previous 12 months, compared with 8% and 4.2% of Hispanic and White MSM, respectively (Sanchez et al. 2006). These Black MSM may be more likely to self-identify as heterosexual or prefer to leave their sexual identity undefined (Operario et al. 2008, Ford et al. 2007), possibly because same-sex behaviors are stigmatized in the Black community and viewed as inconsistent with beliefs of Black masculinity (Jackson 2006, Woodyard et al. 2000). Racism in the mainstream White gay community has exacerbated feelings of exclusion for Black MSM, contributing to the sense of discordance between these men's racial and sexual identities (Teunis 2007). Furthermore, for some Black MSM race is prioritized above sexual identity, as stronger racial/ethnic identity development is associated with greater levels of

life satisfaction among Black MSM whereas sexual-identity development is not (Crawford et al. 2002).

In summary, for Black men, HIV risk exists within a complex framework in which sexual risk behaviors cannot be superficially understood. Black MSM do not engage in high risk behaviors more frequently than their White counterparts. Assumptions of Black sexuality and behaviors, coupled with decontextualized understandings of risk, lend credence to suggestions that HIV risk factors that are ostensibly considered to be equivalent between Black MSM and other ethnic groups might in fact be determined by the contextual nature of those risk factors. That is, the confluence of historical, sociocultural, and structural factors may collaborate to uniquely situate HIV risk among these men—this thesis aims to explore the factors informing this risk. Accordingly, interventions to reduce HIV rates amongst African Americans should be conceived through a culturally congruent lens (Wyatt et al. 2008).

1.5 Structural contributors of HIV risk

Understanding the underlying structural, social, economic, and cultural contributors that contextualize specific risk for Black MSM requires an appreciation of the lives and environments from which these men have emerged. Structural factors refer to the economic, social, policy and organizational environments that "structure" the framework in which risk is produced and perpetuated (Rhodes 2002). It is now widely accepted that structural factors (such as neighborhood characteristics and social networks) are critical determinants in HIV incidence and prevalence (Sumartojo 2000). This thesis explores men's perceptions of how structural factors contribute to their own high and low risk behaviors.

Opportunities to engage in high risk behaviors are shaped by one's physical and social environment. Linkages between neighborhood characteristics, sexual risk

taking behaviors, and HIV prevalence have been established. Latkin et al. (2007) used structural equation modeling to examine relationships between neighborhood characteristics, depressive symptoms, drug use, and sexual partner types among a sample of African Americans (59% male) living in an inner-city environment with a history of drug use. Findings revealed direct associations between neighborhood disorder and psychological distress, neighborhood disorder and sexual risk behaviors, and neighborhood disorder and drug use. Significant indirect associations were also observed between neighborhood disorder and sexual risk behaviors. Moreover, in impoverished inner cities with high rates of crack cocaine and opiate use, greater opportunities exist to have sex with other crack users and injection drug users. High incarceration levels among minority inner-city (mostly) male residents also leads to fewer opportunities to have lower-risk sexual partners (Latkin et al. 2007, Thompson & Sampson 2005).

Studies have examined the associations between residential location and poor health. Crime, physical decay, litter, drug use, residential immobility, crowding, unemployment, and other characteristics of impoverished communities may have toxic health effects. STIs and HIV have repeatedly been demonstrated to be geographically clustered (Law et al. 2004, Zenilman et al. 1999) and impoverished communities have higher rates of STIs and early sexual debut (Cohen et al. 2003, Upchurch et al. 1998). Additionally, fear of crime, the drug trade, noise and pollution can lead to physiological stress responses (Lepore 1997) which have been linked to depressed immune function (Herbert & Cohen 1993). Chronic social and environmental stressors are associated with psychosocial consequences such as learned helplessness, particularly in poor urban populations, and mental health problems (Avison & Turner 1988, Turner & Lloyd 1995). Neighborhood-associated stressors are often clustered and disadvantaged communities may experience the intersection of several chronic and acute stressors (Ewart & Suchday 2002). In turn, depressive symptoms partly attributed to neighborhood stressors can lead to drug use (Flynn et al. 2004, Khantzian 1985). By blunting negative emotional states, drug use may allow men to cope with poverty, violence, and physical illness. Research has

suggested that many inner-city substance users are unable to live within the reigning social constructs of marriage and legal employment and consequently may be more susceptible to low self-esteem, negative self-concept, and depression (Latkin et al. 2007).

Social network factors have also been hypothesized to contribute to racial disparities in HIV prevalence. Structural network features such as network density and connectivity, and network dynamics such as partner concurrency can lead to sustained high rates of disease (Adimora et al. 2002, Adimora et al. 2007, Morris & Kretzschmar 1995). Furthermore, individuals tend to choose sexual partners that are similar to themselves. That is, drug users are more likely than non-drug users to have sex with drug-using partners. This is reflective of the types of neighborhood composition that serve to increase viral loads in geographically- or economically-isolated communities and exacerbate HIV rates in inner-city neighborhoods. Neighborhoods with higher concentration of HIV+ individuals increase the probability of exposure to HIV to other community members (Adimora & Auerbach 2010, Adimora & Schoenbach 2005).

1.6 Social/cultural contributors to HIV risk

Examining the intersections between structural factors, cultural meanings, subjective experiences, individual lives, and health outcomes can provide valuable insight into how HIV risk exists among Black MSM (Mays et al. 2004). Alongside the structural features of Black men's physical environment, sociocultural factors may powerfully shape Black MSM's sexual behaviors. Attitudes toward sexual safety and sexual behaviors are bound to cultural themes associated with masculinity, spirituality, and community beliefs and values. In this way, while exposed to similar episodic factors, the sexual scripts—that is, the socially- and structurally-produced guidelines that inform perceived appropriateness of sexual behaviors and

attitudes—by which these men negotiate their sexual encounters may differ. That is, the evolution of sexual scripts may be differently informed between Black and White MSM and consequently may confer specific sexual risk differently.

Studies have examined psychological and social contributors to HIV risk behaviors, among gay men/MSM, including communication regarding condom use, availability of HIV prevention messages and condoms, condoms for contraceptive purposes, men's norms towards condom use, acceptability of condom use in specific locations, and feelings of boredom (Elwood & Greene 2005, Freimuth et al. 1992, Gold et al. 1992, Kelaher et al. 1994, Offer et al. 2007, Ross et al. 2004, Ross et al. 2004, Seage et al. 1998, Seage et al. 2002, Somlai et al. 1998). However, qualitative research on these psychological and sociocultural contributors to HIV risk in Black MSM—a population with a risk profile that may differ substantively from other MSM populations—has been extremely limited.

Previous studies have qualitatively examined the impact of social factors on HIV risk in American Asian and Pacific Islander MSM (Han 2008, Nemoto et al. 2003, Wilson & Yoshikawa 2004), as well as Latino MSM (Diaz et al. 2004, Deren et al. 2003). An additional qualitative study investigated the psychosocial aspects of sexual risk among HIV positive Black and Latino MSM with histories of sexual abuse (Williams et al. 2004). While qualitative studies focused generally on MSM populations have included Black MSM, they have formed a small minority of the total study sample (Koblin et al. 2006), making it difficult to generalize the results to the larger Black MSM population. Importantly, research questions from qualitative studies aimed at mixed race/ethnic populations likely neglect the important contextualized nature of HIV risk among Black men. Thus, the dearth in appropriate Black MSM-targeted qualitative research has resulted in limited data on the influence of racism, poverty, homophobia, family characteristics, religion, and dual minority status on HIV risk. Similarly, this has also resulted in an incomplete understanding of the resiliency factors employed by Black MSM to protect against HIV infection (Millett & Peterson 2007).

Qualitative studies which have targeted Black MSM have helped to illuminate the complex role of sociocultural factors on informing HIV risk. Stokes and Peterson (1998) considered the psychological impact of homophobia on HIV risk among Black MSM. The authors reported that men perceived negative attitudes towards same-sex behaviors from within the Black community and believed Blacks to be more homophobic than their White counterparts. The authors reported that these participants seemed to internalize these negative views, resulting in psychological distress and lowered self-esteem. The authors conclude that internalized homophobia may impact the ability of Black MSM to negotiate safe sex with sexual partners and increases the likelihood of substance use and being placed in sexually risky situations, which in turn has been suggested to influence risk of HIV infection. Subsequent studies have published similar results (Kraft et al. 2000, Rosser et al. 2008).

Woodyard and colleagues (2000) qualitatively considered the role of the church on sexual risk through semi-structured interviews with 76 Black MSM. They found that Black MSM consistently had high levels of involvement in Black churches. Despite perceived homophobia from within the church, men in this study did not acknowledge any contradictions between being a Black MSM and being involved in Black churches. Men attributed continued church involvement to various reasons. The church functioned as a social meeting venue for Black MSM free from unwarranted social pressure or scrutiny. Second, in the face of multiple oppressions (e.g. racial, sexual, economic), the church reaffirmed Black male identity. Finally, the church allowed Black men to contribute their skills and talents to their community. In spite of these favorable aspects of church involvement, study authors hypothesized that Black MSM internalized the negative attitudes of the church towards same-sex behaviors, and found church attendance encouraged Black MSM to be secretive about their sexual behaviors, which may lead to higher risk behaviors.

Operario et al.'s (2008) examination of non-gay identified Black MSM endeavored to learn about their perceived risks for unsafe sex. Men described cultural norms and social pressures that reinforce heightened masculinity and male gender dominance, discouraged overt emotionality and help-seeking, and punished same-sex attraction. Consequently, men who felt sexual attraction to other men had sex secretively, spontaneously, and in anonymous settings. Some men turned to alcohol or other substances to mask or divert emotional frustrations, and others engaged impulsively in sex to express their hidden sexual desires.

These studies demonstrate the breadth of information to be gained by qualitatively examining the sociocultural factors informing situational risk among Black MSM. Self esteem, masculine identity, cultural and social norms, and racism and discrimination operate within a complex framework to place Black MSM at greater risk for HIV infection than other MSM (Ford et al. 2007, Malebranche 2003, Mays et al. 2004, Myers et al. 2003, Operario et al. 2008, Stokes & Peterson, 1998, Wyatt et al. 2008). However, to date very few studies have examined the implications of these factors on influencing how Black MSM reach or negotiate decisions regarding sexual behaviors. In concert with structural and sociodemographic forces, the effects of sociocultural beliefs and values may uniquely shape the situational HIV risk that Black MSM are exposed to. Chapters 2, 4, 5, and 6 provide in-depth discussion of the sociocultural context of HIV risk in participants' lives.

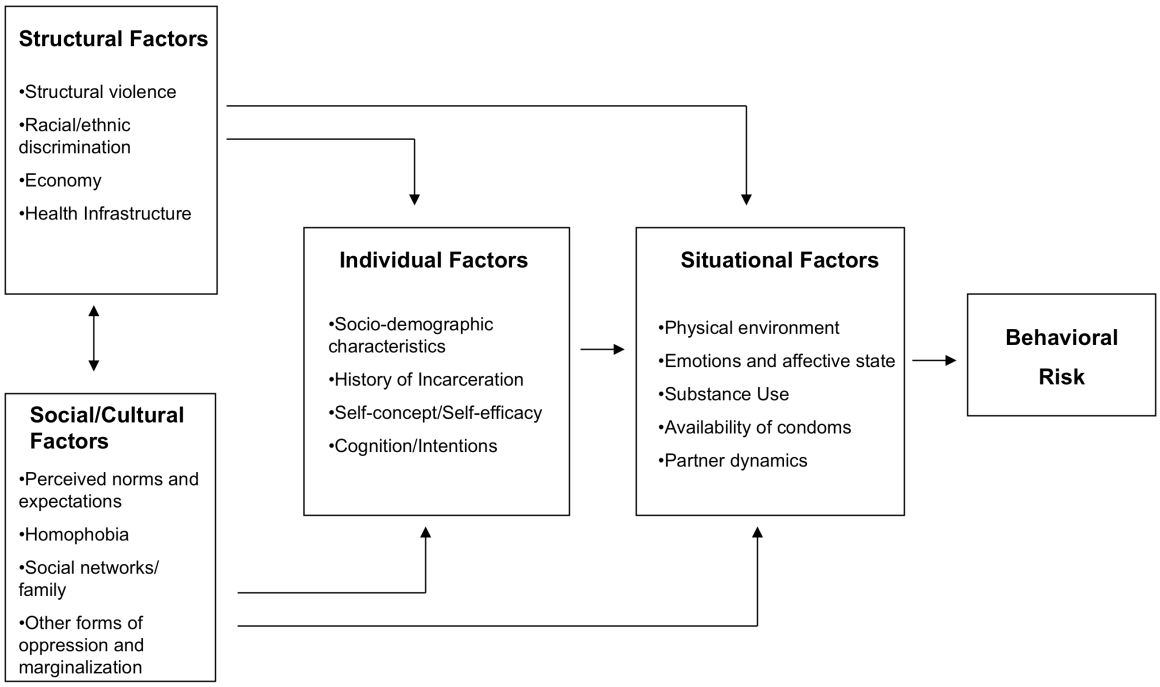


Figure 1.1: Conceptual framework of Black MSM's construction of HIV risk.

1.7 Situational context of HIV risk: Significance and existing evidence

Developing interventions that address the structural *and* social factors driving HIV infection among Black MSM is a difficult but important challenge facing prevention scientists. HIV prevention strategies often employ models of behavior change that exclusively target behaviors at the individual level, such as individual HIV testing, skills training, and risk-reduction counseling (Fisher et al. 2002). While important to understanding independent sexual-behavior decision making, these strategies often overlook vital socio-structural factors influencing personal decisions to engage in sexually risky behaviors, and in doing so frequently result in individuals being held responsible for their well-being and blamed for poor health (Becker 1993). Prevention approaches focusing solely on individual-level factors are unable to fully explain risk (Kalichman et al. 1996) and to account for inconsistencies in individuals' tendencies to engage in risky sexual behaviors—i.e. that a person with

high levels of HIV-prevention knowledge and positive attitudes towards condom use may behave differently in different situations (Kelly et al. 1991, Ross et al. 2004). Moreover, situational and environmental determinants of HIV risk do not affect members of the same population similarly (Taylor et al. 1997). To date, environmental and situational factors remain under-represented in the HIV prevention research for Black MSM.

Macro-level forces such as poverty, social inequality, and racism that inform HIV risk are difficult to address in HIV prevention strategies (Adimora & Auerbach 2005), and interventions focused solely on changing individual-level risk behaviors demonstrate mostly short-term effects (Frye et al. 2006). This highlights the complexities inherent to developing effective prevention strategies that balance individual needs with that of the larger population. In keeping with this, an examination of situational and environmental factors may predict sexual risk taking behaviors more directly, account for within-subject variability and provide an important pragmatic point of intervention for the public health community.

Although sexual risk taking behaviors do occur in temporally and geographically bound environments (Ross et al. 2004), within the scope of HIV prevention, situation does not simply refer to a physical setting or place, but also subsumes "meanings people [attach] to the physical setting and how the complex interrelation of setting, meaning, and behaviors influences decisions regarding sexual behaviors and prevention measures" (Elwood & Greene 2005, pg. 135). The situational or environmental context of unsafe behaviors are integral to HIV prevention strategies because the immediate context of behavior can help to determine the level of risk to which an individual is predisposed to, outside of socio-structural, social-cognitive, and dispositional factors (Ross et al. 2004). For example, *physical environments* can determine whether individuals use condoms during specific sexual episodes (e.g. if they are having sex in a public versus private space; if sexual acts occur in locations associated with high risk sexual behaviors, such as bathhouses or private sex parties); *partner dynamics/type* can influence individuals' decision to use condoms

during particular sexual episodes (e.g. if they are having sex with an anonymous partner versus a steady partner; if power dynamics makes condom negotiation difficult); *emotional states* can determine if individuals are in an affective state that allows or undercuts rational thought regarding protected sexual encounters (e.g. feeling lonely or depressed); *substance use* can affect decisions to participate in either sexually risky or protective behaviors; *condom availability* can determine whether they engage in protected versus unprotected sex. Situational factors may be determined by broader socio-structural factors (such as poverty, racial oppression, or gender inequalities) but can operate independently of these factors.

Level	**Example**
Individual level, biological	Immune status, hormonal variables
Individual level, psychological	Self esteem, extraversion
Individual, behavioral	Condom use, sexual behaviors
Situational level	Partner characteristics, arousal, presence of condoms, alcohol/drugs
Environmental level, physical	Place of contact, lighting, time
Environmental level, social	Social supports, norms
Structural level, policy	Laws, policies, regulations, discrimination
Structural level, culture	Religion, cultural norms, gender norms

Table 1.2: Levels of environmental influences on sexual behavior. Adapted from Ross et al. (2004).

The situational context of HIV risk has been examined in Latino MSM (Diaz et al. 1998, Diaz 2001, Diaz et al. 2004, Diaz et al. 2008). Diaz reports that at a generalized, distal level, sociostructural factors are importantly implicated in HIV risk; however, he also locates risk at the situational level, occurring at a specific time and place which may or may not draw out risky behaviors. Diaz and Ayala (1999) reported that certain situations may "trigger" unsafe sexual behaviors by influencing an individual's efficacy to use condoms or by motivating risky sex.

Moreover, Latino MSM may purposely enter into high-risk situations (e.g. frequenting public cruising areas for anonymous partners) or unexpectedly find themselves in situations that can facilitate unsafe sex (e.g. feeling overcome by sexual arousal) (Diaz & Ayala 1999, Diaz 1999, Diaz et al. 2008). While interventions may be unable to address structural factors, Diaz writes that HIV interventions can help MSM identify and manage specific high-risk situations. Research with Black MSM has also shown that having sex in particular settings (Malebranche 2003), disclosure of sexual orientation at time of sexual encounter (CDC 2003), the way sexual partners first meet (Liau et al. 2006), and substance use prior to and/or during sexual encounters may increase risk of HIV exposure and are relevant to understanding the high rates of HIV. However, most of these studies were quantitative and formed statistical associations between variables assessed in survey research. These studies lacked understanding of the experiences and meanings Black MSM give to certain situational contexts.

Venues used to meet and/or have sexual relations with a partner may influence specific HIV risk. MSM utilize many venues for meeting sexual partners such as public parks, adult bookstores, beaches, alleys, restrooms, sex parties, and gyms (Binson et al. 2001, Humphreys 1975, Leap 1999, Parsons et al. 2003, Reece & Dodge 2003), as well as commercial sex environments such as bathhouses and sex clubs (Elwood & Williams 1998, Elwood & Williams 1999, Parsons & Halkitis 2002, Tewksbury 2003). Telephone survey data of MSM living in four U.S. cities found that men using party drugs (e.g. nitrites, ecstasy, methamphetamines, and other party drugs such as ketamine and rohypnol) and engaging in unprotected anal intercourse with casual partners were more likely to attend sex venues than men who did not report similar behaviors (Binson et al. 2001). Conversely, research has also demonstrated that some men who patronize environments perceived to be high risk avoided engaging in unprotected anal intercourse because these men assumed their partners more likely to be HIV positive (Elwood & Williams 1999). A recent study of 398 MSM found great variability in risk taking behaviors according to venue (Xia et al. 2006). It was found that men who had attended sex clubs/bathhouses engaged in

the highest rates of sexual risk behaviors including having unprotected anal intercourse, having 5 or more male sexual partners, and engaging in unprotected anal intercourse with casual partners. However, a subsequent comparative study of participation in sexual risk behaviors by venue type demonstrated that MSM meeting partners at gay bars/clubs, private sex parties and the Internet experienced higher rates of unprotected anal intercourse than MSM who met sex partners at bathhouses, the gym, or public cruising areas (Grov et al. 2007). Other studies have shown that sex parties catering exclusively to HIV-infected MSM experienced high rates of unprotected anal intercourse with multiple sex partners (Clatts et al. 2005). It has also been reported that some MSM use sexual environments such as bathhouses, tearooms, cottages, sex clubs, and adult bookstores, to be in situations where they can fulfill desires to dissociate themselves from daily life stressors and safer sex norms (Kelaher et al. 1994, Kippax et al. 1997, Ostrow et al. 1997).

The past fifteen years has given rise to the Internet as a significant tool for MSM to meet sexual partners (Bolding et al. 2005, Grov et al. 2007, Ross 2005). A meta-analysis of MSM's use of the Internet to meet partners revealed that up to 40% of MSM have met partners online. These men tended to be younger, more likely to have a previous STI, be non-gay identified, and report sex with women (Grov et al. 2007). Some studies indicate that MSM using the internet to meet partners were more likely to be White (Bull & McFarlane 2000, Bull et al. 2004), while others have found no differences in race/ethnicity (Elford et al. 2001, Kim et al. 2001).

Clearly, understanding how and where Black MSM meet their sexual partners can provide important information by which to effectively design targeted interventions to reach those at highest risk. However, most studies examining episodic HIV risk among MSM have not focused on Black MSM. In cases where Black MSM are included, they have comprised small portions of the study sample. The ways in which Black MSM decide to meet sexual partners and engage in sex may be informed by important sociocultural and structural factors unique to these men. Using HIV risk data from generalized (i.e. in most cases, majority White) MSM

populations may be ineffective at reaching Black MSM whose venue-type distribution may substantially differ from other populations.

1.8 In summary: Why study HIV risk among Black MSM?

In the United States, Black MSM are most severely burdened by HIV infection, being the only population to experience recent increases in HIV incidence (CDC 2012). The sociocultural and structural factors informing the lives of Black MSM generally differ from that of White MSM; consequently, the contextual nature of HIV risk and the ways in which decisions regarding sexual risk taking behaviors are reached may also differ. Understanding and appreciating these differences has the potential to reveal how HIV risk may specifically be conferred to Black MSM populations.

Qualitative methods allows men to share perceptions of their own risk behaviors and in doing so nuances existing quantitative data by exploring the underlying motivations, pressures, and intentions driving sexual behaviors. To date, only three interventions have been found to successfully reduce HIV risk behaviors among Black MSM (described in Chapter 7), highlighting the need for greater in-depth consideration of factors contributing to risk in this population, as well as novel and innovative prevention strategies targeted to this group. Indeed, a holistic understanding of how risk is experienced by Black MSM may be critical to designing interpersonal, individual, and community-based interventions, as well as providing pragmatic points for intervention.

1.9 Research Questions

The sociocultural context of HIV risk among Black MSM necessitates a consideration of the totality of men's experiences. This thesis will explore the impact of a lifetime

of recollected experiences—from childhood to adulthood—on participants' approaches toward sexual safety, decision-making processes, and high risk and low risk behaviors. As will be demonstrated, participation in high or low risk behaviors is the result of the interaction of multiple, reinforcing risk factors that work collaboratively over the course of participants' lives to drive participation in protected or unprotected sexual risk behaviors. Qualitative methodologies will be used to explore the following research questions:

1. Which characteristics of participants' immediate physical environment preceding sexual intercourse are perceived to drive high risk and low risk sexual behaviors among Black MSM?
    a. Where are Black MSM meeting their sex partners?
    b. Where are Black MSM having sex with their sex partners?
    c. Are alcohol/drugs available in these environments?
    d. Are condoms available in these environments?

2. What characteristics of the non-physical environment do participants perceive to drive high risk and low risk sexual behaviors?
    a. How are daily stressors perceived to impact the decision to engage in high risk and low risk behaviors?
    b. What emotional/affective states are perceived to impact the decision to engage in high-risk and low risk behaviors?
    c. How do participants perceive their childhood experiences to drive sexual behavior decision making?
    d. How does participants perceive their sources and quality of social support to influence their sexual risk behaviors?

1.10 Overview of chapter contents

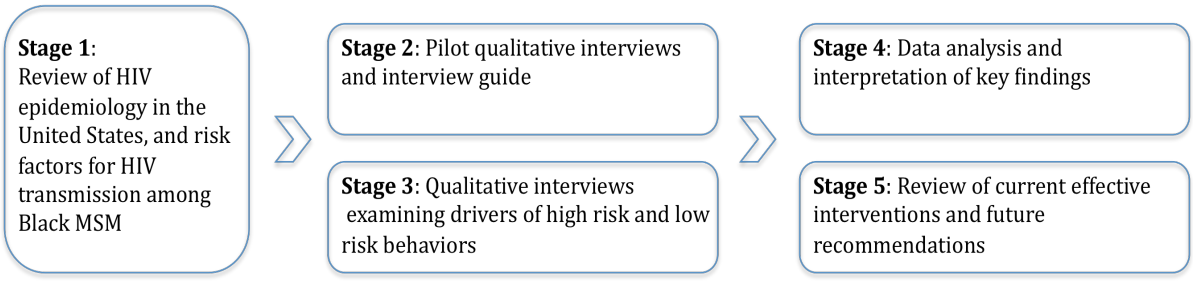


Figure 1.2: Overview of study design.

Chapter 1 of this thesis provides a background of the HIV epidemic in the United States, describes the epidemiology of HIV among Black Americans, outlines the evidence on risk factors for HIV transmission among Blacks, and explores the structural, sociocultural and situational context of HIV risk.

Chapter 2 describes the range of theoretical approaches to understanding HIV risk. This includes a review of the most widely used traditional theories in HIV prevention HIV risk (the Theory of Reasoned Action, the Health Belief Model, the Social Cognitive Theory, and the AIDS Risk Reduction Model.) Reflecting the contextual nature of HIV risk behaviors, Chapter 2 also describes the Socio-Epidemiological Model of HIV Risk, the Syndemic Production of Disease, the Life Course Approach, as well as the theory of Minority Stress.

Chapter 3 details the qualitative interview methodology employed in this thesis. It revisits the research objectives and questions, provides in-depth detail on research ethics approval, the study site, and data collection techniques, including recruitment and sampling strategy, challenges to recruitment, and eligibility criteria. It also describes the interview guide, the interview process, as well as data quality, storage, and analysis. This chapter ends with a discussion of the methodological limitations of the research design.

Chapters 4, 5, and 6 report the results of participants' qualitative interviews. Chapter 4 describes participants' recollections of childhood experiences and how they perceived these experiences to impact their sexual risk behaviors as adults. Childhood experiences discussed include socioeconomic circumstances, family dynamics and family life, as well as experiences of childhood sexual abuse. Chapter 5 describes the situational context of participants' sexual episodes, and distinguishes between situational contexts contributing to higher risk sex and situational contexts contributing to lower risk sex. It also explores the interpersonal, internal/psychological, and episodic factors men perceived to drive their unprotected and protected sexual behaviors. Chapter 6 describes participants' sources and quality of social support, including family, peer, and partner support, and the psychological consequences of strong or limited social support and its effects on HIV risk and protective behaviors.

Chapter 7 summarizes and interprets the key study findings and discusses the theoretical implications of these findings. It provides recommendations for future HIV intervention approaches and research strategies. The current effective evidence-based interventions targeted to Black MSM are described and their limitations highlighted. Finally, the overall limitations of this study are discussed.

CHAPTER 2: THEORETICAL APPROACHES TO HIV RISK

2.1 Overview

This chapter reviews and examines the range of existing theoretical principles for the understanding and prevention of HIV sexual risk behaviors. During the first ten years of the HIV/AIDS epidemic, many models for addressing changing HIV-related behaviors were used. Most of these models focused solely on individual factors (attitudes, beliefs, cognitions, intentions), overlooking more complex extra-individual factors involved in unprotected and protected sexual behaviors. Some of the most cited of these theories (Theory of Reasoned Action, Health Belief Model, Social Cognitive Model, and the AIDS Risk Reduction Model) are described in this chapter, and their applications to HIV prevention—particularly in Black MSM—are considered and critically appraised.

Although these models have shown some successes in changing HIV-related behavior, the limitations of these models largely reflected the limited appreciation of the broader social, cultural and structural determinants of risk for HIV transmission. Early studies endeavored to understand HIV risk by quantifying number of sexual partners, frequency of different types of sexual practices, occurrence of previous sexually transmitted diseases, and other similarly quantifiable behavioral factors that might shed light on the spread of HIV infection (Mayer & Pizer, 2009). These studies hoped to test associations between empirical data on sexual behavior and (mainly) psychological theories of individual behavior change (Parker 2001). However, as HIV prevention needs evolved, scientific understanding about the nature of HIV transmission moved beyond an exclusive focus on individual-level determinants of risk. Studies of HIV risk in ethnic minority communities, and in particular Black MSM, highlighted limitations in the individual-level approach and urged for a consideration of social, motivational, and interpersonal factors as determinants of risk.

As a result of the limitations of individual-level theories, social and behavioral scientists developed more complex models that provided a contextualized framework to understanding HIV risk. One of the most important of these models—the Socio-Epidemiological Model of HIV Risk and Syndemic Theory of Disease Production—considered the multiple sources influencing this risk. The second half of this chapter describes these specific contextual theories for understanding HIV risk in Black MSM. We will illustrate how two important theoretical constructs—Minority Stress Theory and theories of resilience—are integral to understanding how and under which circumstances Black men engage in sexual risk behaviors, as well as the social, motivational, and interpersonal factors that protect men from engaging in these behaviors.

2.2 Traditional theories in HIV prevention, and their limitations

The most widely used—the Theory of Reasoned Action (Fishbein & Ajzen 1975), the Health Belief model (Janz & Becker 1984), the Social Cognitive Theory (Bandura 1994), and the AIDS Risk Reduction Model (Catania et al. 1990)—have been described extensively in the literature and are described here only briefly in order to communicate the progression of HIV/AIDS prevention models and provide the necessary perspective for understanding current theoretical trains of thought regarding HIV prevention in the changing face of HIV/AIDS.

Theory	Basic premise	Variables that predict health behavior	Applications to HIV prevention	Limitations in HIV prevention research
Theory of Reasoned Behavior	Behavior is determined by intention to perform the behavior. Intention is determined by personal attitudes toward the behavior and wider social norms	Intention Attitude Social norms	Attitude-based arguments for condom use found to effectively increase behavior change across many populations	Does not incorporate broader structural and environmental determinants of HIV risk
Health Belief Model	Behavior is determined by perception of the severity of a potential illness, perception of susceptibility to the illness, the perceived benefits of taking a preventative action and the perceived barriers to taking that action.	Perceived threat Perceived severity Perceived benefits Perceived barriers Perceived efficacy Cues to action	Useful to predict and prompt health behaviors, and understand why individuals do or do not utilize available services.	Does not incorporate broader structural and environmental determinants of HIV risk Does not incorporate the impact of social norms and peer influences on behaviors
Social Cognitive Theory	Development of behavior is determined by the interaction of personal, environmental and behavioral factors	Human thought processes Safer sex self efficacy Agency Appropriate knowledge and skills Outcome expectancies	Provides appropriate intervention framework for understanding how learning and behaviors are developed.	Does not incorporate changes across one's lifetime Minimal consideration of motivation, emotion, and conflict.
AIDS Risk Reduction Model	Behavior is determined by recognition and labeling of one's behaviors as high risk, making commitment to reduce these behaviors and increase low risk behaviors, and taking action	Risk assessment/labeling behavior Commitment to change Taking action Enact change	Useful for explaining and predicting individual behavior change as it specifically relates to HIV/AIDS	Does not incorporate broader structural and environmental determinants of HIV risk

Table 2.1. Individual-Level theories of health behavior commonly used in HIV prevention.

The Theory of Reasoned Action (Fishbein & Ajzen 1975) posits that humans are inherently rational and that individual behaviors are under volitional control. The model outlines that behavioral intentions are a function of salient information or beliefs about the likelihood that engaging in a particular behavior will lead to a specific outcome. This theoretical framework connects individual beliefs, attitudes, intentions, and behavior. Specifically, behavioral and normative beliefs influence individual attitudes and subjective norms, respectively. In turn, attitudes and norms shape a person's intention to perform a behavior. Simply stated, an individual's behavior is influenced by their own attitude toward the behavior, as well as how they believe others would perceive them if they were to engage in the behavior. The individual's intent to engage in the behavior is formed by his or her own attitude, as well subjective norms. For example, if an individual thinks a behavior—such as using a condom to protect against HIV transmission—is positive (i.e. their *attitude* towards it), and feels that their partner(s) and/or peers will be accepting of their condom use (the *social norm*), their *intention* to use condoms will increase. In this model, the intent to perform a behavior is the best predictor of that behavior being enacted.

The influence of attitudinal and normative variables over a person's intent varies. While the Theory of Reasoned Action holds that a person's intent (as informed by *both* personal attitude *and* subjective social norms) is the strongest predictor for engaging in a behavior, studies have shown variations in the importance of these factors in informing intent. For example, a study from northern Thailand revealed men's perception of peer norms to be the strongest predictor of condom use (VanLandingham et al. 1995), while another study of female college students in the United States reported that an individual's own attitude towards using condoms to be the strongest predictor of condom use (Middlestadt & Fishbein 1990).

One of the primary limitations of this individualistic model is its inability to account for the broader determinants of health behaviors, including important environmental and structural factors housing instability, and employment and

family difficulties—factors demonstrated to contribute to HIV risk in Black MSM. Moreover, individuals may first change their behavior and subsequently change their beliefs and/or attitudes towards the behavior, but the rigid linear nature of the theory does not allow for changing sequences to be incorporated.

The Health Belief model (Janz & Becker 1984, Rosenstock et al. 1994), attempts to explain and predict health behaviors by focusing on individual attitudes and beliefs. The central tenants informing this model's ability to explain and predict behaviors is the interaction between its theoretical components, which are perceived threat, perceived benefit, perceived barriers, cues to action, and self-efficacy. Perceived threat is comprised of an individual's perceived susceptibility to a health condition and the perceived severity of a health condition (e.g. how likely an individual believes they are to contract HIV following unprotected intercourse). Perceived benefits refer to the effectiveness of the strategies designed to reduce the risk of becoming ill (e.g. the perceived effectiveness of condom use in preventing HIV infection). The inclusion of perceived barriers underscores the influence of potentially negative consequences that may result from specific health actions, including physical, psychological and financial demands. For example, the risk of a parent finding condoms may prevent a teenage girl from using condoms, or the potential for being rejected by a sex partner if a person requests to use a condom may prevent suggesting condom use.

The limitations to the Health Belief Model include a) most research based on this model utilizes only select components of the model, thereby not testing the validity of the model as a whole; b) it does not account for environmental or economic factors that can influence health behaviors; and c) the impact of social norms and peer influences on health behavior decisions is not incorporated into the model. Winfield and Whaley (2002) test of the Health Belief Model's ability to predict condom use among African American college students found that while core components of the model were able to predict condom use, high levels of HIV/AIDS knowledge did not correlate with condom use. The authors suggested the

development of a broader conceptual framework that included sociocultural factors to more accurately capture and explain sexual decision making and condom use among African American populations. Moreover, most earlier applications of this model used highly emotional scare tactics in the hope that negative affect would prompt condom use—e.g., an image of the Grim Reaper as the source of an HIV-prevention message (Rigby et al. 1989)—but these strategies were found to be counterproductive or detrimental for proactive behaviors like condom use (Albarracin et al. 2005). Lastly, while the Health Belief Model incorporates variables found to be influential in influencing behaviors (e.g. attitudes and behavioral skills), a meta-analysis of the effectiveness of central assumptions of prominent health behavior change theories found that even when increases in perceived threat were positively associated with behavior change, no threat-inducing argument had any positive effect on behavior, thus disconfirming the most distinctive prediction of this model (Albarracin et al. 2005).

Social-Cognitive Theory, a widely used model for understanding sexual risk behaviors, posits that providing information alone is insufficient for behavior change, but instead requires the individual to possess the necessary skills for the behavior change, as well as the ability to consistently use these skills in difficult situations (Bandura 1994). For HIV prevention, this model suggests that knowledge of HIV, expectations of condom use, and social norms guide individual cognitive processes that involve weighing the pros and cons of engaging in safe sex practices. It also posits that for behavior change to occur, individuals must possess effective self-regulation skills (i.e. such as self-motivation and self-guidance) (Bandura 1994). This process is thought to influence an individual's self-efficacy, that is, an individual's confidence in their ability to practice safer sex in challenging situations. Specifically, four components are considered critical to the process of behavior change: (1) information to increase awareness and knowledge of sexual-health related risks, and individuals must be persuaded that their behaviors can change; (2) the development of self-discipline and risk reduction skills to prevent sexual risk behaviors involves communicating to individuals what their risks are and how they

can be changed; (3) increased self-efficacy in implementing these behaviors; and (4) the provision of social support for the individual as they engage in the new behaviors. Social Cognitive Theory for understanding HIV risk has been successfully tested in different risk groups including gay men (Wulfert et al. 1996), HIV + individuals (Wulfert et al. 1999), and heterosexual adults (Wulfert & Wan 1993). However, a large-scale multisite sexual risk reduction intervention among low-income at-risk populations that employed a Social Cognitive Theory approach found that while all variables mediated sexual risk behaviors, some intervention effects were quite small, including self-efficacy, perhaps, the most important facet of Social Cognitive Theory (National Institutes of Mental Health 2001). Moreover, this theory has been criticized for being too loosely organized and lacking a unifying principle, which limits the implementation of the model as a whole. It also neglects individuals' maturation and changes over the course of their lifetime, and minimal consideration is given to motivation, emotion, and conflict.

Finally, the AIDS Risk Reduction Model attempts to explain and predict behavior change at three stages (Catania et al. 1990). Unlike the other theories described, the AIDS Risk Reduction Model has a time dimension and is more of a process-focused theory. The first stage involves an individual's recognition and labeling of their own behavior as high risk. The second stage involves individuals making a commitment to increase low-risk sexual activities while reducing high-risk sexual activities. The final stage involves seeking information and enacting solutions to reduce high-risk sexual behaviors. In addition to these stages, the authors acknowledge that aversive emotional states (e.g. alcohol or drug use that numb emotional states) may facilitate or hinder the labeling of one's behaviors. Moreover, external motivators such as public health education campaigns or informal support groups may cause people to reflect and possibly change their sexual behaviors. A test of the AIDS Risk Reduction Model in a mixed-race, mixed-gender sample of heterosexual adults with known HIV risk factors found that participants who labeled their sexual behaviors as risky were associated with having a history of STIs (Catania et al. 1994). Commitment to use condoms was associated with increased labeling, and supportive condom norms,

and high levels of condom use was associated with greater commitment to use condoms. However, similar to other studies testing this model, the authors did not consider movement across the different stages and consequently were unable to identify those who may have deviated from the Model's stages of change. Furthermore, the Model's general focus on the individual is a major limitation. As a result of other studies showing the role of broad socio-structural factors on sexual health behaviors (as described in Chapter 1), the model's authors conceded that these factors should be given greater consideration in their ability to influence or restrict an individual's behavioral choices and ability to take action (Catania et al. 1990).

HIV interventions based upon these theories have shown some successes (Albarracin et al. 2005, Albarracin et al. 2006), however, these models' important contributions may now be limited. The increasingly disproportionate rise in HIV incidence among Black men and women has led researchers to consider previously neglected factors implicated in HIV risk; sociocultural and psychosocial factors play a decidedly more prominent role than previously appreciated (Malebranche 2003, Mays et al. 2004, Millet et al. 2006, Millett et al. 2007, Operario et al. 2008). For Black men, sociohistorical forces have created an environment in which racism, stigma, gender role expectations, and beliefs surrounding sexuality have acted in concert to inform the complex nature of risk these men experience (Collins 2005, Ford et al. 2007, Jackson 1997, Mays et al. 2004, Millett et al. 2006, Operario et al. 2008).

2.3 General contextual theories to improve understanding of HIV risk

Several important contextual theories for understanding and explaining health behaviors have been developed over the past 30 years. These theories—including Ecological Systems Theory (Bronfenbrenner 1979), the Theory of Gender and Power

(Connell 1987), and Social Network Theory (Morris 1997)—were among the first to recognize the social and structural pathways influencing individual health behaviors. These theories refreshed perspectives on the factors influencing individual health behaviors. As the profile of HIV risk continued to change and prevention needs evolved, researchers developed specific contextualized theories to understand the unique framework of HIV risk in Black MSM populations. The early days of HIV/AIDS prevention research focused on individual-level and cognitive-based models of risk that prioritized factors such as intention and motivation but did not account for the sociostructural factors—such as social networks, partner selection, stigma and discrimination, and socioeconomic status—implicated in more recent scholarship. Accordingly, the Socio-epidemiological Model, the Syndemic Theory of Disease Production, and the Life Course Approach were selected as sensitizing devices for their ability to 1) understand not only how participants perceived individual factors to impact their sexual behaviors but also how social and structural factors impact sexual behaviors, 2) describe the interactive and reinforcing nature of these factors, and 3) account for the perceived impact of earlier life events on later sexual health strategies. These theories will now be described.

Theory	Basic Premise	Applications to HIV prevention	Limitations
Socio-Epidemiological Theory	HIV risk determinants are located at multiple interactive levels, including individual, social, and structural levels. *Individual*-level factors include behaviors such as condom use and partner selection, and individual characteristics such as gender and age. *Social*-level factors include social networks characteristics such as sexual networks and network dynamics, and neighborhood effects such as the social environment and socioeconomic factors. *Structural*-level factors include structural violence such as racism and stigma, and the policy environment such as economic policy, and health policy and access to care.	Incorporates the general and specific factors and life experiences of Black MSM that may lead to differences in sexual risk behaviors, and provides multiple prospective actionable points for intervention	Difficulties associated with developing clear testable hypotheses for determining which aspects of model are relevant to different populations Challenges associated with measurement and analysis
Syndemic Production of Disease	Diseases do not exist in a vacuum. Epidemics exist in clusters, and these clusters of interacting epidemics are largely socially produced and mutually reinforcing. Adverse social conditions and inequalities put socially devalued groups at increased risk. Social factors include poverty, racism, sexism, and isolation	Useful framework for understanding how multiple occurrences (e.g. HIV, poverty, racism) interact to guide high risk behaviors in the lives of Black MSM	Difficulties in analysis of the impact of different factors, particularly assessment of statistical significance of multiple interacting factors
Life Course Approach	Biological, environmental and psychosocial processes and experiences function across an individuals' life course and have an impact on later health or risk of disease	Important for understanding how Black MSM's early life experiences (e.g. child abuse, poor family dynamics) may impact later sexual risk behaviors	Development of a testable life course model remains elusive. Analysis difficulties associated with latent exposure.

Table 2.2: General contextual theories for understanding HIV risk.

2.3a Socio-Epidemiological Model of HIV risk

Rooted in Ecological Theory (Bronfenbrenner 1979) two multi-level frameworks for understanding risk have come to the forefront. The Social Ecological Model of HIV risk presents six levels of analysis to which HIV prevention interventions can be

targeted (Waldo & Coates 2000). These levels are the individual, dyadic/small group, organizational, community, and societal/cultural. A second framework, introduced by Poundstone et al. (2004), has incorporated and expanded on Waldo and Coates' (2000) levels of analyses. Poundstone et al.'s (2004) socio-epidemiological framework locates determinants of HIV risk at three levels: individual, social, and structural. The interplay of these factors may help to explain the high incidence of HIV among Black MSM and provide points for intervention.

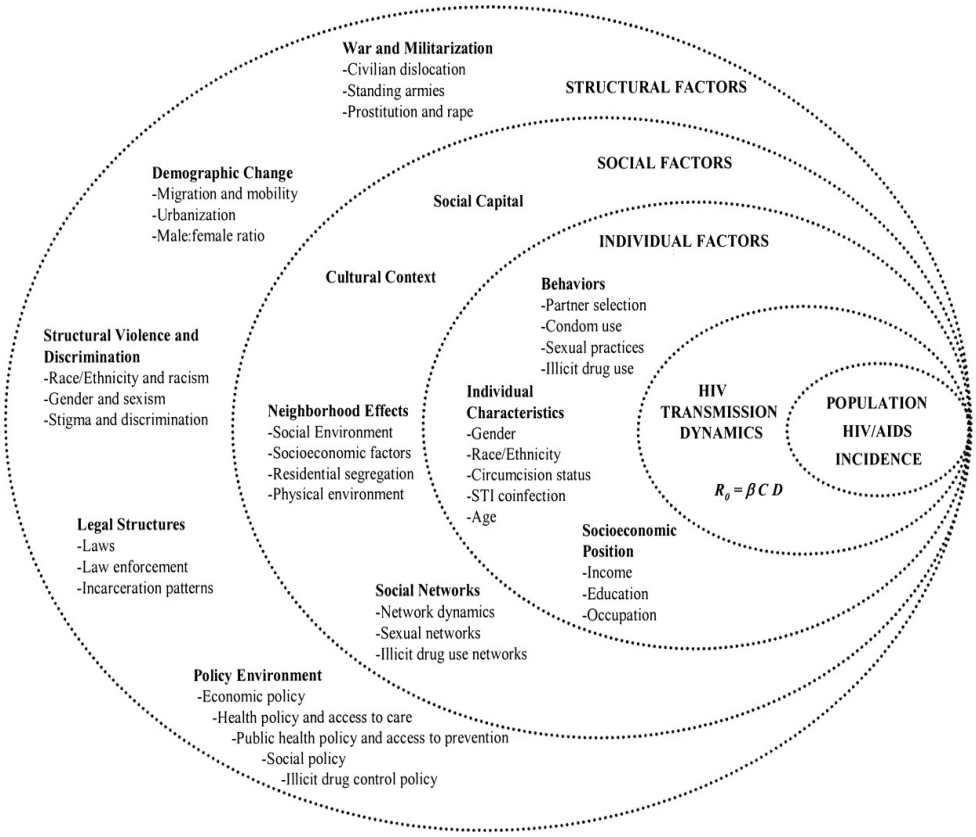


Figure 2.1: Multiple levels of social epidemiological analysis for understanding HIV transmission. (Adapted from Poundstone et al. 2004)

Structural level factors, especially structural violence, are of particular relevance to HIV in the Black community. As broadly defined by Galtung (1969), structural

violence refers to 'sinful' social structures characterized by poverty and deep social inequality. These social structures fundamentally interfere with the ability of individuals to care for their health or to participate in behaviors that are conducive to their own good health (Farmer 1999). Structural violence is most readily apparent in patterns of racism, sexism, stigma, and discrimination (Poundstone et al. 2004). These factors have been theorized to lead to emotional and behavioral damage, as evidenced by substance abuse and depression, and limited life opportunities, particularly in education, employment, and income. The interaction of these factors is thought to lend itself to high risk sexual behaviors, such as having multiple partners, and engaging in injection drug use or sex work. For example, the high number of Black men in incarceration creates a disproportionately low ratio of Black males to females and may encourage concurrent sexual partnerships and discourage monogamous relationships (Aral et al. 2008).

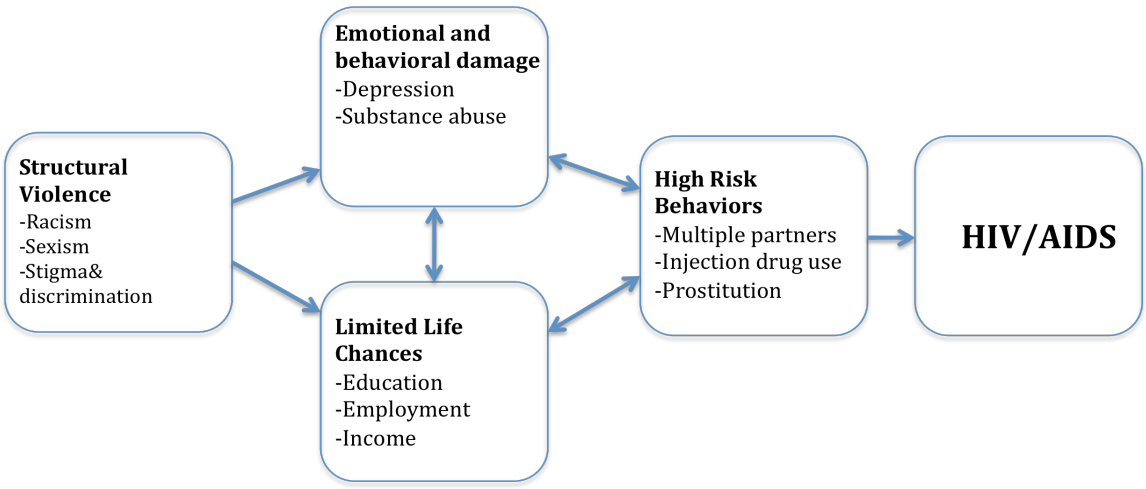


Figure 2.2: Potential pathways from structural violence to HIV/AIDS. Adapted from Poundstone et al. 2004.

The second level of the socio-epidemiological model of HIV risk concerns social factors such as social capital, cultural context, physical neighborhood effects, and social networks. Research into social networks has illuminated specific characteristics that are associated with HIV/AIDS, including partner selection

patterns (Laumann & Youm 1999, Zaric, 2002,) and concurrent sexual partnerships (Morris & Kretzschmar 1997). Social networks have been shown to influence individual risk behaviors of African Americans (Latkin et al. 1996, Latkin et al. 2003). Furthermore, network-related normative influences are predictive of substance use (Lovell 2002) and patterns of condom use (Latkin et al. 2003, Sherman 2001). In addition to social networks, neighborhoods in which individuals live may directly or indirectly affect HIV/AIDS patterns; this is particularly relevant to Black MSM living in impoverished neighborhoods. Direct mechanisms include an increased likelihood of coming into contact with an HIV positive individual, as a result of residential segregation and social isolation of marginalized populations. Indirect mechanisms include residing in areas of high unemployment and illicit drug availability (Poundstone et al. 2004).

Interventions aiming to impact social factors are often carried out at the community level, specifically targeting schools, prisons, and churches, frequently in economically disadvantaged areas. Community level interventions can seek to redefine social norms regarding sexual behaviors towards avoidance of high-risk practices. This can be achieved by engaging popular opinion leaders and well-liked peers, who often have wide-reaching influence within that community (Kelly 1992). Studies have demonstrated that normative perceptions of safer sex practices are important in an individual's own sexual behavior (Catania et al. 1990, McKusicket al. 1985). For instance, while Hart et al. (2004) found that Black MSM who did not carry condoms and reported unsupportive condom use norms among their peers were more likely to engage in high risk sexual behaviors, interventions aimed at increasing safer sex norms through the use of popular opinion leaders have been demonstrated to reduce risk behaviors in Black MSM (Jones et al. 2008). However, popular opinion leaders and peer educators may not always be effective, as demonstrated by Elford et al.'s (2001) intervention among a population of gay men in London, UK. The researchers attributed the lack of any significant impact of peer educators on HIV risk behavior to recruitment and retention challenges, difficulties

in engaging in conversations about sex, as well as cross-cultural differences between MSM populations.

Finally, individual level factors affecting HV risk have been well documented and the most frequent focus of HIV interventions. Poundstone et al. (2004) identify three individual level factors important to HIV risk. HIV risk is most directly influenced by *unsafe sexual behaviors* such as lack of condom use, multiple sexual partners, concurrent sexual partners, 'poor' partner selection, substance use, and sharing or improper sterilization of drug paraphernalia. Engaging in these behaviors is strongly influenced by *individual characteristics*, such as gender, race, and age. These individual characteristics are in turn strongly influenced by an individual's *socioeconomic position*, as determined by income, education, and occupation. That is, sexual risk behaviors are determined by multiple factors which Black populations disproportionately experience: individual characteristics, such as higher levels of STIs, as well as socioeconomic factors such as being low-income, or having limited education (as described more fully in Chapter 4). Individual level interventions that can directly or indirectly affect HIV risk in Black MSM may include risk reduction counseling, motivational interviewing, job and skills training, literacy education, HIV testing and STI treatment (Saleh & Operario 2009).

Important limitations to the Socio-epidemiological Model must be considered. The model is primarily descriptive and does not clarify the mechanisms and pathways by which the multiple levels have influences on specific behaviors that determine HIV transmission, especially unprotected sex. Challenges associated with developing clear testable hypotheses, as well as measurement and analysis exist. As quoted by Poundstone et al. (2004), Diez Rouz described these challenges to include "nested data structures, variables and units of analysis at multiple levels, contextual effects, distal causes, and complex causal chains with feedback loops and reciprocal effects" (2002, pg. 516). Finally, this framework also focuses on how populations in general are at risk, but not how individual members of a population might be at risk. Despite

these limitations, this model makes important contributions to understanding HIV risk among Black MSM.

2.3b Syndemic Production of Disease

Syndemic theory presents a complementary framework to the Socio-Epidemiological model, in which the spread of HIV/AIDS is contextualized by key cultural and social factors (Singer 1994, Singer & St. Clair 2003). It seeks to explain how under conditions of health and social disparity, there exists the tendency for multiple, co-terminus and interacting epidemics to develop and make each other worse (Singer et al. 2006, Stall et al. 2008), such as the SAVA syndemic (substance abuse, violence and AIDS) (Singer 1996), the hookworm, malaria and HIV/AIDS syndemic (Hotez 2003), and the malnutrition and depression syndemic (Heflin et al. 2005). The syndemic production of disease holds that the cluster of interacting epidemics that exist in populations is largely socially produced and subject to change across generations or populations. Singer postulates that the interaction of diseases and other health problems arises because of adverse social conditions and inequalities that put socially devalued groups at increased risk. Syndemic theory incorporates the consequences of socially-produced dysfunction (Meyer 1995, 2003) with ideas of stressors and strengths specific to minority communities (Diaz 1998).

In the case of Black men, the mutually reinforcing occurrences of HIV, poverty, racism, childhood sexual abuse, depression, and substance use work in concert to lower the overall health profile of the population more so than expected by each individual epidemic (Singer et al. 2006, Stall et al. 2008). The Urban Men's Health Study (Stall et al. 2001), a notable study in the late 1990s that explored a wide range of health conditions among MSM living in urban American settings found that the most prevalent and lethal conditions are interconnected and that each makes the others worse. Multivariate models demonstrated the extent to which each epidemic

acts as an independent correlate of another epidemic. Childhood sexual abuse was found to be independently associated with partner violence and depression; depression was independently associated with childhood sexual abuse, multidrug use, and partner violence; multidrug use was independently associated with partner violence and depression; and partner violence was independently associated with childhood sexual abuse, depression and multidrug use. Moreover, the study revealed that men who scored higher on numerical measures for any one of these conditions were at greater risk for HIV transmission and infection, demonstrating that syndemic processes are at work and this is one driver of HIV risk in this population. Owing to the disproportionately earlier onset of depression, anxiety, substance use and HIV among MSM, any understanding of the syndemic production of HIV must incorporate the experiences of men during childhood and adolescence. For this study, syndemics is useful for understanding the ways in which sociocultural and socioeconomic factors interact and drive the risk of HIV transmission of Black MSM. However, syndemics and syndemic production of disease have important limitations. While good at explaining clustering of problems and health disparities, syndemics does not necessarily explain individual differences—that is, why some people within the same community are at higher risk and others are not. Moreover, as with the Socio-epidemiological Model and other general contextual theories of risk, measurement and analysis difficulties exist, particularly with statistical assessments of the impact of multiple interacting factors. Tests of synergism are unable to statistically determine whether the combined effects of multiple co-occurring psychosocial health outcomes are greater than the individual effects.

2.3c Life course perspective

A life course approach offers an additional framework by which to examine HIV risk in Black MSM populations, and has been promoted for the study of health and development by psychologists, sociologists, demographers, biologists,

anthropologists, and epidemiologists (Baltes et al. 1998, Braveman & Barclay 2009, Elder 1998, Elford et al. 1991, Giele & Elder 1998, Graham 2002, Hertzman et al. 2001, Henry & Ulijaszek 1996, Leon 2001, Panter-Brick & Worthman 1999, Uhlenberg 1996, Smith et al. 2000). Kuh et al. (2003) define life course epidemiology as "the study of long term effects on later health[,] or disease risk of physical or social exposures during gestation, childhood, adolescent, young adulthood and later adult life." The aim of a life course approach is to understand the biological, environmental, and psychosocial processes that function across an individuals' life course. This approach highlights the significance of both conventional risk factors (e.g. smoking or alcohol abuse) *and* sociocultural life factors in early and later life on elucidating the risk and protective processes functioning across one's life course (Kuh et al. 2003). It examines how socially patterned exposures throughout an individual's early life experiences influences their risk of disease in adulthood as well as, for example, their socioeconomic position. Socioeconomic and structural factors at different life stages may operate through 'social chains of risk' or by affecting exposure to casual factors in early life that initiate or propagate long term psychosocial or biological chains of risk. The study of a life course perspective to understanding HIV risk requires a time-dependent ordering of prospective life risk exposures, as well as the interactivity and relationships between these exposures. Indeed, this has given rise to many new birth cohort studies (Golding et al. 2001, Smith & Joshi 2002), and resulted in reexamination of previous birth cohorts (Barker 1998, Leon et al. 1998, Susser et al. 2000). In keeping with the life course approach, this study aims to understand the gradual accumulation of risk across a life course, through adverse social, environmental, and physical effects, as well as mediating factors that can interrupt these pathways from exposures to risk behaviors and poor health. Kuh and colleagues (2003) hypothesize these exposures to be independent and occurring in isolation, as well as dependent with clustering of risk factors (see Figure 2.3).

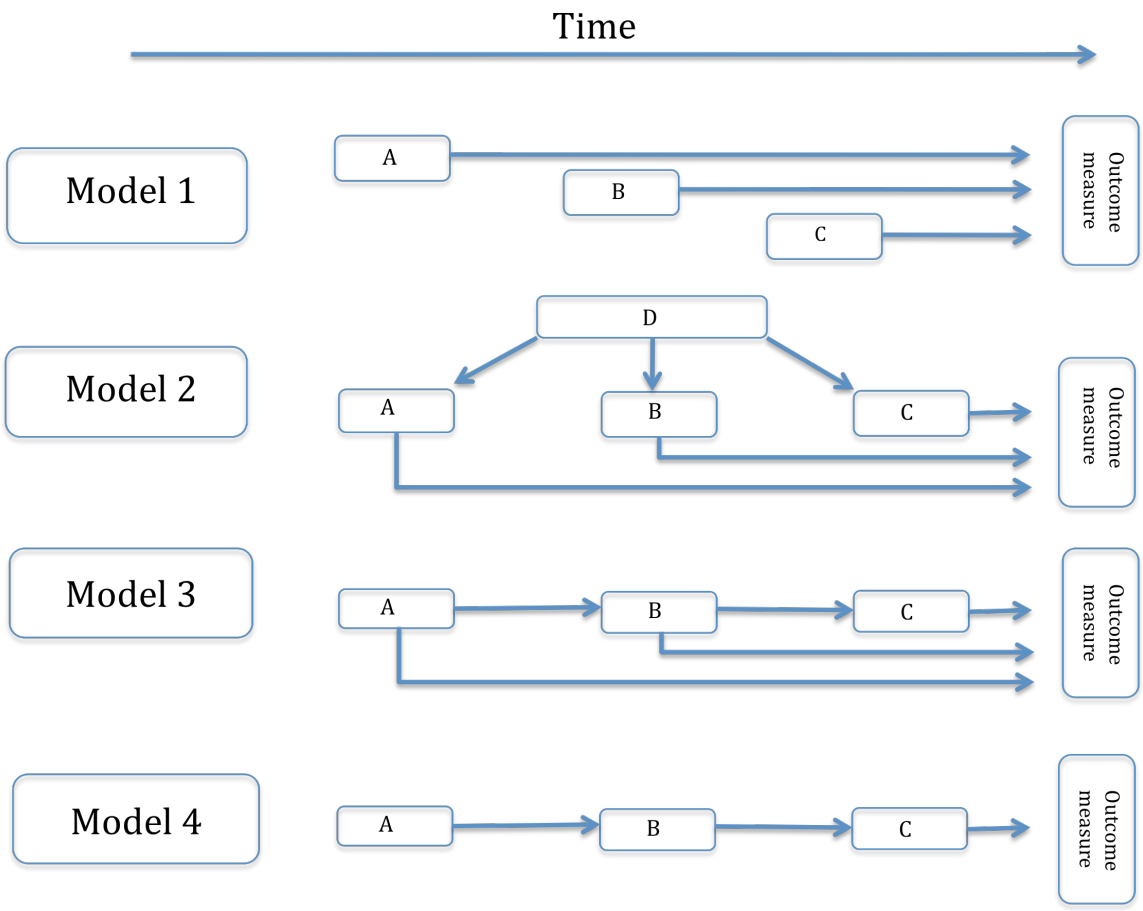


Figure 2.3: Hypothesized life course causal models. Adapted from Kuh et al. 2003.

In light of the benefits of using a life course approach to studying risk, several important limitations must be considered. The development of a testable life course model remains elusive. To date, no theoretical models exist to allow researchers to determine the risk and protective factors operating at each life stage. Moreover, life course effects are not mutually exclusive and may operate simultaneously, making the empirical testing of these potentially cumulative exposures difficult (Kuh & Hardy 2002). For example, Figure 2.3 depicts different life course models. In Model 1, multiple factors act independently across a life course to each have an independent impact later in life. Model 2 suggests that one general factor impacts multiple factors that each have their own impact. Model 3 depicts that in addition to the effect of multiple independent factors, factors are also linked through time, with

earlier events or experiences affecting later events or experiences. Finally, Model 4 suggests that life course factors do not act independently, but instead the effects of life course factors occur in a time-wise fashion, with earlier adverse events affecting subsequent events. However, Kuh and colleagues (2003) make note of the difficulties associated with testing the measurable impacts of the various hypothesized factors. Other methodological limitations include analysis difficulties associated with hierarchical data, latent exposure, or multiple interactive or small effects (Ben-Shlomo & Kuh 2002, Hallqvist et al. 2004, Kuh & Hardy 2002). Nonetheless, the life course approach is still important for uncovering adverse and protective life exposures, and better understanding the multiple determinants and drivers of HIV risk among this population of Black MSM.

In summary, these general contextual theories are important theoretical tools for understanding HIV risk in the lives of Black MSM. They provide a holistic appreciation of the multiple, interactive and reinforcing factors that function to increase participation in high risk behaviors.

2.4 Specific contextual theories to understanding HIV risk in Black MSM

2.4a Minority Stress

Studies report that MSM tend to participate in more risky health behaviors, such as illicit drug use and unprotected anal intercourse, than heterosexual men (Hamilton & Mahalik 2009). Contrary to earlier reports, Black MSM are not more likely to engage in sexual risk behaviors than White MSM or other MSM of color (Millet et al. 2006, Millet et al. 2007). Therefore, to understand differences within MSM groups and between MSM and other groups' health behaviors, it is necessary to understand the social context in which these behaviors occur. The minority stress model

provides an important conceptual framework by which to understand these behaviors and appreciate the experiences of members of racial and sexual minority groups.

Drawn from multiple social and psychological theoretical underpinnings, minority stress is described as the juxtaposition of dominant and minority values and the resulting conflict with the social environment that minority group members experience (Meyer 1995). Early scholarship suggests that such conflict between an individual and their experience of the environment is the root of social stress for minority individuals. Indeed, when a minority person lives in an environment characterized by stigma and discrimination, the conflict between that individual and the dominant culture can be problematic, and the resultant minority stress considerable.

The underlying assumptions of the minority stress model are that minority stress is a) unique—in that minority stress is in addition to the general stressors that are experienced by members of both minority and dominant groups; consequently, stigmatized people are subject to adaptation efforts above that of individuals that are not stigmatized; b) chronic—in that minority stress arises from fairly unwavering sociocultural structures; and c) socially based—in that its foundation is formed in social processes, institutions, and structures beyond that of the individual, as compared with individual events or conditions that characterize general stressors (Meyer 2003).

Social comparison and symbolic interaction theorists argue that social environments give meaning to individuals' lives and organization to their experiences (Pettigrew 1967, Stryker & Statham 1985). Considered from an alternate perspective, the process of categorizing differences among social groups (e.g. race, income, education, etc.) leads to important between-group processes such as competition and discrimination, and provides an anchor by which members of a group define themselves and their group (Tajfel & Turner 1986, Turner 1999).

Consequently, negative perceptions from others can lead to negative self-perception (Rosenberg 1979) and can result in adverse mental health outcomes (Crocker & Major 1989, Jones et al. 1984). Societal Reaction Theory, a contributor to the minority stress model, contends that the effects of stigma, discrimination and negative social attitudes on characteristics or behaviors outside the dominant culture can lead to negative labeling and negative societal reaction, which in turn may lead stigmatized individuals to develop maladaptive responses that can include poor mental health and decision-making outcomes (Lemert 1967, Link & Cullen 1990, Schur 1971), as well as emotional distress (Clark et al. 1999, Ross 1990); others have described these maladaptive responses of stigmatized individuals as 'traits due to victimization' (Allport 1954). These responses may be caused by psychological mechanisms such as self-hate and within-group aggression. While minority group members are exposed to negative life experiences associated with their stigmatization and discrimination (Brooks 1981, Dohrenwend & Dohrenwend 1969), minority stress arises not only from negative events, but from the totality of their experiences in dominant society. The individual's experience is anchored by the discrepancy between their culture, needs, lived experience, and societal structures.

Black sexual minorities face the particular challenge of dual minority status (i.e. experiencing racism and heterosexism) that places them at risk for negative life events (e.g. employment-related difficulties and home life issues) and chronic daily stresses due to racial and sexual bias (Brooks 1981, Crawford et al. 2002). Many studies have attempted to assess the effects of minority status, particularly race, on mental health. The most common approach compares the rates of distress between minority and non-minority groups, and studies suggest that if being a minority is stressful and if that stress is associated with psychological distress, then it would follow that minority groups have higher rates of distress than non-minority groups (Meyer 1995). These conclusions have not gone undisputed; for example, some have argued that rather than stigmatization and discrimination, economic differences account for adverse mental health outcomes in ethnic minorities

(Mirowsky & Ross 1989). However, Meyer argues that this claim suggests that at higher socioeconomic status, members of minority groups should experience no negative mental health outcomes, which is not known to be true.

Many studies of minority stress have been subject to methodological difficulties that initially led researchers to doubt the existence of minority stress. A major limitation of earlier studies was sampling selection bias. For example, studies comparing sexual minorities and non-minorities found that individuals who accept their same-sex behaviors experience better mental health and less distress (Bell & Weinberg 1978), but studies have also shown that those who are not fully 'out' or do not accept their same-sex behaviors are less likely to participate in studies of minority stress than are those who accept themselves (Joseph 1986, Meyer 1993). This selection bias leads to oversampling of 'healthier' members of the minority group, thus leading to inaccuracies in estimates of distress. Other methodological problems of studies of minority stress include cultural differences in response to standardized measures of distress, particularly when presented with competing explanations for between-group differences that may not be relevant to all groups (Dohrenwend & Dohrenwend 1969, Mirowsky & Ross 1980, Sowa & Lustman 1984). Despite these problems, early studies have been able to show support for the effects of minority stress on health outcomes. A reanalysis of eight epidemiological surveys that initially found race differences in distress to be entirely explained by social class, found that while higher overall levels of distress amongst African Americans were explained by socioeconomic status, the direct effect of minority stress is most acute at low socioeconomic status (Kessler & Neighbors 1986). More importantly, the authors encouraged researchers not to prematurely accept the conclusion that minority status was unrelated to distress, and to reinvest their efforts in reexamining the role of minority status on distress. In response to this, Meyer (1995) carried out a pivotal study of the mental health effects of three minority stressors in a sample of 741 MSM. To avoid the methodological pitfalls of earlier studies, Meyer used theoretical conceptualizations to examine specified causal relationships, and formulated hypotheses that directly tested those relationships.

Instead of making between group comparisons of rates of distress, Meyer studied within group variability, and examined the differential effect of minority stress on members of minority groups. This study led Meyer to identify three concrete stress processes through which minority stress occurs: internalized homophobia, expectations of rejection and discrimination (perceived stigma), and actual prejudicial events (such as verbal or physical violence) (1995, 2003). These experiences resulted in negative consequences for participants, such as the development of post-traumatic stress disorder, as well as impacting their sense of the world and own personal security (Garnets et al. 1990, Meyer 1995). This can lead to various risk behaviors; for example, internalized homophobia has been associated with greater substance use (Glaus 1988, Meyer & Dean 1998), sexual risk behaviors (Meyer & Dean 1998), and suicidality (Remafedi et al. 1998).

An important limitation to Meyer's minority stress is the singular focus on stress due to stigma/sexual identity-related factors. While this may be the most prominent source of stress in the lives of some Caucasian MSM, it may be only one of many social stresses in the lives of Black men. Moreover, while Meyer's prior research has shown statistical associations between minority stress variables and their consequences for HIV risk behaviors, it provides little insight into individuals' lived experiences. Qualitative studies might be able to examine more deeply these statistical findings and provide the more complex understandings of individuals' motivations and drivers that are necessary to designing effective HIV interventions targeted to Black MSM. Below, we review the processes through which minority stress is considered to function through.

2.4a.1 Internalized homophobia

Homophobia refers to a fear, hatred, or otherwise negative attitudes toward homosexuals, and may lead to stigma, discrimination, and/or violence (Herek 1984, Meyer 1995). In turn, internalized homophobia refers to negative feelings towards

oneself because of one's own homosexuality. It occurs when an individual directs negative societal attitudes towards homosexuality at oneself (Hamilton & Mahalik 2009). Upon first recognizing their same-sex attraction, individuals may simply feel different from others and have a vague understanding of the social undesirability of that difference. However, soon after individuals come to apply the 'gay' or 'homosexual' label, the learned negative societal attitudes toward homosexuality may formally become incorporated into their self-concept, and the psychologically problematic effects of societal/environmental homophobia take place. (Meyer 1995, Huebner et al. 2002) Alongside acknowledgement of same-sex attraction, a deviant identity may begin to form, and this has negative consequences on the psychological wellbeing of that individual. Though strongest early in the sexual identity development, it is difficult for internalized homophobia to completely subside, even if the person accepts their same-sex behaviors and attraction, due to repeated exposure to societal stigma. Thus, due to powerful early socialization experiences and continued exposure to antigay attitudes, internalized homophobia remains a critical factor affecting an individual's psychological profile through life (Hetrick & Martin 1984, Gonsiorek 1988, Malyon 1982, Nungesser 1983). It is important to note here that many studies have described the unwillingness of some Black MSM to self-identify as gay due to stigma, discrimination and potential for violence from within and outside of the Black community (Malebranche 2003, Mays et al. 2004).

Internalized homophobia has been linked to sexual risk behaviors. Stokes and Peterson's (1998) qualitative interviews of Black MSM in Atlanta, Georgia revealed strong evidence that many study participants had internalized negative attitudes of homosexuality. They offered several mechanisms through which this may lead to increased sexual risk behavior. Lower self-esteem may counteract motivators for self-protection, for example, low self-esteem may lead an individual who would otherwise consistently practice safe sex to engage in unprotected sex or lead men to seek self-validation through multiple sexual encounters. It may also lead to a desire to lower behavioral inhibitions through the use of substances that may impair judgment and the ability to engage in safe sex practices. Other studies have found

that in young MSM, internalized homophobia is positively associated with sexual risk taking behaviors (Meyer & Dean 1998, Waldo et al. 1998). Herek & Glunt (1995) demonstrated that internalized homophobia was inversely associated with feelings of self-efficacy for practicing safe sexual behaviors (e.g., how to use condoms), and directly associated with partner-related barriers to practicing safe sex (e.g., power imbalance preventing negotiation of condom use). Moreover, internalized homophobia is associated with lower awareness of HIV prevention services run by community-based organizations, as well as lower post-intervention self-efficacy scores (Huebner et al. 2002).

2.4a.2 Perceived stigma

Stigma refers to the general experiences of prejudice and discrimination toward an individual as a result of a devalued characteristic of that individual (Goffman 1986, Preston et al. 2004). Link and Phelan (2006) identify five components of stigma. The first component involves a social selection process in which human differences are identified and labeled, and the second component occurs when the identified label is linked to undesirable characteristics, thus leading to stereotyping. The third component occurs when the group applying the label separates 'them' – the stigmatized group – from 'us'. The fourth component sees stigmatized persons experiencing discrimination and loss of status. When individuals are identified, labeled, 'othered', and linked with unfavorable characteristics, a rationale is created for their devaluation, rejection, and exclusion. The final component, the exercise of power, is critical to the process of stigmatization. Stigmatized individuals often lack the social, cultural, economic, and political capital to transform their negative experiences and social status. The effects of stigma are far reaching, and include strained and uncomfortable social relationships (Farina et al. 1968), more limited social networks (Link et al. 1989), reduced quality of life (Rosenfield 1997), low self-concept and self esteem (Wright et al. 2000, Preston et al. 2004), and unemployment. The disproportionate weight of negative experiences that

stigmatized individuals face compared with unstigmatized populations has been suggested as a source of chronic stress, and consequently result in negative effects on physical and mental health (Gibbs & Fuery 1994). Maladaptive or defensive coping by stigmatized individuals can have substantial health consequences. Allport (1954) suggests that vigilance as a result of stigmatization helps to explain the defensive coping that those with minority status may develop. High levels of perceived stigma may lead Black MSM to maintain a high degree of vigilance over the minority aspects of their identity in interactions with members of the dominant group. This vigilance is stressful in that it is consistently and continually present in the daily life of the minority person, and significant amounts of energy are required to adapt to it. The most common coping strategy involves the monitoring of appearance and behaviors; for example, stigma related to same-sex behaviors in Black communities lead many Black MSM to conceal their behaviors rather than risk rejection by family members and friends who are at risk for also being stigmatized because of their gay family member (Preston et al. 2004). This can lead minority group members to approach their social interactions with dominant group members with general feelings of fear and mistrust.

Perceived stigma has consequences for HIV risk behaviors, and serves as a significant impediment to HIV prevention efforts (Brooks et al. 2005, Herek et a. 2002). For some, the stigma related to testing positive for HIV infection acts as a disincentive to seek HIV counseling and testing (Valdiserri 2002). Studies have also demonstrated that stigma serves as a barrier to practicing safe sex behaviors such as condom use, limiting number of casual sex partners, participating in HIV prevention programs, and disclosure of HIV status (Goldin 1994, Herek 1999, Herek et al. 2003, Malebranche 2003). In the Black community, as well as other communities of color, the effects of stigma on sexual behaviors can be particularly acute (Mays et al. 2004, Collins 2005). Homophobia and stigma often results in Black MSM's reluctance to self-identify as gay or bisexual (CDC 2003, Kennamer et al. 2000), and has led some men to identify as heterosexual while secretly engaging in sex with men. (Malebranche 2003). Operario et al. (2008) demonstrated that men

who engage in secretive same sex behaviors had the tendency to compartmentalize and personally disengage from their actions, as well as engage in spontaneous and unplanned sex, with both circumstances leading men to be less likely to use condoms.

2.4a.3 Discrimination and violence

As occupying the dual minority status, Black MSM are subject to racially discriminatory events, as well as prejudicial events as a result of their same sex behaviors. The most apparent sources of minority stress that Black MSM may face are rejection, discrimination, and homophobic violence (Garnets et al. 1990, Herek & Berrill 1992, Herek et al. 1999, Kertzner 1999). Victimization of minority individuals can lead to psychological distress, and interfere with one's perception of the world and ultimately lead to self-devaluation (Garnets et al. 1990). The Urban Men's Study, a large study that examined the mental and physical health of MSM living in urban cities, reported that recent experiences of homophobia-related harassment, discrimination, and physical violence were associated with lower self-esteem and higher levels of suicidal ideation. Poor self-concept and self-esteem have been linked with increased sexual risk behaviors and apathy towards engaging in sexually protective behaviors (Bandura 1994, Kang et al. 2004).

Discrimination and violence are crucial contributors to minority stress because of their meaning within the framework of societal heterosexism and minority oppression (Meyer 2003). Prejudicial events are powerful contributors to the minority stress that Black MSM experience, more so because of the deep cultural meanings attached, rather than to the consequences of the events themselves (Brooks 1981). For example, a seemingly minor event, such as a racial or homophobic slur directed at a Black man may evoke deep feelings of rejection or fear of potential violence disproportionate to the event that gave rise to the feelings. Studies describing the level to which African Americans with same-sex behaviors

face greater prejudice and discrimination than Caucasian with same-sex behaviors have shown mixed results. For example, one large multisite longitudinal study of cardiovascular risk factors found that higher numbers of Caucasian MSM than ethnic MSM reported homophobic discrimination (Krieger & Sidney 1997), while a different study of 144 HIV+ gay men living in New York City reported that Black MSM experienced more gay-related minority stressors than Caucasian men (Siegel & Epstein 1996). More generally, experiences of discrimination can directly and indirectly result in men engaging in sexual risk behaviors. Directly, Black MSM may attempt to ward off discrimination by concealing same sex behaviors; indirectly, discrimination can lead to increased alcohol and/or drug use, multiple partners, and reduced self-efficacy to practice safe sex. In addition to sexuality-related discrimination, the racially motivated discrimination that Black MSM face in the gay community may render them less able to negotiate condom use with non-Black sexual partners, or may lead Black MSM to believe that insistence on safer sex may greatly limit the number of interested sexual partners. This may be a consequence of White MSM not being sexually or physically attracted to Black men, or as a result of condom use interfering with racially-motivated fetishes with Black men's penis size or fantasies of Black men's sexual prowess (Denizet-Lewis 2003, Dyson 2001). Thus, when discrimination is considered within a framework of risk that includes internalized homophobia and perceived stigma, it becomes reasonable to speculate on the considerable far-reaching interactive effects that these stressors may have on sexual risk behaviors.

2.5 Resiliency Models

What explains how some individuals experience long-term negative outcomes under adverse circumstances while others are protected against these outcomes under similar circumstances? Literature suggests that a range of factors can act synergistically to buffer an individual's vulnerability to poor outcomes; this may include the resiliency and coping ability of the individual, as well as the existence of

protective factors in the individual's life such as a strong support network (Masten 2001). For example, consider the hypothetical situation of an individual Black MSM whose lifetime experiences are characterized by poverty and childhood sexual abuse—factors known to increase likelihood of poor health outcomes (Masten 2001). Despite these adverse circumstances, if he has a strong family and friend support network and felt loved throughout his childhood, he may be more likely to be protected against the negative outcomes predicted by his circumstances. Similarly, if that same individual has a weak support network, and conceals his same sex behaviors for fear of rejection, he may be more likely to succumb to poor outcomes such as engaging in unprotected sex, and becoming dependent on drugs and/or alcohol. While many studies have focused on MSM's vulnerability to poor outcomes, relatively few have examined sources of resilience for men in high-risk situations (Stall et al. 2008).

In developmental psychology, resilience describes the attainment of competence or positive developmental outcomes under adverse conditions that may challenge an individual's adaptation. In other words, resilience refers to the ability and action of individuals experiencing positive outcomes despite serious challenges to their adaptation or development (Masten 2001, Masten & Coatsworth 1998). In general, the study of resilience is an important theoretical construct that has been narrowly defined through rigorous scientific testing and statistical modeling; however, for the purposes of this thesis, resilience has been conceptualized more broadly—in line with Rutter's work on resilience (1987)—and is defined as the ability of individuals to overcome challenging circumstances, as well as an understanding of the mechanisms by which individuals are able to overcome these challenges. Generally, these challenges have been shown to interfere with an individual's normal emotional, mental, or physical development and demonstrated to be associated with higher probability of a 'bad' outcome. For example, both, low socioeconomic status and exposure to violence are well-established predictors of poor outcomes, through either the development of specific problems or a broad range of problems (Kraemer et al. 1997, Masten & Garmezy 1985, Masten & Wright 1998). Individuals who do

experience lifetime difficulties often experience multiple, concurrent challenges that are syndemic in nature, and the culmination of these risks are strongly associated to rising risk for negative health-related outcomes; however the occurrence of these outcomes does not make poor outcomes inevitable (Masten 2001). Meyer suggests that 'minority coping' may most readily explain the disparity of outcomes between individuals who experience minority stress. Researchers have agreed that positive coping is common and beneficial among minority group members (Clark et al. 1999); for example, by actively coping with stigmatization, a minority group member may be protected against its consequences (Garnets et al. 1990, Meyer 1995, Meyer 2003). This is in keeping with the minority stress framework, which assumes within-group variation in experiences and effect of minority stressors. Coping by minority group members may help stave off poor outcomes by providing opportunities for social support, by affirming and validating minority group members' culture and values, and by allowing minority group members to reassess and diminish the stigmatizing beliefs held by the dominant culture (Garnets & Kimmel 1991, Shade 1990).

It is important to note that the processes that facilitate minority coping are thought to operate at the population/group level, not the individual level. At the individual level, minority group members may vary in the extent to which they employ minority coping, but the viable coping options available to them are predetermined at the community level (Meyer 1995). While available to all minority group members, the beneficial effects of group-level resources are present when accessed and used by individuals; the ease of access and use of which are determined by multiple factors. Group-level resources shape the extent of individual coping efforts such that, in the absence of these resources, even the most resourceful individual will have deficient coping. Individual-level resources such as personal coping mechanisms (e.g. personality), resilience, and hardiness are subject to within-group variability, whereas group-level resources such as Black churches or connectedness to the gay community are ostensibly available to all minority group members, including Black MSM (Branscombe & Ellemers 1998, Meyer 1993). Consequently,

minority coping can be conceptualized as a group-level construct, related to the minority group's ability to mobilize self-enhancing structures to neutralize the effects of minority stress. This conceptualization of minority stress prioritizes the "degree to which minority members may be able to adopt some of the group's self-enhancing attitudes, values, and structures rather than the degree to which individuals vary in their personal coping abilities" (Meyer 2003, pg. 7). This understanding of minority stress reveals how an individual may have strong personal coping resources, but lack minority-coping resources. For example, a gay student at a conservative Historically Black College or University that discourages group affiliations to LGBT organizations or personal affiliations with other gay students, may be unable to access and use group-level resources, and therefore be vulnerable to the poor health outcomes associated with minority stress irrespective of his personal coping abilities. Importantly, minority coping is not always beneficial. For example, concealing one's same-sex behaviors or drug use are common ways of coping, but both have been shown to have detrimental health effects (Cole et al. 1996a, 1996b, Cole 2006, Operario et al. 2008, Weinberg & Williams 1974).

Group-level sociostructural factors can lead to positive mental and physical health outcomes (Jones et al 1984, Meyer 2003), such as allowing men to develop a sense of belonging and community. Thus, while being a member of a minority group is associated with minority stress, it is also associated with important resources related to the population such as group solidarity and cohesiveness which help protect minority group members from the ill effects of minority stress and can lead to improved sexual-behavior decision making (Branscombe et al. 1999, Clark et al. 1999, Crocker & Major 1989, Kessler et al. 1985, Miller & Major 2000, Postmes & Branscombe 2002, Shade 1990). However, differences in group characteristics and peer pressure can also lead to worse sexual-behavior decision making. Minority group members with a strong sense of community cohesiveness tend to evaluate themselves in comparison with other group members rather than members of the dominant group, and it may also allow minority group members to reappraise the

source of stress and in the process lessen its negative effects. Branscombe and colleagues (1999) found that while Black participants' experiences of prejudice were related to negative well-being, they were also related to positive well-being through its facilitation of enhanced in-group identity. Living in a racially segregated environment has been shown to negatively impact physical health (Williams & Collins 2001) but enhance within-group acceptance and contribute to greater overall well-being and life satisfaction (Branscombe & Wann 2002). In addition to coping with racial minority status, studies have demonstrated the importance of coping with stigma associated with being a sexual minority. Morris et al. (2001) reported that coming out as gay, lesbian, or bisexual allowed individuals to cope with and overcome the negative effects of stress, demonstrating that stress and resilience interact in predicting mental health wellbeing. Garnets et al. (1990) suggested that while antigay violence can have potentially significant negative mental health outcomes, it also presents the opportunity for growth. In a study of gay men, self-acceptance of gay identity and family discussion about AIDS showed strong positive relationships with measures of support (Kertzner 2001). Moreover, a study of sexual minority adolescents found that self-acceptance and family support ameliorated the poor outcomes associated with homophobic abuse (Hershberger & D'Augelli 1995). Thus, members of sexual minorities offset minority stress by creating alternate structures and values that enhance their group.

It is important to note that limited research has explored the minority stress experienced by Black MSM and the resiliency methods employed by this population. Occupying dual minority status leaves Black men vulnerable to two sources of minority stress, and the dearth of research into both minority stress and resilience in these men may hinder the usefulness of HIV prevention strategies for this population. Most studies focus on minority stress as it relates to either sexuality or race, but fail to fully examine the intersection of these variables and its impact on Black MSM's sexual risk behaviors. Indeed, many studies of sexuality-related minority stress include primarily White MSM participants, with results not generalizable to Black MSM—the ways in which individuals manage stress, and the

resiliency and coping tools available to men may be influenced by cultural values and norms.

2.6 Summary

This chapter has described some of the key theories to understanding HIV risk in general, and in Black men specifically. A summary and critique of general individual-level theories was provided, followed by multi-level frameworks that are appropriate for understanding HIV risk in vulnerable populations in general (Socio-epidemiological Model of HIV Risk, Syndemic Theory of Disease Production, and Life Course Approach), as well as in Black MSM in particular (Minority Stress). Particular factors that have been theorized to contribute to HIV risk in Black MSM included structural factors such as racism and educational systems, and social factors such as socioeconomic power, geographic segregation, poor mental health and self-efficacy, internalized homophobia and stigma.

Based on this theoretical review, this thesis will describe the perceived factors leading Black MSM in this sample to engage in sexual risk behaviors, and the mechanisms through which protective factors are potentially able to reduce men's participation in these behaviors, and encourage low risk behaviors. The thesis will focus on understanding participants' life experiences through the lens of these theories, and its influence on the actualization of high risk and low risk behaviors. Appropriate theory-based research is critical to the development of effective interventions targeted to Black MSM.

CHAPTER 3: STUDY METHODOLOGY

3.1 Research Objectives and Questions

This study explored the contextual factors leading Black MSM to engage in both sexually risky and sexually protective behaviors. Based on the comprehensive review of the social science, behavioral science, and epidemiological literature in this area and the identified gaps in knowledge, four objectives were identified for this dissertation research. These objectives are:

Objectives:

1. To examine perceptions of the situational/episodic circumstances (e.g. location, condom availability, alcohol and/or drug use, etc.) that characterize the context of unprotected sexual episodes versus protected sexual episodes.
2. To examine perceived emotional/affective states associated with engaging in higher risk behaviors and lower risk behaviors.
3. To examine perceived partner dynamics (e.g. how partners meet; communication between partners, etc.) that characterize the context of higher risk and lower risk sexual episodes.
4. To examine how perceived daily life stressors (e.g. housing, employment, violence, etc.) influences the decision to engage in high risk behaviors and low risk behaviors.

The research questions guiding this thesis were derived directly from gaps identified in the review of the literature. The research questions are as follows:

1. How do participants perceive situational characteristics of a sexual episode to influence sexual risk behaviors?
    a. What situational characteristics preceding sexual intercourse did participants perceive to influence their high risk sexual behaviors?
    b. What situational characteristics preceding sexual intercourse did participants perceive to influence their low risk sexual behaviors?
2. How do participants perceive sexual partner dynamics to influence sexual risk behaviors?
    a. What sexual partner dynamics did participants perceive to influence participation in high risk sexual behavior?
    b. What sexual partner dynamics did participants perceive to influence participation in low risk sexual behaviors?
3. How do participants perceive daily life stressors to influence sexual risk behaviors?
    a. Which daily life stressors did participants perceive to lead to their participation in unprotected behaviors?
    b. Which daily life factors did participants perceive to lead to their participation in protected sexual behaviors?

3.2 Qualitative methods for the study of HIV risk among Black MSM

Qualitative methodology serves the study of risk and protective factors well, and is particularly well suited to reveal the mechanisms through which individuals are placed at greater or reduced risk of HIV. In collaboration with quantitative techniques, qualitative methods allow the researcher to uncover risk factors implicated in individuals' lives, and fully acknowledges the breadth of unique trajectories of risk across respondents' lives. The cultural and social factors implicated in individuals' sexual behaviors are reflective of the contextual nature of risk, and are more richly captured through qualitative methods (Ungar 2003).

Qualitative interviews are able to reveal unnamed processes. As is the nature of risk, the ways and extent to which an individual mobilizes the resources available to them is dependent on multiple factors and unique to an individual's personal situation; qualitative methods are better able to capture these nuances than quantitative methods. For this study, qualitative methods also allowed for a directed focus on the specific context of HIV risk for Black MSM, and the information it elicits strengthens the richness of the understanding of that concept. That is, a narrative approach to collecting data allowed participants to fully describe their own personal context of risk, and in doing so allows for the appreciation of the full range of life course factors affecting their sexual behaviors. Narrative approaches are uniquely able to give power to the 'voices' of minority group members in ways that quantitative methods are unable. It provides insight—in a person's own words—into what they understand their own personal framework for HIV risk to be, as well as their perceptions of what constitutes positive outcomes. This in turn lends itself to greater tolerance of Black MSM's specific constructions of risk and protective factors, because it avoids the need to generalize to larger populations for the sake of transferability (Ungar 2003). Indeed, narratives have specifically been suggested to have the "capacity to reveal truths about the social world that are flattened or silenced by…more traditional methods of social science" (Ewick & Silbey 1995, pg. 199), Accordingly, narratives are grounded in the social structures experienced by those sharing them, and represent the ways in which individuals conceive of and communicate their understanding and perspective of the world (Ewick & Silbey 1995).

3.3 Research Ethics

Ethical guidelines for this study were informed by a multitude of sources on research ethics, qualitative interviewing methodologies, and practice guidelines (Connelly & Clandinin 2006, Patton 2002, Strauss & Corbin 1998). Literature reviewed included research focused on Black MSM populations and HIV risk in this

population, as well as the lived Black experience and Black sexuality. The study was given ethical approval by the Central University Research Ethics Committee at the University of Oxford (ID: SSD/CUREC2/08-54) and the Institutional Review Board at Brown University (ID: 0907000012). The doctoral candidate received extensive training on ethical procedures including obtaining informed consent, confidentiality, and data storage. All participants were provided with a verbal overview of the informed consent form and then provided with a written copy for their review and signature. All study personnel were required to complete the Brown University Education Program in the Protection of Human Research Participants prior to interacting with participants or study data.

This research presented several ethical and practical challenges. The primary ethical consideration was maintenance of confidentiality and privacy. A number of steps were put in place to help maintain confidentiality: participants were encouraged not to use their names on tape or to use a pseudonym instead; all data collection forms were identified by unique numeric code; and participant names were kept on a separate roster, which was stored separately from the data collection forms. Practical challenges included stigma associated with sexual matters and HIV/AIDS; participants need for privacy; as well as disclosure of psychological problems including suicidality and severe depression and other mental health issues including bipolar disorder and post-traumatic stress disorder. Strategies developed to manage these challenges are described later (in Section 3.9c.4). Due to the sensitive nature of this study, cases of physical, sexual, and emotional abuse were revealed, in which case necessary referrals were made. In addition, when appropriate, participants were provided with advice regarding issues of concern including housing, sexual health services, and local community social services. All participants were reimbursed $50 for their time.

3.4 Study Site

Fieldwork was carried out in Providence, Rhode Island, USA, the smallest, but second most densely populated state in the United States. HIV/AIDS poses a significant health burden on Rhode Island's Black population who experience the highest rate of disease in the State. As reported by the Rhode Island Department of Health (2010), while comprising 5% of the State population, they account for 25% of all AIDS cases and in 2008 accounted for 28% of all newly diagnosed HIV cases. Specifically, Black men and women account for 22% and 39% of HIV cases from 2004-2008, respectively. MSM are the highest exposure group; Black MSM account for 16% of HIV-infected MSM from 2000-2008. The capital city, Providence, serves as the focal point of the HIV/AIDS epidemic in Rhode Island, with 85% of all cases occurring there. In addition to housing the majority of HIV/AIDS cases, sparse literature on the dynamics of HIV infection amongst Black MSM led to Providence being identified as an appropriate study site.

3.5 Recruitment and Sampling Strategy

Patton's purposeful maximum variation sampling approach, most often used in qualitative studies, was deemed appropriate to the objectives of this research (Patton 1987). Maximum variation sampling allows the researcher to obtain information-rich cases, from which one can gain vast amounts of knowledge regarding issues of core importance to the purpose of the evaluation, instead of gathering small amounts of information from a large, statistically significant sample. Maximum variation seeks to collect a sample that is most different to each other (i.e. sample the broadest range of subjects), thereby making the sample more representative of the general population than convenience sampling; this is particularly important for HIV/AIDS research in Black populations (Patton 2002). While much research has focused on the need to tailor HIV prevention programs and services to this community, there is a relative dearth of HIV research focused on the diversity of risk within the Black community. This highlights a significant strength of this study's methodology; maximum variation allowed for the

recruitment of a range of Black MSM, who do not solely represent the healthier end of the continuum of the population. Accordingly, this study attempts to capture members that span the community, in terms of income, education, occupation, family structure, etc. This includes but is not limited to the unemployed, working class, professionals, college students, socioeconomically disadvantaged, as well as those formerly incarcerated and individuals living with mental illness. Recruitment aimed for a sample of Black MSM who may also have sex with women) with a range of demographic characteristics such as age, socioeconomic status, HIV status, housing and employment (in)stability, as well as life experiences. Recruitment and data analysis occurred concurrently, allowing the researcher to gain an emerging understanding of participants' experiences, which in turn informed the interview guide and the sampling process. Sampling continued to saturation, which occurs when no new coding categories or themes emerge from the data (Kuzel 1999).

As per the theoretical frameworks underpinning this study, different life circumstances and sociodemographic characteristics, including upbringing, education, and employment shape the behaviors individuals engage in and decisions made regarding partner selection, substance use, condom use, etc. Moreover, the sociostructural factors framing the lives of men may also have differential impacts on sexual behaviors. Differences in neighborhood effects; the social and sexual networks to which individuals belong; residential segregation; and employment may lead to vastly different life outcomes in terms of emotional wellbeing and life chances, which in turn can influence sexual risk behaviors. As such, the constellation of factors leading men to engage in unprotected or protected sex may be different in a college educated professional compared with a working-class high school educated individual.

Participants were sampled from a variety of sources. Initially, contact was made with key staff from local community-based organizations that were known to serve members of the Black community, including the Urban League of Rhode Island, an African American organization focused on eliminating racial, economic and social

disparities through the provision of social services; AIDS Care Ocean State, an organization providing testing/counseling, housing and other social services to those living with HIV/AIDS; Youth Pride Inc, an organization dedicated to serving the needs of LGBT youth. Staff from these organizations were briefed on the study objectives and methods and asked to refer any clients they believed would be eligible. Posters and flyers were also distributed at these organizations. In addition, recruitment flyers were distributed at bars and clubs identified as venues where Black MSM frequent, specifically in bathroom stalls and parking lots around these venues. Patrons were also approached individually and provided with a brief overview of the study and given a contact telephone number if interested. Due to safety concerns, nighttime street outreach was not conducted.

Based on guidance from local community-based organizations' (CBO) key informants, study information was also disseminated online on Craigslist's volunteer information board, as well as same-sex internet dating websites with substantial Black clientele, including Adam4Adam (www.adam4adam.com), Manhunt (www.manhunt.net), and BGCLive (www.bgclive.com). Client profiles were used to determine preliminarily eligibility. Clients were electronically approached if they identified as Black or African American, or if their profile picture made their race evident. Discreet messages briefly describing the study and outlining eligibility criteria were sent to those who were online at the same time as the researcher. If clients responded to the private message, further information regarding the study was provided, and interview appointments were scheduled with those who agreed to participate.

In addition, recruitment materials were distributed to subscribers to the Brown University and Rhode Island LGBT listservs, which are mass information emailing lists outlining events and information that may be of interest to the LGBT community. Posters were also distributed in two Providence bathhouses, Megaplex and Club Providence. As females were not permitted to enter the bathhouses, the researcher made contact with staff responsible for providing HIV testing services at

the bathhouses; these staff members posted study flyers in permissible areas and referred potentially eligible clients to the study.

Outreach approach	**Recruitment Venue**
Community-based organizations and institutions	Urban League Rhode Island AIDS Care Ocean State Youth Pride Inc The Miriam Hospital Rhode Island HIV Community Planning Group
MSM-themed spaces	Bars/Clubs: Mirabar, Club Gallery, Providence Eagle, Gerardo's Bathhouses: Megaplex, Club Providence Coffee shops
Virtual/Electronic media	Online dating websites: Manhunt.com, BGCLive.com, Adam4Adam.net Listserv: Brown University Queer Alliance, The Next Thing listserv, Brown Ellipses, Rhode Island LGBT News
General Public Places	Restaurants School campuses (Brown University, Rhode Island School of Design, Johnson &Wales, and Roger Williams University) Farmers market Local festivals Street corners

Table 3.1: Participant recruitment venues.

3.6 Challenges to recruitment

In the early stages of recruitment, it became evident that recruiting this sample group, both in terms of sample size and diversity, would be a challenge. Limits to variation in the sample exist, such as the inclusion of fewer older participants and eligibility criteria excluding individuals under 18 years of age. Ethnic minority

groups in the United States have been shown to be less likely to participate in HIV studies (Silvestre et al. 2006). Studies have particularly noted the challenges in recruitment of African Americans into HIV prevention research (Freimuth et al. 2001, Sengupta et al. 2000). A major obstacle purported to contribute to low participation is African American distrust of government officials and researchers. Thomas and Quinn (1991) argue that the Tuskegee Syphilis study fostered a long lasting distrust of medical officials and lent credibility to the belief that the HIV virus was created by the government to destroy the Black community. The Tuskegee study, a clinical study conducted from 1932-1972 ostensibly with the goal of charting the course of untreated syphilis in the body, created such distrust as a result of researchers failing to provide hundreds of disadvantaged African Americans with penicillin once it was established as an effective cure for the disease. Throughout recruitment for this study, distrust of researchers was most prominent in older populations; younger populations, aged 18 to 26, with limited memories of the Tuskegee experiments, displayed little apprehension. To counteract this distrust, potential participants were provided with detailed, yet relevant, information about the nature and goals of the study, interviewer, interview venue, and confidentiality. The interviewer/researcher's identification as an African American woman may have mitigated some concern about distrust of outside (i.e. Caucasian) researchers.

Another important barrier to recruitment was the belief that discussions surrounding sexual matters are private. Previous studies have established sexual secrecy as a general African American cultural value (Operario et al. 2008). Great concerns were also voiced over potential loss of confidentiality and privacy. Indeed, many of the participants who were ultimately recruited in the study articulated fear of their family or friends discovering their HIV status or secretive same-sex behaviors. Prospective participants were reassured that the interviewer understood their concerns about discussing sexual matters, and they would not have to divulge any information they were not comfortable doing so. Furthermore, great detail was provided regarding procedures in place to protect the privacy and confidentiality of

participants involved in the study. Individuals were encouraged to share their concerns and ask any questions they may have; each of their concerns were addressed prior to beginning the interview.

Direct face-to-face contact may have also served as a barrier; the fact that this contact was by a female may have heightened this barrier. Furthermore, the researcher may have been perceived as an outsider to the relative small 'gay' community and consequently caused prospective participants to be skeptical of the researcher thereby lowering their willingness to participate in the study. Being an outsider to the city of Providence may have also acted as an additional barrier; in particular, the researcher having limited first-hand experience of specific neighborhoods and public housing projects, state-specific social services, local gangs, and regional slang. To address these challenges, the researcher consulted with key staff from HIV/AIDS and Black community-based organizations, who shared their knowledge of the nuances and 'flavor' of Providence's Black community and neighborhoods, and helped the researcher integrate with Providence's Black community.

3.7 Eligibility criteria

A total of 34 participants were recruited into this study. The eligibility criteria are as outlined below:

Inclusion criteria:
1. 18 years of age or older
2. Self-identify as Black or African American
3. Engaged in unprotected receptive or insertive anal sex with a man within the past 12 months AND
4. Engaged in protected receptive or insertive anal sex with a man within the past 12 months

Table 3.2: Study inclusion criteria.

HIV status was not used as an exclusion criterion. Men were excluded from this study if they had not engaged in unprotected or protected anal sex within the past 12 months.

3.8 Sample Group

This study sampled a diverse range of participants (see Table 3.3). Participants were aged 18-51 years. Highest educational attainment also varied; 7 participants did not complete highschool, 1 participant was currently enrolled in highschool, 6 participants had completed highschool, and 4 participants earned their General Equivalency Diploma (GED). Approximately one-fifth of participants were enrolled in college at the time of interview (n=7), five participants had completed some college but did not graduate, 3 participants had completed college, and 1 participant was enrolled in a graduate level degree .

This study included both men who have sex with men and men who have sex with men and women. At the time of interview, 24 participants slept only with men, while 10 participants had sex with both men and women. Seven participants were diagnosed as HIV+. Fifteen participants had previously engaged in sex work or were participating in sex work at the time of interview. The majority of participants were unemployed (n=19); however, of the 15 individuals employed, 7 stated that they were not earning enough to meet daily living requirements. Of those included in this study, 12 had a history of juvenile and/or adult incarceration.

Descriptive Variable	Frequency (n)
Sexual Self Identification	
Gay	20
Bisexual	6
Heterosexual	0
Multiple Categories	2
Transsexual	4
Prefer to not categorize	2
Sexual Partners	
Sex with men only	24
Sex with men and women	10
Highest Education Completed	
Did not complete high school	7
In high school	1
Completed high school	6
Earned GED	4
In college	7
Some college	5
Completed College	3
Graduate/Professional studies	1
Employment	
Unemployed	19
Employed	15
History of Incarceration	
No previous incarceration	22
Previous juvenile/adult Incarceration	12
Sex Work	
No previous sex work	19
Previous or current sex work	15
Self- reported HIV Status	
Positive	7
Negative	27

Table 3.3: Descriptive sociodemographic variables of study participants (n=34).

3.9 Data Collection

3.9a Interviewer

One interviewer conducted all interviews. She completed a 30 hour intensive initial training on qualitative interviewing techniques including interview design, minimizing bias, addressing sensitive topics, as well as the ethical implications of conducting interviews with sensitive and confidential subject matter. Ongoing training and consultations were held with a licensed clinical psychologist, who provided basic mental health and debriefing training, as well as guidance on managing distressed participants and providing participants with confidential referrals to any health, psychological, and substance use treatment facilities, or other appropriate social services. Consultations were also held with staff from various community-based organizations with previous experience in interviewing Black MSM at risk for HIV infection. In addition to this training, the interviewer has had over 10 years of experience in the field of HIV/AIDS in African, African American, Afro Canadian, and Latino populations. She has worked closely with many non-profit organizations and community-based organizations, including the AIDS Committee of Toronto, The AIDS Network, Terence Higgins Trust, Mekane Hiwet Focus, and Harlem United, in the areas of prevention education, harm reduction, HIV testing and counseling, and life skills training.

3.9b Interview Process

All interviews were digitally recorded and took place in a private conference room in the Center for Alcohol and Addiction Studies at Brown University. To maintain privacy and minimize participant interaction with other researchers, staff, and students, the conference room was purposefully selected to be near an exit and only the interviewer and her academic supervisor knew of the exact nature of the study. Some participants did express discomfort in being in a building associated with the University, and this may have contributed to guarded narratives. To counteract this discomfort, participants were reassured that other individuals in the office were unaware that this was a study of the sexual behaviors of Black MSM. Participants were provided with a verbal and written overview of the study and informed consent was obtained. See Appendix 1 for consent form approved by the University of Oxford's Central University Research Ethics Committee and Brown University's Internal Review Board.

In addition to discomfort associated with the interview location, the highly sensitive nature of study interviews may have also contributed to participant discomfort; consequently, every effort was made to ensure participant comfort. During eligibility screening, the interviewer informed potential participants of general topic areas to be covered, the interviewer's gender (female), and that interviews would be recorded, at which point they were able to decline involvement in the study. Prior to beginning the interview, the interviewer again described the points of discussion to be covered and assured participants that everything disclosed would remain confidential. Participants were also informed that they were not obligated to answer any questions they felt uncomfortable with and were able to end the interview at any time without repercussions. The interviewer strove to be relatable to participants and used humor throughout the interview to reassure participants and make them feel at ease.

The interview guide was semi-structured, with open-ended questions to guide participants through their narrative. Each interview began with an exploration of each participant's sexual and racial self-identification. Then, the interview sought to

assess participants' demographic characteristics including age, HIV status, history of incarceration, housing and employment stability, highest education completed, and previous sex work, as well as participants' family dynamics. Once established, the interview shifted to capturing the circumstances surrounding the participant's last episode of unprotected and protected sex. Interviews ranged from approximately 1 hour and 20 minutes to 3 hours, with an average interview time of approximately 2 hours and 30 minutes. From each participant narrative, approximately 10-15 themes emerged.

3.9c Interview Guide

The design of the semi-structured interview schedule was guided by the study objectives and research questions described earlier. The interview guide aimed to explore the situational/environmental factors, partner dynamics, and life course hypothesized to influence HIV risk taking and protective behaviors among Black MSM. To contextualize interview data in larger sociocultural and socioeconomic frameworks, the first portion of the interview guide collected self-reported data on economic, social and community life conditions, including age, race, sexual orientation, employment status, sources of income, income level, educational attainment, and history of incarceration.

As reviewed in earlier chapters, the various factors informing HIV risk do not operate in isolation, and are often informed by one another and together create or reinforce an environment in which decisions to engage in sexually risky or sexually protective behaviors are complex. Accordingly, the second portion of the interview guide design used probing questions to bear out linkages between these factors.

3.9c.1 Interview guide Part 1: Economic, social, and community life conditions

As described in greater detail in Chapters 4 and 5, participants were asked to describe several life factors theorized to influence sexual behaviors. The researcher explicitly probed for factors (briefly outlined below) that previous literature has suggested might be associated with HIV risk: housing, transportation, employment, experiences of discrimination, educational attainment, crime/violence, support networks, family dynamics, and personal and family expectations. Interview discussion was not limited to these specified factors, but used this as an entry point to exploration about the intricacies of sexual risk behaviors (See Appendix 3 for the interview guide).

The interview guide endeavored to understand participants' housing circumstances, specifically their housing stability, or lack thereof. Housing instability was defined as individuals frequently relocating between family, friends or acquaintances, living on the street, or living in temporary accommodations such as homeless shelters. Participants were also encouraged to describe their access to a personal vehicle or public transportation. In cases of limited transportation options, the interviewer probed participants to describe its effect on their lives, if any; for instance, if participants perceived limited access to transportation to hinder their ability to secure or maintain employment.

Participants were also asked to describe their employment history and current employment status. Interview guide questions focused on understanding participants' experiences of employment, unemployment, and underemployment, as well as its effect on their daily lives. Participants unemployed at the time of interview were asked to discuss the last time they were employed and the duration of the work, as well as if they were actively looking for employment. Participants were encouraged to reflect on if and how they believe their employment status and history had influenced their lives (e.g. on their future employment prospects or emotional health.)

Participants were asked to discuss experiences of discrimination, if any, as a result of being Black, 'gay,' transgendered, lower income, unemployed, etc., in the months and days preceding their episodes of protected and unprotected sexual encounters. In addition to discrimination, participants were asked to reflect to what extent they believed their educational attainment had or had not affected their employment prospects, as well as its effect on their daily lives. This allowed for an exploration of linkages between demographic factors and individuals' life course.

To understand how adverse personal circumstances may affect sexual risk behaviors, participants were asked to describe sensitive personal experiences, including any past or ongoing domestic, physical, and/or sexual violence. Participants were also asked about any neighborhood violence and to share any fear of crime being perpetrated against themselves or those known to them. In the case of those experiencing housing instability, participants were asked to describe any dwelling-related crime or violence.

Social and support networks to which participants belong may also have a powerful influence on sexual risk behaviors. Consequently participants were asked to describe any close relationships they may have with family members, friends, or partner(s), and reflect on the influence that those relationships (or lack thereof) have on their behaviors and/or emotional wellbeing.

To conclude the first part of the interview, participants were encouraged to be self-reflective and speculate on the relationship between their economic, social and community life conditions, and their lived experiences. In particular, participants were asked to share their own personal expectations as well as any short term and long term goals, in addition to any expectations, obligations, or goals their family may have for them.

3.9c.2 Interview guide part 2: Unprotected sexual episode

As suggested by the Socio-epidemiological Model of HIV Risk and the Syndemic Theory, high and low risk behaviors are influenced by the interaction of multiple economic and social factors. Participants' perceptions of these economic, social, and community factors were captured in the first part of the interview guide. Once these dynamics of participants' lives were established, the interviewer moved to the second part of the interview guide and asked participants to provide a detailed narrative on the immediate circumstances surrounding their most recent instance of UAI. Specifically, participants were asked to discuss where they had met their partners and how long they had known each other prior to first engaging in sexual intercourse. Drug and/or alcohol use by the participant and if known, the partner, were discussed. Availability of condoms and privacy/convenience of sexual-episode location were also discussed.

The interview guide also explored the emotional/affective states of participants prior to and following unprotected sexual intercourse, as well as comfort and intimacy level with their sexual partner. Communication regarding condom use and HIV/AIDS were also discussed. Participants described if and how the topic of condom use was raised, as well as communication regarding previous partners, sexual health, HIV testing, and the ease and comfort with which these subjects were broached.

3.9c.3 Interview guide part 3: Protected sexual episode

Once discussion surrounding the situational and immediate context of participants' unprotected sexual episode was completed, the interviewer repeated the same questions of participants' most recent protected sexual episode.

3.9c.4 Interview Guide Part 4: Participant debrief and referrals

Immediately following the interview, participants were debriefed. Debriefing, a standard ethical procedure for research involving human subjects, involves conducting a semi-structured conversation with the participant to reduce the possibility of psychological harm resulting from the discussion of sensitive or traumatic events during the course of the interview. While some studies suggest that debriefing is ineffective or may have negative effects, it remains a standard procedure following traumatic events (Ross et al. 2002). Participants were encouraged to discuss their interview experience and share their feelings about the process, including their comfort level throughout the interview, whether any specific areas of discussion were particularly difficult to discuss, and if in retrospect they would still be willing to participate in the interview. Participants were also encouraged to provide feedback on how, if at all, their experiences could have been improved. Where necessary, the interviewer provided participants with referrals to appropriate social services, including housing and RI State support services, sexual health services, drug and/or alcohol addiction services, counseling, and other general human welfare services.

3.10 Data quality and management

The interviewer ensured interview recording quality and completion of all items prior to concluding each interview session. Interviews were carried out in private conference rooms and all efforts were made to minimize ambient noise. Following each interview, the interviewer wrote detailed notes, recalling impressions and observations of the interview conversation, including participant mood, comfort level, and any non-verbal cues. Interview recordings were digitized within 24 hours of completion and transcribed as soon after as possible. Two transcriptionists with previous experience were hired and provided with training, and required to sign a

confidentiality agreement and complete the Brown University Education program in the Protection of Human Research Participants.

3.11 Data storage

All data was treated as confidential and research materials including digital audio recordings, interview transcripts, signed informed consent forms, and reimbursement receipts were stored in locked cabinets and password-protected computers and accessible only to the doctoral candidate. Participants were assigned unique identifier numbers to link data sources. Original copies of digital recordings and interview transcripts were stored on a secured Brown University Center for Alcohol and Addiction Studies (CAAS) server. No individual identities will be used in any reports or publications resulting from the study.

3.12 Data analysis

All transcripts were entered into a computer and coded using *QSR NVivo*, a qualitative data management and analysis software program. Data was subject to open-coding and axial coding. Open-coding identifies and categorizes themes recurrently present in transcripts. Axial coding subsequently re-examines the categorized themes to determine connections and relationships (Strauss & Corbin 1998). Interviewer notes detailing participant impressions, attitudes, and mood were also included in the analyses. The initial analysis involved data abstracting, coding, and categorization, as a means by which to identify major themes. For purposes of data validation, initial interview analyses were completed by the doctoral candidate and her academic supervisor, Dr. Operario. To gain multiple perspectives and ensure consistency in reading/understanding of the data, a sample of anonymized transcripts were reviewed by the doctoral candidate, Dr. Operario, and a graduate student studying the same population. This team of coders

independently reviewed 5 transcripts and discussed their coding and interpretation of transcribed interviews, in order to finalize a coding scheme.

Qualitative researchers have outlined thematic analysis as a widely used form of analyzing qualitative data (Braun & Clarke 2006). In particular, this study followed Braun and Clarke's (2006) six phases of thematic analysis: 1) becoming familiar with the data; 2) generating initial analysis codes across the data set and grouping each code data; 3) searching for themes by collating analysis codes into possible themes and gathering data that is relevant to each possible theme; 4) reviewing themes and creating a 'map' of the analysis; 5) defining and naming themes; and 6) producing an analysis report and selecting appropriate, vivid quotes in support of described themes. In keeping with this described process, data analysis commenced with transcription of the initial interviews, and proceeded throughout the interview process. The specific analysis plan began with documenting descriptive characteristics, initially based upon interview notes and summaries, and augmented by data from individual interviews. Participants' demographic characteristics were used as a basis for contextualizing data, allowing for the integration of broader determinants—such as housing status or educational attainment—of sexual risk into the analysis. Through ongoing review of the transcripts, a list of thematic content codes were developed and upon finalization provided an exhaustive categorization tool of phenomena, concepts, and themes described by the participants. One or more codes were assigned to each line of the transcript using QSR NVivo. Coding helped to organize data and aid in identifying patterns of relevance in the text and determine whether linkages exist among particular categories. The objective here was to develop propositions and/or to relate concepts in order to examine the research questions and objectives. Narratives were analyzed for themes that directly or indirectly revealed participants' perspectives on the sexual episodes they described and the psychosocial and situational circumstances shaping these episodes. Particular attention was given to areas where narratives and observations diverge or conflict; these points of departure illuminated important phenomena and emerging community issues

related to the study. Consequently, at the descriptive level, analysis involved the identification and summarizing of patterns of experience related to sexual behaviors of Black MSM. At the theoretical level, the analysis involved understanding how and why specific situational/episodic and life course factors lead to observed outcomes.

3.13 Methodological limitations

To minimize the methodological limitations of this study, all stages of the study design, data collection and analysis phases were compared against the critical appraisal tool for evidence-based qualitative research developed by the Critical Appraisal Skills Programme of the U.K. Public Health Resource Unit. This checklist of 10 critical appraisal questions allows researchers to make sense of their evidence and assess study rigour, relevance, and credibility of the research methods employed. While, this study did "pass" the critical appraisal questions, some limitations remain and must be highlighted.

The primary limitation of the research approach was use of self-reported data and subjective recall of personal narratives. Self report measures inherently suffer from issues of reliability and validity (Weinhardt et al. 1998). Participants were not asked to provide documentation of employment status, HIV status, educational attainment, etc., which may have led to inaccuracies in the data collected. Furthermore, participants may have misremembered or falsely represented the protected and unprotected sexual episode in question. Participants may have under-reported stigmatized behaviors and over-reported normative behaviors. To counter this, the interviewer asked several follow-up questions and repeated the same question more than once at different points of the interview to ascertain accuracy and internal consistency of the narrative being provided. Finally, participants provided subjective narratives that reflect what they 'believe' to be real, but no means exist to assess the validity of the narrative. That is, causal associations cannot be made from

participants' narratives. However, narratives are able to nuance the drivers of risk and protective factors in this population of men.

In addition, even though avoided as much as possible, the interviewer may have unintentionally brought bias and personal opinions into the interview session. Interviews are interactional events and consequently many characteristics can lead to researcher bias, which can affect the relationship between the interviewer and the participant, in turn inadvertently shaping the data collected in the interview (Rosenthal 1966). For example, participants in this study may have been less forthcoming about sexual details to the female interviewer or may have been more likely to embellish their sexual exploits. Moreover, self-selection bias also presents itself as a possible methodological limitation. Men who are willing to participate in a research study on sexual behaviors might not be representative of the larger African American male population.

Due to the nature of semi-structured interviews with open-ended questions, the narratives provided by participants were not uniformly detailed. This may have been a consequence of participants' personalities or fears related to privacy and confidentiality. Moreover, interviewer/interviewee dynamics and interactions varied with each interview; this may have influenced the level of detail provided by study participants.

This study is also subject to sampling bias. While the sample size of 34 respondents may appear to be small in comparison with quantitative studies, qualitative interviews aim for depth and breadth and the collection of a thick data set; consequently large numbers of in-depth individual interviews are often not feasible or necessary. Furthermore, a smaller sample size is acceptable when a strong sampling strategy is employed (Ritchie & Lewis 2003). Recruitment and interviews of participants continued until data saturation was reached. However, it should be noted that the unavoidable use of an unknown sampling frame made it unclear if a

truly diverse and comprehensive sample existed, or if important subgroups were missing from the study.

This study could also have benefitted from the inclusion of more individuals living with HIV. However, difficulties related to participants' fear of loss of privacy limited the sample of HIV+ individuals. Moreover, the seven HIV+ participants included in the study described life histories and unprotected and protected sexual episodes with similar and overlapping themes. The study also did not include anyone under the age of 18 years, an age group experiencing a drastic increase in HIV incidence. However, the inclusion of youth was inappropriate as the factors mitigating HIV infection amongst youth may be drastically different than adults, and fell outside the scope of this study. The oldest individual included in this study was 51 years of age, mostly due to difficulty in the recruitment of older populations willing to participate in this study of sexual behavior. Further to this, generational differences in attitudes, knowledge and behaviors towards HIV/AIDS and sexual safety may have been missed. These afore-mentioned factors limit the generalizability of study findings to young and middle-aged Black men who have sex with men, and cannot be generalized to older populations, Black women, or other non-Black populations.

3.14 Reflexivity

In qualitative studies, the researcher is considered to be the primary "instrument" of data collection and analysis, making reflexivity a critical component of the qualitative methodology process (Glesne 1999, Merriam 1998, Russell & Kelly 2002, Stake 1995). Through reflection, the researcher may become aware that their own biases, assumptions, and perspective inform the manner in which they receive and perceive data (Russell & Kelly 2002). In this study, my perspective as a researcher and Black woman deeply concerned about the HIV/AIDS crisis among Black men and women in the United States undoubtedly impacted the ways in which I designed this study, my interaction with participants, and my analysis of the data. As

suggested by Gilgun (2010) I aimed to be particularly reflexive in two general areas. First, I was aware of the personal meanings I attached to the general topic of HIV/AIDS among Black men, in addition to the topics specifically discussed in the interview guide. Indeed, my perspective as a researcher influenced my understanding and experiences not only of HIV/AIDS, but also of the sociostructural (dis)advantages experienced by others. Second, I aimed to be reflexive on the perspectives and experiences of the participants that I interviewed. This included being aware of my understanding of the meanings that participants gave to the highly personal and intimate interview subject matter, as well as the tension between the multiple lenses of perceptions and perspectives.

My social identity as a middle/upper-middle class Canadian of East African ethnicity resulted in several socioeconomic and cultural differences between the predominately African American participants and myself (e.g. different social experiences and vernacular, differing perspectives on social/family dynamics, education, life expectations, etc.). These differences presented both methodological advantages and disadvantages. To a certain extent, it allowed me to interview participants as a detached "other," and understand and interpret participant's responses with a certain amount of objectivity. However, these socioeconomic and cultural differences also had the potential to hinder my relatability to participants or diminish my ability to understand their perspectives. To address this, I made concerted efforts to gain a thorough understanding of the literature pertaining to the social experiences of African Americans, which was supported by anecdotal recollections of the "Black experience in America" by Black scholars, friends, colleagues, and members of the community. In addition, this sensitive awareness of my role in all aspects of this study (e.g. study design, data collection, and data analysis) led me to seek the guidance and advice of multiple researchers. These researchers had divergent understandings and beliefs of this research project, and provided my research with a context in which my subconscious biases and assumptions could be revealed and appropriately addressed.

CHAPTER 4: ADVERSE CHILDHOOD EXPERIENCES AND HIV RISK BEHAVIORS

4.1 Overview

This chapter examines the perceived determinants of sexual risk behavior in Black MSM, as articulated by the Syndemic Theory and life course theory reviewed in Chapter 2, by focusing on the relationship between participants' childhood experiences and adult sexual risk behaviors. As will be shown in this chapter, narratives suggested that:

1) Early childhood experiences form a developmental foundation for later adult health risk behaviors—particularly sexual risk behaviors associated with HIV transmission.
2) Among the most important childhood experiences that participants perceived to be implicated in their adult sexual behaviors were family economic circumstances, family characteristics and family life, and the occurrence of abuse.
3) Important counter-normative patterns emerged from the data, suggesting that the developmental pathway leading from adverse childhood experiences to adult sexual risk behaviors may be modulated by additional variables.

Studying and addressing the impact of recollected adverse childhood experiences (ACE) to outcomes later in life has important health, social and economic consequences. In the early to mid 1990s, scientists began studying the relationship between adverse experiences in childhood and adult health and behavioral risk factors (Felitti 1991, Felitti 1993, Gould et al. 1994, Springs & Friedrich 1992). For example, Felitti et al.'s (1998) work showed childhood abuse or household dysfunction was positively correlated to increased risk factors for the leading causes of death in adulthood, and Gould et al. (1994) reported that experiences of childhood abuse was related to suicide attempts later in life.

The National Scientific Council on the Developing Child has defined three types of childhood stress: positive stress (i.e. short-lived; e.g. getting a toy taken away), tolerable stress (i.e. more intense adverse experiences but fairly short-lived; e.g. death of a loved one), and toxic stress (i.e. intense adverse experiences over weeks, months or years) (2005). Toxic stress is child maltreatment including neglect and abuse, and children are usually unable to effectively manage this type of stress on their own (Middlebrooks & Audage 2008). The terms positive, tolerable, and toxic refer to the stress response system's effect on the body, rather than the event itself. Toxic stress can disrupt brain development; lower a child's threshold for stress, leading to over-reactive stress responses throughout their lifetime; suppress immune responses; and damage the brain's memory and learning center. This typology of stress complements earlier work by developmental psychologists who posited that a 'hierarchy of needs' exists and that basic needs—such as physiological needs, safety needs, love/belonging/social needs, and esteem needs—must be met before higher-level needs such as self-actualization can be addressed (Larkin 2009). Both frameworks suggest that basic psychological needs provide a foundation for future healthy development, and that the developmental process can be compromised by early stress experiences – especially toxic forms of stress.

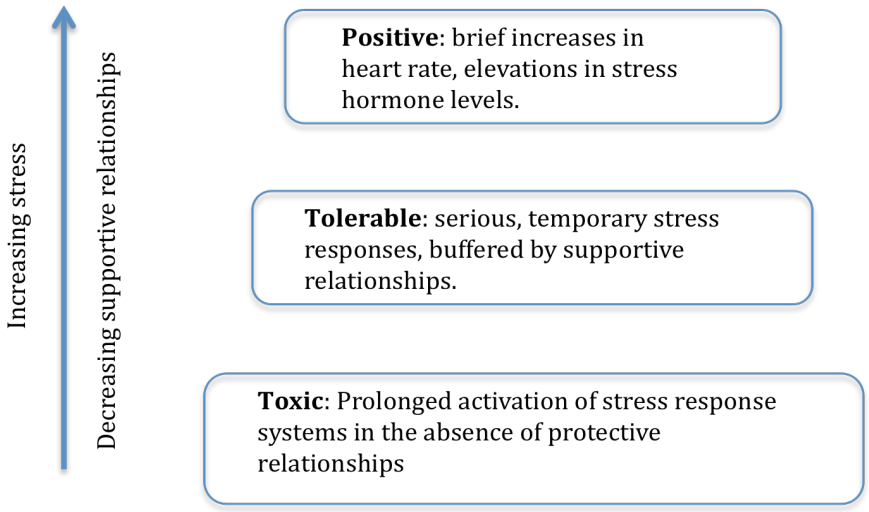


Figure 4.1: Effect of different types of stress on the bodily stress response system.

Adapted from
http://developingchild.harvard.edu/topics/science_of_early_childhood/toxic_stress_response/

Narratives will be used to determine how participants describe their experiences of childhood stress and basic development needs, and whether participants' narratives can allow us to identify linkages between these early experiences and their sexual risk behavior. Findings that support this developmental linkage may suggest that identifying and addressing these long-term effects of adverse childhood experiences is necessary, and socially and economically prudent, in the context of HIV prevention for the Black community.

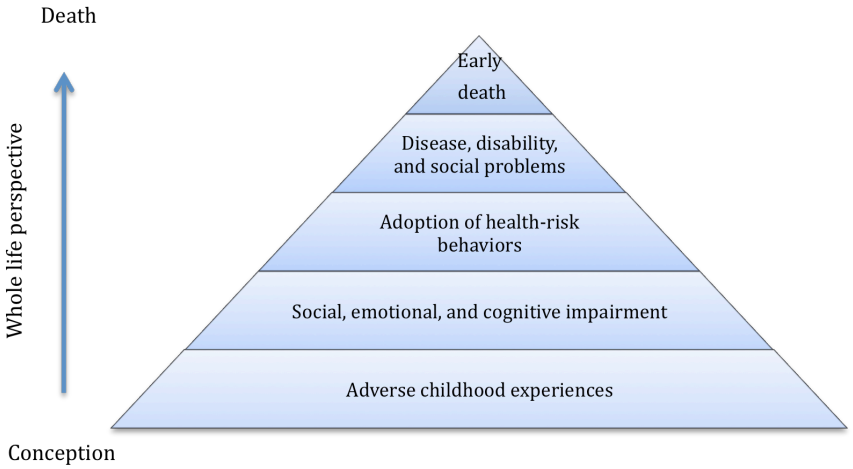


Figure 4.2: Impact of adverse childhood experiences. Adapted from Felitti et al. 1998.

4.2 Adverse childhood experiences and adult health

Studies of general populations suggest that childhood experiences may influence sexual behaviors and risk taking in adulthood (Wilson & Widom 2011, Wilson & Widom 2009). Childhood adversity generally describes experiences in childhood that have the potential to be psychologically or developmentally traumatic, both in

childhood and adult life. Such adverse childhood experiences may include, but are not limited to, parental drug addiction, limited support networks, poverty (or extreme stress related to poverty), discrimination, housing (in)stability, as well physical, sexual, or emotional abuse. Although statistical associations between difficult childhood circumstances and adult health have been documented, little is known about Black MSM's subjective perceptions of experiences of childhood adversity as potential determinants of engaging in risk or protective sexual behaviors.

The prevalence and range of adverse childhood experiences are far more common and diverse than earlier thought by developmental psychologists and public health researchers (Felitti 2002). While researchers have used survey methods to quantitatively examine the associations of specific types of ACE with adult health outcomes in general populations in the United States, there have been fewer studies of the lived experiences of ACE and the potential linkages between these experiences and adult sexual risk behavior in Black MSM populations. Owing to some of the common experiences associated with Black and MSM identities, there might be unique developmental experiences in this population that warrant specific attention in HIV prevention literature.

Mixed-race/sex studies and studies on women have examined the effects of adverse childhood experiences on risk taking behaviors and found strong positive relationships between number of adverse childhood events and STD/HIV prevalence, increased risk of early first intercourse and multiple sexual partners, less condom use, and higher self-perceived risk of HIV/AIDS (Catania et al. 2008, Dube et al. 2003, Hillis et al. 2000, Hillis et al. 2001, Kang et al. 2002, Newcomb et al. 2003, Parillo et al. 2001, Rodgers et al. 2004), as well as other behaviors known to increase HIV risk such as alcohol or drug use (Bensley et al. 2000, Dube et al. 2003, Heffernan et al. 2000, Kendler et al. 2000, Spak et al. 1998, Wilsnack et al. 1997), promiscuity (Cavaiola & Schiff 1988, Odonne-Paolucci et al. 2001) learned helplessness, low self-esteem, and reduced self efficacy (Freshwater et al. 2001,

Liem & Boudewyn 1999, Briere 1992, Genuis et al. 1991), poor mental health (e.g. depression) and psychosocial outcomes (Brodsky et al. 1997, Edwards et al. 2003, Kingree et al. 1999, Mullen et al. 1993, Nelson et al. 2002, Odonne-Paolucci et al. 2001, Osofsky 1999, van der Kolk et al. 1991, Zlotnick et al. 2001). It has been suggested that adverse experiences in childhood may act as initiators for STDs and risk-taking behaviors later in life (Hillis et al. 2000), often as a consequence of unresolved childhood trauma, which affects victims' beliefs, feelings, thoughts, and attitudes (Klein et al. 2007).

Early psychological and sociological research on the associations between childhood experiences and adult health most often focused on the frequency of child abuse (Berger et al. 1988, Finkelhor et al. 1990, Landis 1956, Straus & Gelles 1986, Wyatt 1986) and its long-term effects (Beitchman et al. 1992, Egelend et al. 1983, Finkelhor & Browne 1985), but often lacked a rich understanding of its effect on adult health. Indeed, most of the research on this area has been limited to adolescent general health (Council on Scientific Affairs 1993, Cunningham et al. 1994, Hibbard et al. 1990, Nagy et al. 1994, Nelson et al. 1995), adult mental health, (Nelson et al. 1995, Mullen et al. 1988) and patients visiting specialized clinics (Drossman et al. 1990, Harrop-Griffiths et al. 1988). Moreover, most studies of ACE often focused on single types of exposure, particularly childhood sexual abuse, with relatively few examining the effects of multiple types of abuse (Briere & Runtz 1988, Briere & Runtz 1990, Bryant & Range 1995, Claussen 1991, McCauley et al. 1997, Moeller et al. 1993). This focused analysis on a singular ACE often occurred without a consideration of other forms of abuse that may have coexisted within the household, both directly related to children within the home (e.g. verbal or physical abuse directed to the child), as well as general household dysfunction (e.g. substance use, housing or family life instability, neglect, and poverty). Exposure to one category of ACE is associated with an 80% likelihood of exposure to another—they do not occur in isolation (Felitti et al. 2002). Indeed, "*a child does not grow up with an alcoholic person or with domestic violence in an otherwise well-functioning household*" (Felitti et al. 2002, pg. 45). As a result of a narrow focus on ACEs,

resulting long-term consequences may have wrongly been attributed exclusively to single forms of abuse, and the cumulative effects of multiple forms of ACE might have been ignored.

This significant gap in the literature's understanding of multiple forms of ACE was addressed in Felitti et al.'s seminal ACE Study that examined the relationship between *a range* of adverse childhood experiences and consequent health risk behavior and disease in a sample of mixed-sex adults living in San Diego, a large urban center in southern California (1998). Using survey data, variables included into the regression were seven categories of adverse childhood experiences: psychological, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. The number of ACE exposures endorsed by participants was then regressed on measures of adult risk behavior, health status, and disease, allowing researchers to determine the association between the cumulative number of ACE exposures and risk factors for the leading causes of death in adult life. Controlling for relevant co-factors, researchers found a strong positive correlation between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several leading causes of death in adults, such as heart disease, cancer, and liver disease. The authors observed that the primary mechanisms linking ACE and health risk behaviors and adult diseases included behaviors such as alcohol/drug abuse, or sexual behaviors.

Subsequent analyses of the ACE study more precisely narrowed in on the associations of ACE exposures and sexual-health related outcomes. Hillis et al. (2000) examined the relationship between seven ACE categories and subsequent STDs in a sample of 4263 men and 5060 women. They found a strong graded relationship between ACE and self-reported history of STDs, such that the prevalence of STDs was found to increase as the number of exposures to ACE increased. For men, experiencing household dysfunction increased the risk of STD by 160%, those with an incarcerated family member had an increased STD risk of

90%, those who had been sexually abused had an increased STD risk of 50%, those who lived with someone with drug/alcohol addiction had an increased STD risk of 50%, those who had been physically abused and/or emotionally abused had an increased STD risk of 40%, and those with a mentally ill family member had an 20% increased STD risk. These results illustrate a potentially powerful link between an individual's cumulative childhood experiences and sexual risk and likelihood of STDs.

However, the relevance of these findings on understanding the sexual health and HIV risk of Black MSM may be limited. Of 8056 participants, only 385 identified as Black or African American, and data were not disaggregated by race/ethnicity and data on participants' sexuality was not reported. In addition, the majority of men in the sample were over 35 years of age, had at least some college education, were married, and were either employed full-time or retired; these sample characteristics might not be representative of the Black MSM population (US Census Bureau (2010). The authors also did not provide data on participants' socioeconomic status, nor was it controlled for as a potential confounding factor. Consequently, while this study did show strong associations between several ACEs and important causes of death, the applicability of these findings to Black MSM and the mechanisms by which they might explain HIV and sexual risk in Black MSM must be considered carefully. Surprisingly scant research has been conducted on the experiences and effects of ACE on the sexual risk behaviors of Black MSM. This clearly highlights a pressing area in need of further research, in the light of epidemiological data reviewed earlier that indicate Black MSM are among the most-at-risk groups for HIV infection in the United States.

4.3 Childhood experiences, development, and physiological responses

The childhood home environment and family relationships have also been demonstrated to be significant in a child's development. Developmental psychologists and neuroscientists have shown that healthy development hinges on the quality and reliability of a child's relationship with those who are important in their lives, particularly family members and caretakers (Berscheid & Reis 1998, Collins & Laursen 1999, Dawson & Fischer 1994, Dunn 1993, Panksep 1998, Reis et al. 2000). Relationships throughout childhood affect nearly all aspects of a child's development, including intellectual, social, emotional, physical, and behavioral development, as well as moral skills and perceptions. These relationships help individuals define who they are, their expectations and dreams for the future, and their sense of value to self and others (Bornstein 2002, Cassidy & Shaver 1999, Cochran et al. 1990, Fogel 1993, Rogoff 1990, Shonoff & Phillips 2000, Thompson 1998). In the words of Urie Bronfenbrenner, the preeminent developmental psychologist, "*in order to develop normally, a child requires progressively more complex joint activity with one or more adults who have an irrational emotional relationship with the child. Somebody's got to be crazy about that kid. That's number one. First, last, and always*."

The strength of relationships and attachments in early childhood help to develop a range of skills and capacities important throughout one's life, including feeling comfortable with one's self, and possessing healthy social and relationship skills (e.g. richer understanding of emotions and commitment) (Belsky & Cassidy 1994, Thompson 1999, Thompson 2000, Waters et al. 1991). Parental mental health illness and violence within the home also negatively impacts a child's emotional development and increases vulnerability to adult-onset depression (Dawson & Ashman 2000, Dawson et al. 1999). Moreover, in general, studies suggest that neurobiological mechanisms may function alongside psychosocial mechanisms to explain the effects of ACE in adult life (Dube et al. 2003, Green et al. 1981, Perry et

al. 1995, Van der Kolk & Fisler 1994, Weiss & Wagner 1998). In studies comparing individuals who experienced adverse childhood events with those who had not, researchers have documented higher brain-wave abnormalities, reductions in hippocampus, intracranial and cerebral volumes, adverse effects on limbic system (the area of brain responsible for emotional responses), as well as other physiological and anatomical differences among those who reported experiencing adverse childhood events (DeBellis et al. 1999, Stein et al. 1997, Teicher et al. 1997, Weiss & Wagner 1998).

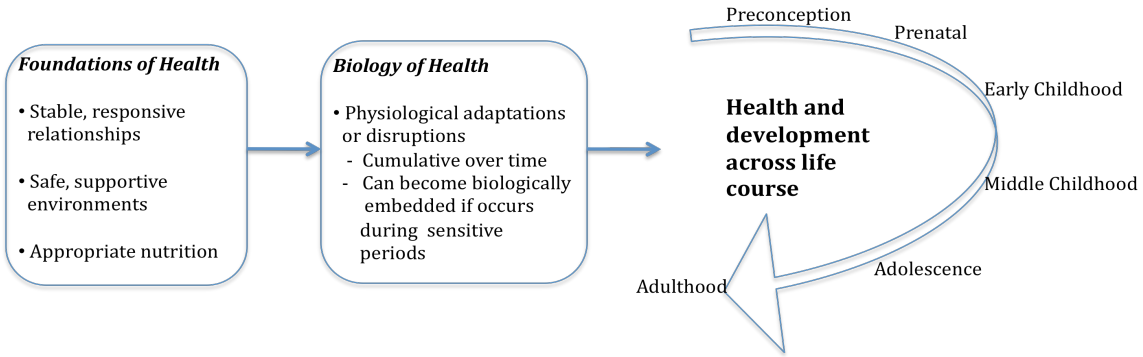


Figure 4.3: Childhood developmental basis for adult health and wellbeing. Adapted from 'The Foundations of Lifelong Health Are Built in Early Childhood, The Center on the Developing Child at Harvard University (2010).' www.developingchild.harvard.edu

4.4 Research Questions

Epidemiological data showing that Black men have a higher incidence of HIV/AIDS than any other group in the United States highlights the need for an examination of the potential childhood-related factors informing their sexual health behaviors later in life. As described in previous chapters, current social-cognitive models of sexual risk behavior do not sufficiently explain this health disparity. Broader frameworks are needed to incorporate multiple variables that operate across levels of analysis

and developmentally over time to explain HIV and sexual risk behavior in Black MSM. These may include socioeconomic and cultural variables such as education, urbanization, income level, social norms, values and life goals.

Based on this review of the potential role of ACE on HIV and sexual risk behavior, this chapter aimed to explore the following questions:

1. In what ways do participants perceive childhood experiences (either positive or negative) to have an influence on their adult sexual behaviors?

2a. Are there trends among participants' narratives about specific childhood experiences that influence their adult sexual behaviors?

2b. Based on their narratives, how do participants understand the processes by which childhood experiences influence their adult sexual behavior?

3. Are there trends in the narratives that might differentiate the experiences of participants who described multiple, consistent high risk sexual behaviors from those who described fewer high-risk behaviors in terms of their childhood experiences?

Qualitative data were analyzed and interpreted with the goal of uncovering salient themes of participants' childhood experiences and the potential pathways by which these experiences may or may not influence adult sexual behavior.

4.5 Factors of childhood experience implicated in sexual risk behaviors

4.5a Socioeconomic circumstances

Although there was socioeconomic variability within this sample, the dominant theme among participants was having a childhood characterized by varying degrees of poverty. A subset of participants (n=26) described having a low socioeconomic upbringing during childhood (see Section 4.5a.1 in Table 4.1), in which their families were in receipt of one or more of state or federal social assistance programs, such as general public assistance (i.e. welfare), social security disability, supplemental nutrition assistance program (i.e. food stamps), or were living in subsidized public housing. A frequent characteristic of these families, according to participants' narratives, was a lack of employed adult members in the household, often due to an inability to find work, physical disability or mental illness preventing work, or substance abuse/addiction preventing long-term employment. Participants also described limited parental/guardian levels of education, usually not beyond high school level. Owing to this socioeconomic adversity, participants reported dropping out of middle or high school to find employment to financially contribute to the household, sometimes being the main provider in the home. Several of these participants reported turning to illegal activities to earn income, namely selling illicit drugs.

The extent to which participants were cognizant during childhood of their family poverty varied, with some only retrospectively identifying in adulthood their upbringing as materially 'poor.' As one participant, Harold, stated "Nah, didn't know nothing about it…always had food and shoes...my grandmother did a good job of hiding (our poverty) from us." Other participants were aware that they were poor throughout their childhood. Upon reflecting on his childhood, one participant, Adrian, recollected that he "had less than other people," while another commented

that his childhood was "really messed up. We was broke, very broke." Participants' understanding of their childhood socioeconomic circumstance during their childhood was often a reflection of the severity of their poverty. For instance, those children whose guardians were unable to provide the most basic necessities such as food, clothing, and shelter were more cognizant of their socioeconomic circumstances than those participants whose families were able to provide basic material needs. For example, one participant whose childhood was characterized by a deeper level of poverty than most, remarked "my family was poor. We grew up making clothes out of rags, we had to hand wash our clothes." Importantly, in most cases participants did distinguish their feelings toward their childhood socioeconomic circumstances from their feelings toward their childhood; that is, participants did not equate having a materially poor childhood with having an unhappy childhood. While many participants did describe unhappy childhoods, their unhappiness was mostly a result of family dynamics, abuse, and weak support systems rather than the presence or absence of material goods.

Slightly less than one quarter participants (n=8) described having a middle or upper-middle class upbringing (see Section 4.5a.2 in Table 4.1). These participants described never lacking basic necessities such as food, clothing, and shelter, and several reported attending private schools throughout their childhood. Notably, at the time of interview, the majority of this group (7 of 8) was enrolled in or had graduated from a 4-year college or university. Generally, these middle or upper-middle class participants described having childhood social networks consisting of other children/families of similar socioeconomic status, thus believing their childhood socioeconomic circumstances to be normative. In addition, similar to other participants, they did not mix their feelings toward their 'good' socioeconomic upbringing with having a happy childhood. Notably, narratives from some participants from middle- or upper-middle class backgrounds described unhappy childhoods stemming from family dynamics, rather than socioeconomic factors. Keenan, a participant who came from a relatively higher socioeconomic background commented:

> "I mean, we had everything…but there was no love. My family was and still is very cold….yeah, definitely no hugs in my house. [My parents] showed me how not to be when I have my own family."

This participant acknowledged that while being raised in a financially secure household was important, his childhood was characterized by a family atmosphere lacking in love, warmth, and affection.

Participants from higher socioeconomic backgrounds reported a family culture in which education was held in high esteem, with parents (or guardian) holding the expectation of college attendance. It was noteworthy to observe that participants from lower socioeconomic backgrounds had few academic or career expectations placed on them, while participants raised in better socioeconomic circumstances had higher parental/guardian expectations, particularly with respect to educational attainment, career planning, as well as the general expectation of being a productive member of society (see Sections 4.5a.3 and 4.5a.4 in Table 4.1). This observation from our narrative interviews is supported by data demonstrating that parental educational attainment and expectations are important determinants of children's personal expectations and their future attainment in adulthood (Haveman & Wolfe 1995).

4.5b Socioeconomic status and sexual risk behaviors

Based on close qualitative analysis of participants' recollection of their recent sexual encounters, participants were categorized as engaging in either higher sexual risk behavior or lower sexual risk behavior. Categories were determined based on sexual behavior narratives alone, independent of other social or health risk factors. These categories were then used to identify potential narrative trends that might reveal social contextual factors that influence – directly or indirectly - risk behavior among

participants. These narrative explorations described here are not intended to indicate quantifiable correlations, but rather to bring to light possible linkages in narratives on early childhood experiences and adult sexual risk behavior. Indeed, participants' perceived experiences are perhaps best understood as occurring along a continuum, with rigid distinctions not possible.

Examination of the narratives among men in this sample indicated that participants who recalled having lower childhood socioeconomic circumstances also described a greater range of sexual risk behaviors than those who perceived having higher socioeconomic status childhoods. These high risk sexual behaviors included unprotected anal intercourse with casual partners, multiple concurrent sexual partners, and sex with anonymous partners (see Section 4.5b.1 in Table 4.1).

Childhood socioeconomic circumstances may influence adult sexual behaviors directly or indirectly. Directly, in light of many pressing and competing socioeconomic needs, participants may have learned to prioritize securing socioeconomic needs ahead of sexual health. Since those raised in lower-income homes frequently described childhoods characterized by daily struggles to secure basic necessities (e.g. food and housing), while those raised in higher socioeconomic circumstances did not as commonly describe similar challenges, we might interpret that participants from higher socioeconomic groups may have been afforded a broader perspective and set of priorities than participants from lower socioeconomic groups. In other words, participants' socioeconomic backgrounds may determine life priorities and shape expectations for the future. For example, fewer economic and social resources, greater housing instability, and poorer educational quality may lead to perceptions of diminished life prospects which in turn may affect perceptions of risk and consequent engagement in risk behaviors. The reasons explaining this possible association are yet unclear, but hypotheses may include a narrowed time orientation (e.g. immediate gratification prioritized over delayed benefits) which prioritizes attention to immediate needs over distal goals, limited coping resources (e.g. friend or family support) which do not allow for

productive ways of dealing with life stressors, and limited self-regulation skills which may promote risk-taking as a way of dealing with life stressors.

In the face of difficult socioeconomic circumstances, immediate and 'urgent' matters such as securing food and clothing tend to be prioritized over health promotion, which may be viewed as a more hypothetical or intangible concern because it lies (with uncertainty) in the future. For instance, Danis et al. (2010) recently examined the priorities of low-income residents in urban Washington D.C. for interventions targeted to the socioeconomic determinants of health, and found immediate concerns such as health insurance (95%), housing vouchers (82%), and dental care (82%) to be more highly prioritized than matters with delayed benefits such as job training (72%) and health behavior promotion (68%). Identifying the different ways in which the intersecting factors of low-income and parental priorities can impact children's adult HIV risk has been identified as an important area of research (Haveman & Wolfe 1995, Mulligan 1997).

Childhood experiences may also affect adult sexual behaviors through even more circuitous, indirect pathways. Studies of intergenerational income mobility and poverty persistence have shown that childhood socioeconomic status predicts adult socioeconomic status. That is, children who are raised in households characterized by poorer socioeconomic circumstances are likely to become adults who experience similar socioeconomic circumstances, while children who are raised in financially secure households are likely to become financially secure adults. Income levels during one's childhood persist through life at rates far higher than previously believed (Solon 1992, Mazumder 2005), and parental economic resources predict many categories of children's adult attainment (Corcoran 1995, Haveman & Wolfe 1995). Years of education has been suggested as one possible factor driving this trend (Aaronson & Mazumder 2008, Haveman & Wolfe 1995). National and international data have demonstrated that low socioeconomic status in adulthood has been associated with poor health outcomes (Adler & Ostrove 1999, Baum et al. 1981, Ewart & Suchday 2002, Lantz et al. 1998,), including increased HIV risk-

taking behaviors and higher HIV prevalence (Kalichman et al. 2006, Riley et al. 2007, CDC 2011). Thus, in addition to participants' own low socioeconomic status as adults influencing sexual risk behavior, the long lasting effects of familial priorities and life perspectives may have impacted adult sexual risk behaviors. Participants from lower-income childhood homes may have placed lower priority on sexual health in adulthood, compared with those who were raised in more advantageous socioeconomic circumstances. This may have led to the former describing their likelihood of engaging in sexual risk behaviors and the latter describing lower sexual risk behaviors

It is interesting to note that almost all participants were able to describe general sexual safety strategies to avoid HIV and other STDs. However, the strategies described by participants appeared to vary according to their socioeconomic background. The most common sexual risk reduction strategy described by participants from lower socioeconomic childhoods was to scrutinize prospective partners for evidence of illness (i.e. being HIV+) mostly through visual or behavioral cues (e.g. genital ulcers or sores, lipodistrophy, medication taking); if physical evidence was observed, they would refrain from sexual intercourse with those partners (this is further described in Section 5.5e). For example, one participant who described consistently relying on visual or behavioral cues shared that he would not "mess around with any [man]" with scabs or sores in his genital area (this is further described in the following chapter). By contrast, participants with higher socioeconomic childhoods described sexual strategies characterized by strictly refraining from unprotected intercourse with anonymous or casual partners, only engaging in unprotected sex with committed monogamous partners, and discussing HIV testing results with partners (see Section 4.5b.2 in Table 4.1). For example, Xavier, a participant from a higher socioeconomic background described having a rigid approach to condom use, an approach that was not mentioned by participants from lower socioeconomic backgrounds:

Interviewer: Why do you think that when sleeping together [with a casual

partner], you have not gotten to a point where you sleep with each other without using condoms?

Xavier: Cause that's crazy. You just never know. That's not something that I'm comfortable with. And it's not something that he's comfortable with. I mean we both trust each other and that's great, but… [you never know!]

Interviewer: If that relationship were to go on for an extended period of time?

Xavier: No, absolutely not. [He] doesn't know what I do all the time, I don't know what he does all the time. Yeah, so, I look out for myself.

Moreover, narratives from participants with higher socioeconomic childhoods revealed a more consistent correspondence between their general risk reduction strategy and their ongoing behaviors. Participants with lower socioeconomic childhoods often did not behaviorally adhere to their own purported sexual strategies. Failure of participants from lower-income childhoods to practice their sexual safety strategies was most often attributed to 'not thinking' about their strategies, or 'pushing it out of [their] mind.'

4.5c Family characteristics

Family composition varied across participants. The majority of participants described being raised in a single parent home, most often by their mother or by a grandparent (see Section 4.5c in Table 4.1). A small number reported being raised within the foster care system. This observed pattern of family composition corresponds with the 2010 US Census data reporting that approximately 60% of Black children lived with a single parent, a grandparent, or other relative, while approximately 35% lived with two married parents (US Census Bureau 2010). In

this study, common contributors to participants being raised by someone other than their biological parent were parental drug/alcohol addiction, abandonment, incarceration or death.

4.5c.1 Parental substance use

Approximately one half of participants who were raised by a biological parent or guardian reported parental/guardian substance use inside the home. Here, Nathan, a participant with challenging family dynamics recalls how his mother's drug use made it difficult for her to care for her children:

> "My mom ended up disappearing because she was doing drugs. My dad was doing drugs. My aunt...had just died on my birthday which made it worse. And after that it went downhill because my mom kept having kids with different people and then she ended up losing all the kids."

As alluded to in the above quote, participants' narratives revealed parents' transient presence and involvement in their lives, which led many participants to harbor conflicted feelings towards their parents. For instance, Christian, a participant discusses how his mother's substance use led to her intermittent involvement in his life:

> "My grandmother actually took care of my brother and myself. My mom had six kids. She was married twice. Four of the children went to live with their dad, and my brother and myself went to live with my mom's mother. My mom was an alcoholic. An addict, she had her own issues and that's why she put us in a safe environment, so to speak… I, I never really got along with my mom because of her drinking. I didn't like her very much. She was never there, I mean. When she was there, she wasn't there. And when she wasn't, then she wasn't there. Yeah, we felt she pawned us off, you know what I

mean, growing up."

4.5c.2 Lack of love and affection

Childhoods lacking in love and affection emerged as a major theme in participants' family relationships. Many participants described parents or guardians that showed very limited affection, communication, support, and affirmation, which resulted in many strained family relationships. Participants described "walking on eggshells," so as to not upset others within the home. Family life in these households was characterized as volatile, subject to parental mood swings and oftentimes violence. For example, participants John and Nelson shared, respectively:

> "Anything would set [my mother] off. It could be my [baby] sister crying, or someone waking her up…or her boyfriend not coming home…she would always take that shit out on us…she would go fucking crazy…screaming, throwing shit…all kinds of stuff."

> "[My mother] didn't bother with us…she just didn't pay us any attention. My friends around the block were always jealous."

4.5c.3 Childhood neglect

Participants' narratives highlight the role of childhood neglect in behavioral risk for HIV infection later in life (see Section 4.5c.3 in Table 4.1). Childhood neglect occurs when "young people are treated in manner that is unacceptable by community and professional standards at the time by not being provided with adequate food, clothing, shelter, and/or basic emotional needs like love, encouragement, belonging, and support prior to the age of majority" (Klein et al. 2007, pg. 40). Studies examining the long lasting consequences of childhoods lacking in love and warmth

have shown that emotional neglect can result in increased risk factors for HIV in adulthood. Dube et al. (2003) demonstrated that in a sample of 8613 adults, those who described emotional neglect were more likely to participate in lifelong illicit drug use than those who did not describe similar emotional neglect (28% vs 17%, respectively). Other studies have complemented this research by demonstrating that childhood neglect can result a wide range of adverse outcomes such as reduced self-esteem (Peretti et al. 1998), personality disorders (Johnson et al. 1999), suicidal behaviors (Lipschitz et al. 1999), increased risk of engaging in prostitution (Widom 1999) and risky romantic partnerships (Wilson & Widom 2008). Wilson and Widom (2011) found that abuse and neglect in childhood results in increased likelihood of high risk sexual behaviors in middle adulthood—a time when high risk behaviors decreases for most individuals. Klein et al.'s (2007) study of 250 Atlanta-area 'at-risk' women found childhood neglect resulted in lowered self-esteem, poorer attitudes toward condom use, and increased HIV risk behaviors (see Figure 4.4). The authors suggest that in matters of neglect, the action of *inaction* implies that one does not matter (i.e. is not important enough to warrant any physical or emotional investment). The authors suggest that this may leave victims unable to form a true sense of self-esteem, and consequently invest little or no value in themselves or their futures. This can result in increased risk taking, which may function as a way for the neglected child to form a connection with others as an adult. These results demonstrate that childhoods characterized by a lack of love, encouragement or support can lead to poor outcomes in adulthood, including increased participation in HIV risk behaviors. The majority of quantitative and (very limited) qualitative research on neglect has been in mixed-race populations; further research on the impact of childhood neglect (separate from childhood abuse) on Black MSM is needed.

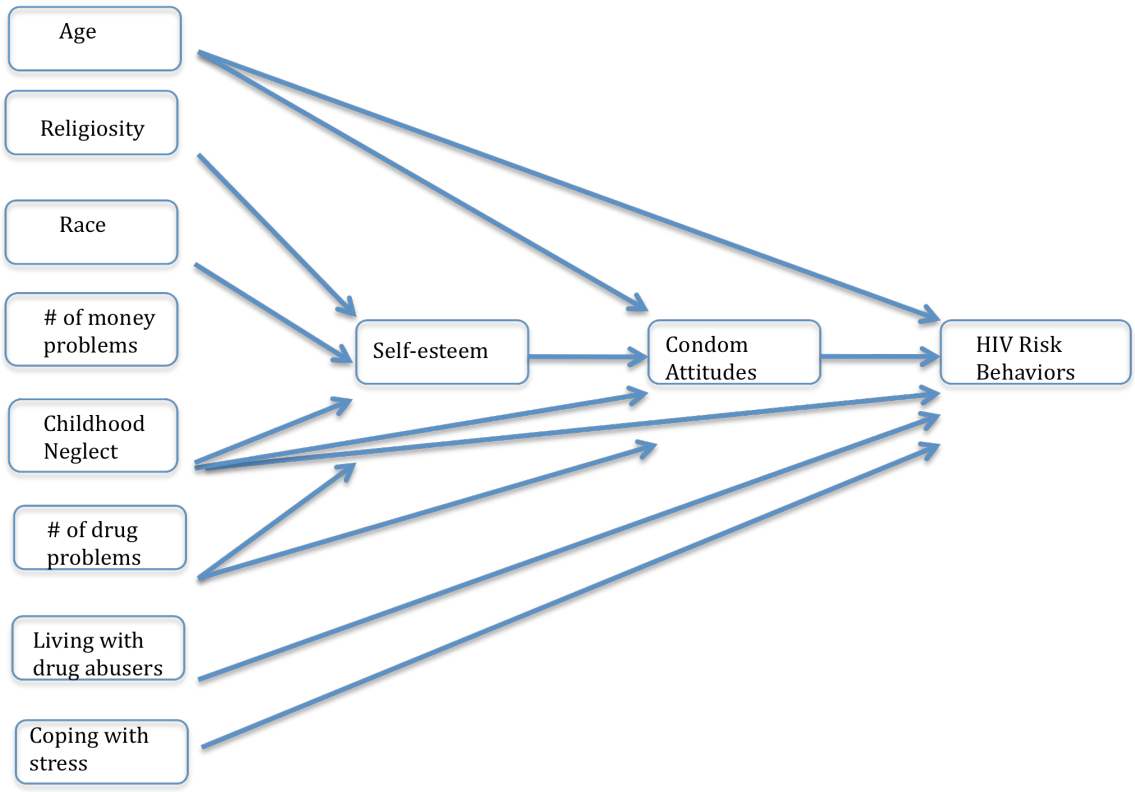


Figure 4.4. Relationship of neglect to self-esteem, condom-related attitudes, and HIV risk. Arrows depict significant relationships ($0.001 \leq p \leq 0.05$). Adapted from Klein et al. 2007.

4.5c.4 Parental violence

Another troubled family dynamics that emerged from these narratives was the witnessing of violence between parents/guardians or other intimate partners. Participants reflected on the consequences of exposure to parental violence on their own lives. Here, Martin, a participant describes an abusive relationship between his mother and stepfather:

> "That was really really hard. So although we weren't the ones physically abused, I would say emotionally and mentally and psychologically and all that, if there's a separation between all of those, we bore the brunt, we all bore the brunt of that, getting kicked out of the house, begging to come back

home."

He also contemplated on the effects of this violence on his own life as an adult:

> "My stepfather was beating, the abuser. So growing up, I saw quite a bit, that without a doubt, had an impact on me, and my life, and the way I think about relationships and that sort of stuff."

Thus, as suggested by the participant above, witnessing violence within the home may influence individuals' later adult relationships and impact their decisions regarding sexual safety. For instance, participants who witnessed intimate partner violence within their childhood home may come to expect partner violence or view it as normal within the general context of adult relationships. Studies show that adults who witnessed violence within their childhood home are at high risk for being involved in intimate partner violence as adults (Coker et al. 2000, Mohr 1999, U.S Dept of Justice 2000). The earlier described ACE Study also demonstrated a positive correlation between frequency of witnessing intimate partner violence within the childhood home and the probability of substance use and depressive symptoms in adulthood (Dube et al. 2002a, 2002b), both of which are known to increase risk taking behaviors.

4.5c.5 Family Rejection

The potential for parental and family rejection was also salient in participants' narratives. Unlike the previously mentioned trends in childhood family adversity, which were independent of participants' sexual orientation, narratives about family rejection were closely linked with participants' homosexuality. Many participants acknowledged that homosexuality was not accepted within their childhood home. Participants reported that parents or guardians often disparaged gay men in the

community, and used accusations of homosexuality to insult or offend others. Being called 'gay' by a family member was considered one of the worst insults. This led many participants to conceal their same-sex feelings, or same-sex behaviors from family members. Despite these attempts, participants often described that their mannerisms or patterns of speech led many others to suspect their homosexuality. Suspicion frequently resulted in verbal harassment within and outside the family. Participants described that gay-related harassment at the hands of parents, siblings and extended family members was a significant source of stress and anxiety throughout childhood. Some participants did acknowledge their homosexuality to family members which was oftentimes received with disappointment, hostility or violence:

> "I told my mother that I was gay, I never talked to my father, because I didn't really care what he thought...I was 23. She went to Atlanta, she came back with a .22 [caliber gun] and she pointed it at my head, and I grabbed her hand and it went off, and into the wall."

A different participant, Nelson, described that poor childhood family dynamics (in part informed by his same sex behaviors) and feeling unloved led him to find love and 'family' in a major national gang.

> "I didn't [come out earlier] because of the issues me and my mom were going through. I just came out and she obviously wasn't comfortable with it, and I felt that she basically shoved me out [of the house], and on top of that, her calling the cops on me, putting waywards out on me. So I felt that she didn't really want me around. I didn't feel love or anything like that from my real family, so I had to get it from someone else."

Nelson also described that in addition to traditional gang activities (i.e. theft, narcotics sales, money laundering, etc.) the gang 'lifestyle' was a 'party' lifestyle in which limited education, excessive alcohol consumption and high number of sexual

partners was routine.

Other participants reported being unable to live openly gay when around family members. For instance, one participant, Jamar shared:

> "My mom, she won't get past it. If I was to get dressed up, look all pretty, and go to [the] Pride [Parade]…She'd flip on me for even getting dressed like that in her house. That would be a problem."

In response to being asked how his mother conveyed her disapproval of him being gay, one participant, Wilson, commented:

> "If I talked about a boyfriend… [My mother would say] 'don't bring that mess in here.' "

Homophobia-related abuse is further discussed in Section 4.5f.

4.5c.6 Summary

Overall, narratives suggested trends linking higher risk sexual behaviors and difficult family characteristics. Emerging from this analysis were two potential pathways by which adverse family characteristics may have contributed to higher risk behaviors in adulthood:

a) *Family and community-related homophobia and intolerance*, and the consequent need to be secretive and discreet about same sex behaviors. We observed multiple reports of participants seeking sex in public venues such as bathhouses, parks, video arcades and adult bookstores. These venue-based partner-selection strategies that prioritize privacy and anonymity are often associated with high-risk behaviors (Binson et al. 2001, Chauncey et al. 1994, Grov et al. 2007, Reisen et al. 2010).

b) *Poor family dynamics leading to higher reported levels of drug and/or alcohol addiction and housing instability.* Multiple participants who reported housing instability or drug/alcohol use reported prostitution or other forms of transactional sex. These behaviors can reduce the capacity for safe sex planning and/or execution, or diminish the ability to negotiate condom use. However, these behaviors may also be attributable to other causes, including low childhood socioeconomic status. Indeed, it is most likely that poor family characteristics and socioeconomic disadvantage collaborated to affect participants' sexual-behavior decision-making and sexual risk assessment, leading to the reported outcomes.

4.5d Alternative depictions of childhood family life.

While nearly three quarters of participants perceived adverse family dynamics, others shared mostly positive memories of childhood family life, ones marked by love, support, and stability. Most often, these participants lived with their biological parents, and described them as attentive and involved, with experiences mostly free of substance use/addiction, volatility, and abuse. Moreover, these participants shared how they felt safe in their homes, and were able to consistently rely and depend on their parents/guardian. Several participants echoed the sentiments shared by one individual, "my parents sheltered me." Typically, these participants described their parents/guardians as strict, which they believed ultimately molded the type of individuals they became as adults. Here, a participant, Lawrence, describes a strict matriarchal upbringing:

> "She was strict, and that paid off…my grandmother, her mother, my grandmother, she was strict. When we go to the house to eat, she made sure that we ate that food, and didn't put it in the garbage, so then when we got there, we didn't have a choice, we had to go to church. It wasn't what we wanted…They loved us…took care of us."

A recurrent theme among participants who recalled positive memories of their family life in childhood was family support and encouragement. Participants described parents/guardians as their "number one fan," who encouraged them to "reach for [their] potential," and "follow [their] dreams." On being asked whether he considered his childhood to be happy, one participant, Anthony, commented on the quality of care provided by his grandparents who acted as primary guardians:

> "Great, it was absolutely amazing. I love my grandparents, they're really fine…good, good Lord, everyone's always been supportive, really, really supportive."

The importance of family support extended to support of participants' gay identity, which some participants believed to be critical to their happiness as children. To be sure, not all those with positive family characteristics grew up in a household that openly and explicitly accepted homosexuality. However, these participants reported that their family setting did not feel so oppressive as to warrant extreme measures to hide their same sex desires and behaviors (see Section 4.5d.1 in Table 4.1).

Furthermore, these participants' outlook and hopes for the future guided many of their decisions and informed a stricter set of rules regarding sexual safety, as well as stronger self-regulation skills; for instance, these participants less often engaged in unprotected sex to meet an immediate need for sexual gratification (see Section 4.5d.2 in Table 4.1).

In contrast to participants who perceived challenging family characteristics, narratives suggested that men who reported lower risk behaviors more often described positive family characteristics. Participant narratives suggest that positive family characteristics may have resulted in low risk behaviors as a result of participants' limited experiences of housing instability and drug/alcohol addiction (see Section 4.5d.3 in Table 4.1). The absence of these experiences may have

prevented the high-risk sexual behavior outcomes associated with such circumstances. There were no reports of prostitution or transactional sex and very limited reports of alcohol or drug dependency among participants who perceived positive family characteristics.

4.5e Family characteristics and sexual risk behaviors

Following the data analysis procedures described earlier, we sought to identify potential narrative trends linking childhood family dynamics and adult sexual risk behaviors. Narratives revealed two dominant themes: 1) participants who perceived adverse and challenging family dynamics described high sexual risk behaviors; and 2) participants who perceived positive family dynamics described lower risk sexual behaviors. Narrative also suggested that participants who described having adverse family dynamics during childhood also described being less insistent on condom use and less rigid in the rules guiding their sexual behaviors, despite being aware of the risks of unprotected sexual behaviors. By contrast, narratives suggested that participants who perceived positive childhood family dynamics described limited unprotected anal intercourse, multiple sexual partners, and concurrent sexual partners.

Although this general pattern of behaviors was observed, narratives revealed one somewhat surprising trend: participants who recalled troubling childhood family dynamics also described frequent HIV testing. HIV testing is important because knowledge of HIV status is critical to HIV prevention efforts and generally reflects a positive public health behavior. However, in this instance, the higher reported frequency of HIV testing among participants from difficult family dynamics can be interpreted as a reactive rather than a preventative behavior. According to narratives, frequent HIV testing most often occurred as a way to allay fears of HIV infection *following* recurrent participation in high-risk sexual behaviors. For

example, one participant, LeVar, reported that after learning that a sexual partner of one of his own unprotected casual sexual partners had tested HIV positive, he decided to be tested. Upon learning that he tested HIV negative, LeVar expressed a sense of relief:

> "Right, and I came out negative. I was going around telling everybody, 'oh, look, look, look, I'm negative, I'm negative. I'm still good, I'm still good'… [I told [name redacted]] I got an HIV test too and mine came out negative. Aren't you happy for me?''

By contrast, participants with positive family dynamics described HIV testing less frequently. This was most often attributed to participants' limited engagement in high risk sexual behaviors, which appeared to be linked with participants' perceived diminished need to be tested. As one participant, Jonathan, shared,

> "I try to keep my wits about me…I don't know. [Using condoms] was something that I was taught, and it's just something that I believe in. I try not to do anything that might [result in me] catching something."

Several other participants shared similar beliefs and approach to sexual health safety. For many of these participants, HIV testing often occurred as part of their annual physical exam.

4.5e.1 Summary

Narratives suggested that perceived family dynamics can potentially influence adult HIV risk taking behaviors through challenging family dynamics that influence the likelihood of participating in high risk behaviors, such as alcohol and/or drug use or addiction, compared to positive family dynamics that can buffer against these behaviors. Two other potential hypotheses exist: a) lack of family acceptance of

participants' sexual behaviors can lead some to seek sex in high-risk venues, whereas gay-related family acceptance (or silence) can lead participants to describe greater gay-related self-acceptance, as well as social networks that included men who shared similar attitudes to sexual safety; and b) characteristics of positive family dynamics, which included higher parental expectations placed on participants with regards to their social, moral, behavioral, and financial responsibilities, can lead to stricter rules guiding sexual behaviors. These hypotheses (which are explored in Chapter 6) warrant further examination in future research.

4.5f Occurrence of Abuse

Ten participants, nearly one third of participants, reported childhood sexual abuse. Although we cannot draw statistical inferences due to the qualitative study design, sampling approach, and sample size, this number is roughly in keeping with other studies of Black MSM reporting similar rates (Fields et al. 2008). All participants who had described prior episodes of sexual abuse recalled that this occurred at the hand of known individuals, most often a male family member, and in one case by a mother. For most participants, the recalled child sexual abuse episode(s) occurred over an extended period of time during childhood, ranging from 2 to 10 years in duration. Participants reported their sexual abuse starting as young as 4 years of age through to late teenage years. Some participants experienced abuse on a continual, consistent basis (e.g. several times per week), while others experienced abuse periodically (e.g. once every several months) or intermittently (e.g. one instance every year). This variability may reflect the abuser's access to the participant, with close family members having ready access while extended family members having less access and fewer opportunities to inflict abuse. Three participants reported being abused by multiple people over the same period of time.

Here, a participant, Dwight, describes a history of sexual abuse in his family:

> "My mom, well my mother was raped when she was 13, and then it happened to me. I was raped by my two uncles, not my blood uncles, my stepfather's two brothers. And that was it. It happened, it started when I was five years old, and it didn't end until I was like 12."

Participants reported one or more of the following types of abuse: inappropriate touching, indecent exposure, oral sex, penetrative sexual contact, forcing participant to watch sexual acts. Robert, a participant who was abused by multiple family members recalls an instance of abuse inflicted by his brother:

> "I had two brothers that sexually molested me starting at the age of around 4, that I can remember, that I was remembering, and like I have a scar on my lip here when my oldest brother, I was 4, so he was 17, maybe 18, put his penis in my rectum, and then I screamed, and he pushed me with his feet out of the bunk bed, onto my face, picked me up by my hair and said, 'oh my god, he fell on his mouth, look what he did', my tooth came right through the lip, and he was washing my mouth out, didn't realize what was going on down there, nobody thought about that".

Nearly all participants who reported any experience of childhood sexual abuse also experienced verbal and physical abuse by family members. Approximately half of all study participants reported parents/guardians that were volatile or resentful toward the child. When asked why parents/guardians may be resentful, participants often did not know. Participants most frequently reported being hit for trivial reasons, or often times no reason at all. As one participant, John, shared "like whenever I did any little thing wrong, I got hit or whatever." He continued on to describe abuse inflicted by his mother's boyfriend:

> "Yeah, like, he would do it, then when I tell my mother, he'd deny it. But it would be like, one day I was washing dishes; I don't normally wash dishes or

> whatever, and he didn't like the way I was washing dishes, so every time I washed a dish wrong he would hit me in the back of my head or whatever."

Verbal abuse often was related to participant's sexuality or suspected sexuality, with the aim of deprecating or belittling the participants. Many participants report being called "fag," "sissy," or "punk" by their family members. Many participants recalled painful memories of verbal abuse. Wilson shared:

> "A lot of verbal abuse. I always think about that. And that was, in many ways, much more painful than the physical abuse, just because I think I just have a higher tolerance to pain…She would say I would never be anything, I'd never do anything, nobody loved me."

As described earlier, in addition to other forms of abuse, homophobia-related harassment might have a powerful influence on sexual behaviors. For men in this study, the long-term consequences of the abuse (e.g. poor mental health outcomes) may have impacted their sexual risk assessment, partner-selection strategies, self-regulation skills and the ability to maintain healthy relationships.

4.5g Childhood abuse and sexual risk behaviors

Following earlier described data analysis procedures, we sought to identify any potential narrative trends linking experiences of childhood abuse and adult sexual risk behaviors. Narratives suggested that participants who self-reported childhood sexual abuse, or perceived extreme childhood physical or verbal abuse also reported engaging in sexual risk behaviors frequently, including having a high number of unique sexual partners and episodes of unprotected sexual intercourse, often engaging in sexual intercourse with anonymous partners and having concurrent sexual partnerships (see Section 4.5g in Table 4.1). Some participants who reported childhood sexual abuse also reported engaging in prostitution or transactional sex;

there were no reports of prostitution or transactional sex among participants who did not report childhood abuse. Likely due to the related lasting psychological consequences of childhood sexual abuse (Fields et al. 2008, Koening et al., 2004), participants that described childhood sexual abuse also revealed difficulties negotiating their sexual lives and sexual health approaches—in terms of partner selection strategies, self-efficacy for protective sexual behaviors, and involvement in long-term relationships. For example, one participant, Robert, who had experienced chronic childhood sexual abuse perceived that he engaged in multiple high-risk behaviors because these behaviors conferred a sense of control that he lacked as a child.

> "Yes, and I think this is why I'm doing all this sexual stuff because I have control. I'm in control. [During] my childhood trauma of being molested…they had control over me, and they took all my power, I had no power at all to do anything."

Previous qualitative studies of Black MSM who had experienced childhood sexual abuse found poor mental health among the majority of participants. Study authors hypothesized that this exposure may have impacted participants' sexual scripts and subsequent behaviors (Fields et al. 2008; one article reporting three qualitative studies). In our study, only 3 of 10 participants who described sexual abuse had sought professional treatment in dealing with their history of sexual abuse. Consequently, those who had not sought treatment may have developed poorer coping strategies, and as a result, engaged in sexual risk behaviors and had poor relationship-related outcomes as adults. Indeed, prior studies have shown that survivors of childhood sexual abuse may have difficulties engaging in long term relationships, developing bonds with others, and may compartmentalize their sexual behaviors from their emotional feelings, consequently resulting in high-risk sexual behaviors, such as multiple sexual partners and short-term sexual relations (Morrill et al. 2001, Paul 2001, Roesler & McKenzie 1994). However, only one of these studies had a predominately Black MSM sample, thus limiting the

generalizability of the findings to Black MSM.

Narratives indicated that childhood sexual abuse might be linked with emotional difficulties in adulthood such as the inability to trust or be emotionally intimate with others. Participants who recalled childhood sexual abuse also reported mental health problems such as depressive symptoms, diagnoses of clinical depression, suicidal ideation, as well as suicide attempts. Four participants who suffered sexual abuse as children reported a history of being voluntarily or involuntarily hospitalized as a result of their suicide attempts. Participants that experienced childhood sexual abuse often vocalized feelings of powerlessness over their sexuality and sexual behavior decision-making, and they also demonstrated a difficulty in trusting others. Experiences of mental health difficulties and sexual risk behaviors are fully described in Chapter 6. Issues related to powerlessness and mistrust may contribute to participants engaging in high risk sexual episodes and anonymous sexual partners, as well as having limited long-term relationships (Morrill et al. 2001, Paul 2001, Roesler & McKenzie 1994).

Indeed, it has been demonstrated in prior research that the more childhood abuse men experience, the poorer overall mental health they experience (Edwards et al. 2003). In turn, poor mental health related to childhood sexual abuse can reduce self-efficacy for condom use, diminish the ability to negotiate sexual safety with sexually aggressive partners, and contribute to experiencing less satisfaction in personal and sexual relationships (Roesler & McKenzie 1994, Paul 2001, Morrill et al. 2001). Another notable study, the EXPLORE Study, was able to shed considerable light on the mediators between childhood sexual abuse and HIV risk behaviors (Mimiaga et al. 2009). This large scale, 6-city (U.S.), HIV prevention intervention for MSM found depression and drug and/or alcohol use to be more prevalent among participants with a history of childhood sexual abuse. In addition to poor mental health mediating the effects of childhood sexual abuse, the study authors also reported that those who had experienced childhood sexual abuse also reported lower self-efficacy for adopting protective sexual behaviors, poorer communication skills regarding

protective sexual behaviors, and lower social norms that favor protective behaviors. Thus, addressing poor mental health and other factors leading from childhood sexual abuse to adult sexual risk taking behaviors is an integral component of any HIV prevention approach (Clements-Noel et al. 2001, Meyer 2003, Stall et al. 2003).

4.5h Non-normative patterns

A small but noteworthy subset of participants did not follow the behavioral patterns described by the majority of participants. Specifically, some participants who experienced adverse childhood experiences did not report engaging in risky sexual behaviors, and in fact described engaging only in low-risk sexual behaviors. Conversely, other participants from middle/upper class childhoods and with positive family dynamics described high risk sexual behaviors. These counter-normative patterns provide an important point of study. Understanding the resiliency and coping methods of participants who experienced early forms of adversity but who do not report high risk behaviors, and incorporating this knowledge into HIV prevention efforts may prove critical to the next generation of HIV prevention interventions targeted to Black MSM. It may be that for those with childhoods characterized by negative home environments and socioeconomic disadvantage, strong support networks outside the childhood home are able to buffer against the effects of adverse family factors. These support networks may be in the form of relationships within the community, or the Church, or a particularly supportive teacher or guidance counselor. Several participants described a range of strong relationships formed outside the home. One participant described a relationship with a community elder that acted as a paternal figure and mentor. Another participant, Jerry, described a particularly close, supportive, relationship with a Church friend and his family. Jerry, a middle aged participant - who himself volunteers as a mentor for young Black men – shared:

> "[Name redacted]'s family was able "to make me feel loved when I wasn't

> feeling it anywhere. That made the difference for me…for me to know that however my life at home was, that there were people out there that cared for me and that I mattered to them."

This is in keeping with the literature on minority coping that suggests that group- and community-level resources shape individual coping efforts (Branscombe & Ellemers 1998, Meyer 1993), and an individuals' ability to access these resources ultimately determines their ability to cope with past and present adverse circumstances.

While most participants who did not engage in HIV risk behaviors despite adverse childhood experiences did access social support through group-level resources such as relationships within the community and the Church, other participants described relying on individual coping efforts for dealing with difficult family conditions, which although can be successful, are thought to not be as successful as coping through group-level resources (Meyer 1995). For instance, some participants' resilience and coping were derived from childhood passions and hobbies. One participant, Matthew, described an intense passion for listening to and writing music. He described that as a child during particularly difficult times, he would find somewhere he could be alone, such as a neighborhood park, and 'lose' himself in his song writing.

> "I would go to [neighborhood park] at night when not a lot of people were there. If my boys were there they would leave me by myself. I would write for like 2, 3 hours. It helped me clear my head….let me stop feeling whatever bad I was feeling when I got there. Writing would take my feelings in my heart and in my mind and put them on paper."

Another participant, Jermaine, believed that his love for basketball allowed him to cope with challenging family dynamics.

"I'd play ball and get all that aggression out. It caused problems with the [other players]…[but] it was my release. I would get so angry at home…it let me get all that shit out. I played hard."

Interestingly, while these participants did not engage in high-risk sexual behaviors, they were more likely to describe feelings of loneliness and isolation than participants who accessed group/community-level resources, suggesting that the nurturing and encouraging relationships participants had with others were critical to the extent of their ability to cope with adverse childhood experiences.

Table 4.1: Representative participant quotes demonstrating narrative childhood experience themes

Relevant Section	Theme	Quote
4.5a	Low socioeconomic upbringing	"We didn't have too much, but we made it work."
		"My mom and stepdad didn't really have that much money. We lived in the projects. But everyone was like us."
		"We would get food from food banks."
4.5a	Middle/upper-middle class upbringing	"I [didn't] want for anything. Our parents made sure we had everything. We went to North Carolina for vacation every year."
4.5a	Family academic/career aspirations for lower SES participants	"[My family] was happy that I graduated high school. No one else did. My brother got his GED when he was locked up, but I was the first to really graduate."
		"I left after 8th grade. I had to take care of my brothers and sister. It wasn't really a big deal."
4.5a	Family academic/career aspirations for higher SES participants	"College was not an option. It was something we all had to do."
4.5b	Sexual behaviors of lower SES participants (multiple/a range	"My main dude was cool… but I still needed my sidepieces or two…"

	of high risk behaviors	"I tried to pick up [clients] in safe areas, where I know my friends are."
4.5b	Sexual behaviors of higher SES participants	"I enjoy sex, but I enjoy sex with condoms. I enjoy knowing that I'm not opening myself up to all kinds of [STDs]."
4.5c	Single parent homes	"My mom raised us, more or less. My dad left when I was 6"
		"My grandma brought me and my brother up. My mother was too messed up in her own shit."
4.5c.3	Childhood neglect	"It wasn't that my mother wasn't around. She just didn't care…about us, about school, about who we hung out with…who our friends were. Nothing. At the time I fooled myself into thinking like 'wow, I can do whatever I want,' but in retrospect, as an adult, I can look back and see that she was basically an absentee parent…Yeah, I think it probably had an effect on my own relationships. I'm not quick to trust. I've been told by others that it's sometimes hard to connect with me, emotionally."
4.5d	Family support of gay identity	"No, me being gay wasn't talked about. I know my parents didn't necessarily approve of it, but I never doubted that they loved me… I would mention guys' names, but didn't really bring boyfriends around too often….I respected where they were coming from, and they respected where I came from."
4.5d	Sexual health strategies of participants with positive family life	"I couldn't go out and meet some random stranger and have sex with them. Just wouldn't happen."
		"[I've] only had sex with people that I know somehow, friends, or friends of friends, that kind of thing."
4.5d	Lower risk behaviors among participants who described positive family characteristics: limited experiences of housing instability and drug/alcohol addiction	"I mean, I've heard of people having sex with lots of people because they were doing meth and stuff like that, but no, I don't know of anyone in my life that has any experience with that. That's like movie stuff."
4.5g	High risk behaviors among participants who described childhood sexual abuse	"I've messed around with a lot of dudes"
		"I just like fucking without a condom. I know it's not right, but it just feels right. You know what I mean?"
		"Working the streets is something I know. I don't like it, but when shit is getting rough…its something that I do"

4.6 Discussion

This chapter explored patterns between participants' recollected childhood experiences—particularly socioeconomic status, family characteristics, and the occurrence of abuse—and their sexual behaviors in adulthood. Narratives suggested potential linkages of childhood adversity to adult risk behaviors. While connections between adult socioeconomic status and HIV status have been well established in prior studies, research regarding the linkages between childhood socioeconomic status and adult sexual risk behaviors has been lacking. The results from this study highlight a potential pathway between childhood socioeconomic status and risk for HIV infection in adulthood.

Participants who described high risk behaviors perceived problematic childhood family dynamics. Moreover, narratives suggested that these participants often did not negotiate condom use and did not have rigid rules guiding their sexual behaviors, despite being aware of the risks of unprotected sexual behaviors. Strong, positive, and supportive childhood relationships within the family of origin may have had long lasting effects on participants' approach to their sexual lives and romantic relationships. Through example, positive family dynamics may have provided participants with the necessary developmental building blocks for initiating and maintaining healthy relationships as adults. Participants who witnessed close, intimate and supportive family relationships were likely to adopt that as a model relationship and follow those patterns in their own adult relationships. Conger et al. (2000) found that nurturing, warm, involved parenting in the childhood family home was associated with participants having warm, supportive romantic relationships. In our study, participants perceived their own capacity for healthy intimate relationships and their competence within those relationships to be strongly influenced by the relationships they observed and experienced within their family of origin, particularly among participants who experienced positive family relationships. Healthy, close relationships can potentially mediate protective sexual behaviors through open communication,

balanced power dynamics, and fewer sexual partners. However, studies of mixed-gender and ethnicity, as well as female samples have also shown that being in a relationship is also linked to elevated HIV risk behaviors (Hammer et al. 1996, Misovich et al. 1997).

Narratives suggested that participants who reported childhood sexual abuse, as well as verbal and physical abuse described engaging in high sexual risk taking behaviors. Childhood sexual abuse was particularly important, as narratives suggested that those who reported its occurrence had multiple sexual partners, frequently engaged in unprotected anal intercourse, had concurrent sexual partners, and sometimes engaged in transactional sex. These behaviors have important consequences for HIV prevention among individuals who have experienced childhood sexual abuse—a number purported to be as high as 39% of all MSM (Fields et al. 2008). Survivors may have significant mental health issues that may lead to patterns of high sexual risk behaviors.

Several common themes for participating in higher-risk versus lower-risk behaviors emerged across the various perceived adverse childhood experiences examined in this study:

1. Differences in temporal frame: Higher-risk participants generally described decision-making processes and outlooks characterized by short-term time frames focused on immediate outcomes, whereas lower-risk participants generally described decision-making processes and outlooks characterized by a focus on long-term outcomes, as well as future benefits and consequences.
2. Coping strategies for stress: Higher risk participants generally described coping strategies that included having sexual intercourse or other activities that might increase the likelihood of engaging in high risk behaviors (e.g. alcohol use), whereas lower risk participants described strategies that did not include sexual activities or were not likely to lead to participation in high-risk behaviors (e.g. exercise, spending time with friends).

3. Self-regulation: Many higher-risk participants described 'giving-in' to their sexual desires or saying that "one thing led to another" resulting in unprotected sex, whereas most lower-risk participants were generally deliberate in their actions and behaviors (e.g. not drink excessively so as to avoid being placed in a potentially high-risk sexual situation).

These observations support the life course perspective and minority stress theoretical approaches described in Chapter 2, and offer testable hypotheses that can be explored in future research. Participants' own words revealed that these observed factors implicated in high risk and low risk behaviors were at least in part attributable to the long lasting effects of their childhood experiences. Participants' socioeconomic status, family dynamics and experience of abuse impacted their self-esteem, self-efficacy, coping skills, social networks, mental health and life prospects, all of which can have important effects on individual sexual health strategies.

Our findings challenge the conventional paradigm of HIV risk behaviors. Rather than conceptualizing risk behavior as a de-contextualized phenomena, determined by social cognitive processes, these findings suggest that behavior is the resulting outcome of a cumulative contextual and life trajectory process that functions in all individuals. In those with particularly adverse childhood experiences, this life trajectory can have far reaching negative effects on overall health profile. As described in the introduction, adverse childhood experiences are thought to impact adult sexual risk taking behaviors in several ways. Narratives of participants' life course suggest that both direct and indirect events contributed to adult sexual risk behaviors. For instance, participants who experienced sexual abuse in childhood all described multiple high-risk sexual activities. This is supported by extensive literature documenting the increased prevalence of high risk sexual behaviors in adulthood among survivors of childhood sexual abuse, most often mediated through psychological effects, as described in the Introduction section. Narratives also suggested indirect effects of adverse childhood experiences on adult sexual risk taking, This was evident in participants' recollection of childhood socioeconomic

circumstances and description of present day socioeconomic circumstances. Participants who recollected low-income childhoods oftentimes described similar current socioeconomic circumstances, while those with higher-income childhoods reported similar present day circumstances. Literature indicates that childhood socioeconomic circumstances predict adult socioeconomic circumstances, and a higher HIV incidence and participation in sexual risk taking behaviors among those with low socioeconomic status (Pagani 2007). Thus, childhood socioeconomic status may impact adult socioeconomic status, which in turn has an effect on adult sexual risk behaviors. Thus, understanding men's childhood experiences are critical to understanding the adult process that may more directly influence adult sexual risk behaviors.

The findings in this chapter offer support for the application of syndemics in understanding and intervening in the HIV/AIDS epidemic among Black MSM. This is among the first qualitative studies to use syndemic production to specifically examine the ways in which early life experiences (socioeconomic status, family life, and abuse) can act synergistically to inform behaviors later in life. While studies have demonstrated the links between co-occurring factors (e.g. poverty, depression, drug use) (Stall et al. 2001, Stall et al. 2003), none have focused specifically on Black MSM, and none have done so qualitatively.

Giving voice to this population most at risk for HIV is essential to identifying the mediating processes driving these syndemic interactions. Understanding how men perceive and experience the important psychosocial and socioeconomic factors informing their sexual health is critical to designing effective HIV interventions for this group. Our study is one of the first to ask Black MSM how they perceive their own early life experiences to influence their approach to sexual health and relationships. These findings provide nuanced insights to earlier quantitative studies and uncover the complexities inherent to many conscious and subconscious sexual-health decision-making processes regarding risk assessment, partner selection strategies, and rules guiding sexual behaviors. Quantitative methods,

which report measures of central tendency, are unable to capture these important and necessary intricacies. As it becomes increasingly evident that for many populations HIV risk is best understood when considered through a life course perspective, this study has important implications for the versatility and applicability of Syndemic Theory in understanding HIV risk.

CHAPTER 5: CONTEXTUALIZED DRIVERS OF SEXUAL RISK BEHAVIORS

5.1 Overview

The previous chapter examined participants' beliefs of how their adverse childhood experiences influenced their adult sexual behaviors. This chapter extends that data to examine the main factors participants perceived to influence their unprotected sexual behaviors, and contextualize these factors according to their life circumstances at the time of the discussed sexual episode. Analysis in this chapter suggests that:

1. The most important drivers of unprotected sex were apathetic or passive attitudes toward condom use, getting caught up "in the heat of the moment,"

poor emotional health, reliance on visual or behavioral cues, and a pattern of unconscious, routine unprotected sex with main and casual partners.

2. These perceived drivers of unprotected sexual behaviors coincided with challenging personal circumstances in participants' lives, particularly, socioeconomic- and relationship-related difficulties.
3. These challenges were oftentimes interrelated and interacted to reinforce one another.
4. Knowledge of HIV risk transmission and sexually protective behaviors was widespread, but this knowledge often clashed with judgment and behaviors, and did not lead men to refrain from engaging in sexual behaviors they recognized as 'risky.' Discrepancies between knowledge and behavior challenge many cognitive-based models of HIV prevention targeting Black MSM.

5.2 Background

Research has shown that Black MSM do not engage in more risk behaviors than other MSM populations (Harawa et al. 2004, Lemp et al. 1994, Mansergh et al. 2002, Millett et al. 2006, Peterson et al. 2001, Purcell et al. 2005, Ruiz et al. 1998). Black MSM's risk is perhaps best understood when contextualized by the sociocultural and structural factors they experience. These situational (e.g. frequenting high-risk sex-seeking venues), attitudinal (e.g. holding apathetic or complacent views on condom use), or interpersonal (e.g. imbalanced power dynamics or passive approach to condom use) factors may act as barriers that prevent men from adopting lower HIV risk-taking practices. A qualitative exploration of participants' perceptions of why and when they choose to use or not use condoms is an important step in addressing and intervening in their unprotected sexual behaviors. Previous research of MSM populations suggests that these factors may include poor mental health, family and partner dynamics, socioeconomic status, and prevention/safe sex-related fatigue. While individually these life factors may not influence sexual behaviors, when

functioning interactively, they may become implicated in participants' sexual behaviors. For instance, while unemployment alone may not cause unprotected sexual behaviors, when experienced in conjunction with relationship difficulties and housing instability, it may lead an individual to place themselves in high-risk situations or become passive to condom use. In support of Syndemic Theory, these interrelated and interactive epidemics may work to lower the overall health profile of Black MSM populations, through increased high risk behaviors.

Poor mental health has often been described as an antecedent to risk taking behaviors, with studies reporting higher levels of psychological distress and depression among MSM (Mills et al. 2004). Pathways between depression and risk are reinforcing; STDs and high-risk sexual behaviors serve as risk factors for depression (Hallfors et al. 2005, Shrier et al. 2002, Waller et al. 2006), but depression may also increase vulnerability to risk behaviors and infection (Lehrer et al. 2006). This can occur through impaired cognitive function (Channon 1996, Elliot et al. 1997, Elliot 1998, Rao 2006), diminished impulse control (Hanson et al. 2008, Lejoyeux et al. 2002) and motivation (Rao 2006), or increased fatalism (Kalichman et al. 1997). While these effects may influence individuals' risk assessment and ability to participate in protective behaviors, studies examining the relationship between depression and HIV risk—specifically, condom use—have shown mixed results. Some have found no link between depression and lack of condom use (Dilley et al. 1998, Khan et al. 2009, Koblin et al. 2006, Perdue et al. 2003, Stall et al. 2003). A systematic review and meta-analysis of 34 studies that examined the relationship between depression and high HIV risk behaviors failed to find a relationship between depression, anger, or anxiety and high-risk sexual behavior (Crepaz & Marks 2001). On the other hand, some studies have demonstrated depression (Beck et al. 2003, Lundberg et al. 2011, Strathdee et al. 1998) and negative mood states (i.e. depressive, stress, anxiety) (Gold & Skinner 1992, Martin & Knox 1997) to be associated with increased risk taking behaviors.

The mechanisms leading from depression to high-risk behaviors are not fully understood. While depression may predispose an individual to risky situations such

as frequenting venues associated with high-risk behaviors, specific risk behaviors (e.g. sex without a condom) are influenced by more immediate factors such as drug or alcohol use, which may also be linked to depression. Despite mixed results on an independent association between depression and sexual risk taking behavior, literature indicates that the effect of depression on risk behaviors may be interrelated with other factors, and that the additive effect of these interactions may increase vulnerability to HIV infection (Stall et al. 2003). As described in Chapter 2, the higher prevalence of the co-occurring syndemic conditions of substance use, partner violence, depression and childhood sexual abuse that many MSM experience may function to increase overall HIV risk (Aral 2004, Mustanksi et al. 2007, Singer 1994, Singer 1996, Stall et al. 2003). For example, poverty and unemployment, or difficult family relationships, or death of a loved one may lead to poor mental health, which may lead to increased risk behaviors such as multiple partners or substance use, which in turn may increase participation in unprotected sex. While many studies have examined the role of depression on HIV risk behaviors, many have had low proportions of Black participants, have focused on young populations, or have been international. This limits the generalizability of study findings to Black MSM populations. Moreover, the lack of qualitative studies examining men's perceived experiences of the effects of poor emotional health on HIV risk behaviors may hamper prevention efforts.

In addition to poor mental health, apathetic attitudes toward HIV prevention messages and safe sex are also important contributors to increased risk-taking behaviors. Complacency and apathy toward HIV/AIDS has increased in this third decade of the disease, most likely borne out of desensitization to its threat and effects (Elford et al. 2000, Elford et al. 2002, Kalichman et al. 1998, Ostrow et al. 2002, Stolte & Coutinho 2002, Valdiserri 2004, Van de Ven et al. 1999). With the introduction of antiretrovirals in the mid 1990s, the United States saw dramatic decreases in HIV/AIDS-related mortality (Palella et al. 1998), and over time changes in beliefs and attitudes towards HIV/AIDS. Valdiserri (2004) has suggested that HIV/AIDS complacency acts at multiple levels: the individual level (i.e. apathy

toward condom use and HIV/AIDS), the community level (e.g. social norms that no longer support protective sexual behaviors due to diminished belief of HIV infection as a fatal condition), and the societal level (e.g. the de-prioritization of HIV prevention programs). Peterson et al.'s (2003) qualitative study of perceptions of condom use by Black MSM reported that 27% of participants shared that they or members of their friendship and sexual networks were a) generally apathetic about condoms, b) believed that they were not susceptible to HIV infection and as a result did not use condoms, or c) believed that condoms were less important in committed relationships because of trust between partners. This has been supported by other studies reporting that increases in risk behaviors may be due to a lack of belief in one's own susceptibility to HIV infection because of the reduced visibility of AIDS (Rosengarten et al. 2000), the belief that the AIDS crisis has passed (Van de Ven et al. 2000), or that HIV infection does not happen to people like them (Peterson et al. 2003). Indeed, optimistic bias is an important contributor to apathy and complacency regarding unprotected sexual behaviors (Bosga et al. 1995, Gold & Skinner 1992), as are beliefs in the benefits of HIV/AIDS treatment (Elford et al. 2000, Elford et al. 2002, Huebner & Gerend 2001, Kalichman et al. 1998, Morin et al. 2003, Ostrow et al. 2002, Remien et al. 1998, Van de Ven et al. 1999), and waning social support for safe sex behaviors and community norms that have shifted toward making unprotected sexual behaviors more acceptable (Morin et al. 2003). Moreover, apathetic attitudes may also stem from fatigue of prevention messages and burnout as a result of difficulties in maintaining protected sexual behaviors for long periods of time (Flowers et al. 2001, Ostrow et al. 2000, Peterson et al. 2003, Valdiserri 2004). Weakened social norms toward condom use may intensify this individual burnout and further contribute to unprotected sexual behaviors (Validserri 2004).

5.3 Research questions

Factors such as poor mental health and safe sex complacency and/or apathy that drive unprotected sexual behaviors among Black MSM should be considered through a life course perspective, one informed by childhood experiences and present day social circumstances, challenges and relationships. In keeping with Syndemic Theory and the Socio-Epidemiological Theory, this chapter's findings suggest that participants' risk behaviors are determined at multiple levels, and the perceived drivers of these behaviors are interrelated and reinforce one another, with the ultimate effect of increasing participation in risk behaviors. Based on the above review, participants were asked to describe their most recent episode of protected sex *and* unprotected sex. These narratives were then analyzed with the aim of exploring the following questions:

1. Which factors do participants perceive to be most important in guiding sexual behavior decision-making—i.e. engaging in protected sex versus unprotected sex?

2. Which present-day life circumstances do narratives suggest as most importantly involved in participants' protected and unprotected sexual behaviors?

Participants' narratives were qualitatively analyzed with the aim of exploring how men perceive their own HIV risk to be informed, and how this risk is contextualized in their daily lives and challenges. First, we report the situational characteristics of participants' unprotected and protected sexual episodes (i.e. where participants met partners, location of sexual intercourse, and factors driving location choice), followed by an analysis of the most important perceived drivers of unprotected sex.

5.4 Situational context of sexual episodes

5.4a Partner meeting

Participants were asked to describe how familiar they were with the partner(s) they had unprotected and protected sex with. Of 34 unprotected sexual episodes described by participants, 7 participants described sex with anonymous partners. Of these, 3 participants met their partners through online dating websites, 2 met their partners at nightclubs/bars, 1 met his partner at a bathhouse, and another while waiting for a local city bus. Eleven participants had sex with a casual sex partner. Casual partners were described as those with whom there was an ongoing sexual but not committed relationship (i.e. at least 1 previous occurrence of sexual intercourse). Many participants stressed that these casual relationships were restricted to sexual intercourse with very limited to no emotional investment. These relationships spanned in duration from a few months to over 6 years. Eight participants had unprotected sex with those considered to be a friend or acquaintance, 4 participants described unprotected sexual episodes with their current primary partner or boyfriend, while 1 discussed unprotected sex with a former partner; and 2 participants who were sex workers described unprotected encounters with clients.

Of the 34 most recent protected sexual episodes described by participants, 7 described sex with anonymous partners. Of these, three occurred with partners met at a nightclub/bar, 2 met their partners through online dating websites; one met his partner at a 'house party,' and another met his partner at a bathhouse. Nine participants described their most recent protected sexual episodes with casual sex partners, while 4 described protected sex with a friend or acquaintance, 7 with a current primary partner, 3 with a former partner, and 4 participants had protected sex with clients that were met through their sex work.

	Frequency (n)	
	Unprotected (n=34)	Protected (n=34)
Anonymous	7	7
Casual Partner	11	9
Friend/Acquaintance	8	4
Partner/boyfriend	4	7
Prostitution	2	4
Former partner/ boyfriend	2	3

Table 5.1: Partner characteristics of most recent unprotected and most recent protected sexual episode.

5.4b Location of Sexual Encounter

Participants were asked to describe the physical environment in which their most recent unprotected and protected sexual intercourse occurred. Please refer to Table 5.2.

Unprotected Sexual Encounters

Of the most recent unprotected sexual encounters, 19 participants described sexual encounters that took place at the participants' partner's home. Of these 19 unprotected encounters at a partner's home, 13 occurred at a known casual sex partner's home, 5 occurred at an anonymous partner's home, and 1 occurred at a former primary partner's home. Six unprotected episodes occurred at the participants' own place of residence. Specifically, 4 occurred at the participant's own place of residence that was not shared with the partner, 1 occurred at a home

shared with the partner (i.e. the partner described in the unprotected sexual encounter), and 1 occurred at a home in which the participant was temporarily residing with the partner due to social or economic hardship. Eight unprotected sexual encounters occurred in non-traditional settings: 2 were the result of sex work and occurred at the client's home, 1 occurred in a hotel room, 1 occurred at a public library restroom, 1 occurred at a bathhouse, 1 took place in a motor vehicle, 1 took place in a homeless shelter, and 1 occurred at a family member's home.

Protected sexual encounters

Of protected sexual encounters, 16 of 34 participants described sexual encounters that occurred at the partner's home. Of these 16 protected sexual encounters at a partner's home, 10 occurred at a known casual sex partner's home, 3 at a current boyfriend's home, 2 at an anonymous partner's home, and 1 at a former boyfriend's home.

Four protected episodes occurred at the participants' own place of residence. Of these protected episodes, 2 occurred at a home shared with the partner, 1 occurred at the participant's own place of residence (not shared with the partner in question), and 1 occurred at a home in which the participant was temporarily residing with the partner.

Fourteen of 34 protected sexual encounters occurred in non-traditional settings: 4 occurred in a hotel room, 2 took place in a bathhouse, 2 took place in a motor vehicle, and 1 episode occurred in each of the following places: a library restroom, a sex work client's home, an adult bookstore, a participant's friend's home, a homeless shelter, and a family member's home.

Location	Most recent unprotected sexual episode (n=34)	Most recent protected sexual episode (n=34)
	Frequency	Frequency
Partner's home (total)	**19**	**16**
Anonymous partner	5	2
Former boyfriend	1	1
Current boyfriend	-	3
Other (known partner, casual)	13	10
Participant's home (total)	**6**	**4**
Own home (not shared with	4	1
partner)	1	1
Temporarily living with partner	1	2
Other (total)	**8**	**14**
Hotel	1	4

Library Restroom	1	1
Client's home (sex work)	2	1
Bathhouse	1	2
Adult Book Store	-	1
Participant's friend's home	-	1
Vehicle	1	2
Homeless shelter	1	1
Family Member's home	1	1

Table 5.2: Environmental settings of participants most recent unprotected and protected sexual episode.

5.4b.1 Factors impacting location choice

Locations where individuals choose to have sex have important implications for engaging in risk or protective behaviors. Certain locations may be able to foster attitudes that encourage protected sex while others can perpetuate high-risk behaviors or provide opportunities for unprotected sex with anonymous partners. Respectively, this can occur through venue-based provision or ease of access to condoms or HIV prevention messages, as well as general environmental attitude of individuals toward protected sexual encounters vs. environments in which spontaneous sex or one-night stands with anonymous partner is the expected normative pattern (e.g. nightclub/bars or sex-seeking venues). Narratives suggested a range of motivations driving participants' choice of location for the sexual episode described in this study. Convenience and privacy of location were cited as the most important drivers. Participants often used one specific location as the default location for sexual intercourse. A location was defined as convenient if it was easily accessible and close in distance. The need for location-related privacy was of paramount importance to many participants, due to fear of being found engaging in

same-sex relations by family members, friends, acquaintances, and employers. For example, one participant, Michael, an active member of the military who was living on the military base, wanted to avoid harassment and violation of the 'Don't Ask, Don't Tell' policy, by hiding his same sex relationships from his colleagues and superiors.

> Interviewer: Why do you think you had sex with [name redacted] at his house?
>
> Michael: It was convenient, clearly, cause he wasn't coming on [the military] base.

Another participant, Raymond, who was the father to four young children and came from a conservative, religious family did not share his same sex behaviors with family and friends, who he believed would not be accepting of his sexual relationships with men.

> "Cause people too, they like to say things and down you, just to make theirself look good. And who knows, they could be doing the same thing behind closed doors! And don't wanna, and don't wanna say nothing. Which I, I understand, I respect that, but don't down me. That's why I didn't want no one to know about it."

Many participants expressed similar concerns. Convenience and privacy of location were the most often reported drivers of decision regarding where sexual intercourse would take place.

At the time of the sexual episode, a large number of participants lived in unstable housing conditions, leaving many participants with limited location options for sex. Respondents shared that they had "nowhere else to go" and were left to engage in intercourse in public places such as parks, homeless shelters, and most often, at the sexual partner's place of residence. Adrian, a homeless participant who was living in

a shelter at the time of the interview and during the sexual episode discussed in this study described having sex in a library restroom:

> Interviewer: Where did you guys sleep together? At his place?
>
> Adrian: Umm, no, cause he was homeless, too. Yeah, we both was.
>
> Interviewer: Okay, so where'd you guys go?
>
> Adrian: Umm, if I tell you…in public
>
> Interviewer: In public where?
>
> Adrian: Everywhere.
>
> Interviewer: So then this December, where in public did you go?
>
> Adrian: The library bathroom.

This need for engaging in sex at locations that ensured privacy also extended to participants that were college students. Several believed that their same sex behaviors would not be accepted by their predominantly Black friends, which led them to engage in sex with anonymous partners in locations they otherwise would not have, such as off-campus locations in private homes. For example, Xavier, a college student reflected on why he chose to not bring male sex partners to his dorm room:

> "I'm sad to say that people I associate with, the people I choose to associate with, the group of friends that I have, [being gay] is not something that would be accepted…And so that's also really difficult."

In addition, many participants described that to bring a male sexual partner to their family home would be disrespectful to their family, and in family-shared homes with young children, it would contradict family morals and attitudes towards homosexuality. Participants who were unable to bring potential male sexual

partners to their place of residence may have engaged in more high-risk behaviors, as a result of using spaces associated with high-risk behaviors and diminished access to condoms. For example, one participant who did not feel comfortable bringing male sexual partners to his home, preferred to frequent bathhouses for the perceived anonymity they provided. Moreover, feeling unable to bring sexual partners to one's home may lead to more episodes of spontaneous and unplanned sex, as described by Operario et al. (2008), which may have the consequence of increased risk of unprotected sex. As will be described in the next section, participants who participate in unplanned spontaneous sexual encounters may not be carrying condoms, and may have less control in the situation (e.g. due to alcohol or drug use), leaving them less able to negotiate condom use. In addition, participants who engaged in sex work explained that location choice was at the discretion of the client, and that sex often took place in locations that left participants feeling uncomfortable or potentially physically unsafe, such as non-public places like a client's home or a hotel room. In general, regardless of the motivating drivers, more episodes of unprotected sex than protected sex took place in non-traditional locations (i.e. outside the bedroom) than traditional locations.

These results allow for a better understanding of the situational context in which participants' protected and unprotected sexual behaviors occurred. Next, this chapter explores the motivational and attitudinal drivers for participants engaging in protected and unprotected sexual behaviors.

5.5 Drivers of unprotected sexual behaviors

Participants described a range of risk factors driving their unprotected sexual behaviors. These included: transactional sex, attitudes toward condom use, being in the 'heat of the moment', poor emotional health, reliance on visual and behavioral cues for risk assessment, and a prior history of unprotected sex. These self- and

partner-related drivers of unprotected sexual behaviors have been categorized by the above themes.

5.5a Transactional sex

Twelve participants reported engaging in sex in exchange for money, lodging, or some service. Some did so to support basic survival needs (e.g. earning enough to purchase foodstuffs, clothing, etc.) or purchase illicit substances (mostly, cocaine and crack cocaine), while other participants engaged in transactional sex to secure temporary accommodation. All participants who engaged in sex work believed themselves to be experiencing considerable housing instability at the time of the sex work; some were homeless and living on the streets or in a homeless shelter, while others had temporary or transient accommodation with family, friends, or acquaintances. Notably, while sex work presented itself as a significant risk factor for unprotected sex, the underlying factors indirectly driving participants' engagement in sex work or transactional sex are arguably more important. Participants' narratives suggested that they were ultimately driven to sex work as a result of troubling life circumstances, which often began in childhood. These participants described significant adversity throughout the course of their lives, which was most often characterized by poor socioeconomic childhoods, parental drug or alcohol addiction, challenging family dynamics and/or limited support (see Section 5.5a in Table 5.3). This extended into their adult lives, with many participants who engaged in sex work also reporting drug/alcohol use, low socioeconomic standing, inconsistent employment history, limited family and friendship networks, and extended periods of housing instability. Participants believed that these challenging life circumstances resulted in sex work becoming a viable and reliable way to earn an income, most often as a 'back-up' plan.

Several trends emerged as direct driving factors for unprotected sexual intercourse with clients. While most participants who engaged in regular sex work reported carrying condoms at all times, those who engaged in spontaneous and occasional

sex work reported not always having condoms at time of sex. However, carrying condoms did not necessarily translate into participants using the condoms; several men in this study reported unprotected sex despite having condoms on their person (e.g. having condoms in their pants pocket). Reasons included a client's refusal to use condoms or clients offering to pay higher rates for intercourse without condoms:

> "They don't like using a condom. I told him that I don't do nothing without a condom, and he told me no, [that] he could go to his girl if he wanted to hit it with a condom. I needed the cash"

Though reluctant and aware of the associated risks, participants' desperation for revenue ultimately led all but one to agree to the unprotected sex.

5.5b Men's attitudes toward condom use

Narratives suggested that respondent attitudes toward condom use with casual, ongoing, and/or anonymous sexual partners served as a prominent risk factor for reported episodes of unprotected sex. This section will take an in-depth look at how these attitudes influenced reported episodes of unprotected sex. Though similar, there are slight distinctions between participants holding apathetic versus passive attitudes toward condom use:

a) Apathetic attitudes to condom use: some participants used condoms if asked to by their sexual partners but would not and/or did not care to raise the issue themselves. Sexual safety was not a high priority for these participants, with many describing indifferent attitudes toward condoms and protected sexual behaviors, in general. A small subset of this population also described a preference for unprotected anal intercourse.

b) Passive attitudes to condom use: at the time of intercourse some participants had thoughts of condom use on their mind, but remained silent, instead relying on their partner to raise the issue. If their partner did not raise the issue, participants acquiesced to unprotected sex. Participants with passive attitudes acknowledged that practicing safe sex was "the responsible thing to do," and in contrast to participants with apathetic attitudes, often expressed some regret in having engaged in unprotected sex. Some participants with passive attitudes were proactive in suggesting condom use, but would consistently defer to partner's preference even if this included high risk behaviors.

5.5b.1 Apathetic attitudes

> "I don't really care. I mean, that's honest, I mean, I know that's a horrible answer—but it's just honest."

This quote was representative of participants with apathetic attitudes toward protected sex, which emerged as an important trend among participants. Respondents revealed that they would willingly use condoms if asked to by their sexual partner, but if condom use were not suggested, they would be equally likely to have unprotected sex. As one participant described, an apathetic approach to condom use led to unprotected sex:

> Participant: I don't know. I wouldn't mind if he wanted to use a condom, though. You know what I mean? I wouldn't say no.
>
> Harold: So if he said to you, "let's use a condom," you would say okay?
>
> Participant: Yeah,
>
> Harold: But because he (didn't), you don't say anything?
>
> Participant: Right, right.

Indifference to condom use resulted in narratives of participants' sexual activities being characterized by very inconsistent condom use, with both anonymous and ongoing sexual partners.

> Michael: He had some (condoms), you know what I'm saying, so I had to use them, you know what I'm saying…He was like 'oh, should we use a condom?' I said alright, I ain't see a problem with it.
>
> Interviewer: Okay. So you slept with (him) last night too, did you use a condom last night?
>
> Michael: Nah, I didn't use a condom.
>
> Interviewer: What makes you decide when to use a condom and when not to use a condom?
>
> Michael: I don't know. If they ask me to wear a condom, Imma wear a condom. If they don't ask, then no.

Overall, participants demonstrated their apathy most clearly through their lack of interest in suggesting condoms as part of a risk protection strategy, often as a result of sexual safety not being an integral component of their approach to their sexual lives. These attitudes extended to 'sexually-charged' environments—such as video arcades, adult bookstores and bathhouses—where hyper-vigilant sexual safety attitudes towards anonymous partners would be expected (Clatts et al. 2005, Elwood & Williams 1998, Elwood & Williams 1999, Grov et al. 2007, Halkitis & Parsons 2003, Parsons & Halkitis 2002, Tewksbury 2003, Xia et al. 2006). Participants acknowledged the risks associated with patronizing sex-seeking venues, and conceded that they may be interacting with high-risk individuals, however this was not sufficient enough to produce a change of attitude or behaviors in some men who continued to practice unprotected anal intercourse. Indeed, we observed many reports of participants employing condoms as a means of contraception when having sex with women, but not for STD protection when

engaging in sexual intercourse with men or women. The use of condoms primarily for contraception purposes rather than STD protection is further explored in Chapter 6.

When considered within the cultural context of homosexuality within the Black community, apathetic attitudes to condom use may have also resulted from participants' attitudes toward their own same-sex attraction and behaviors. This may be the long-term consequences of family/friend/community-related homophobia or intolerance of same sex behaviors. For participants with negative views of homosexuality, suggesting condoms may result in being confronted by their own same-sex behaviors—it forces a direct acknowledgement of their behaviors. Practicing condom use requires a certain amount of planning and intent, which may be problematic for participants uncomfortable with their same-sex behaviors; not suggesting condoms may be a strategy to avoid confronting the reality of their actions. Operario et al.'s (2008) qualitative study reported that within the cultural context of being raised in the Black community, Black MSM who believed homosexuality to be wrong often reduced their same-sex behaviors to an act, rather than an identity, therein making those behaviors personally irrelevant, which other researchers have suggested makes men less likely to develop protective HIV sexual health strategies (Myrick 1999).

5.5b.2 Passive attitudes

In addition to apathetic attitudes, narratives revealed passive attitudes to be an important impediment to sexually-protective behaviors. As previously observed, despite acknowledging the major risks associated with engaging in unprotected sex, and viewing unprotected sex with non-monogamous partners as 'bad,' it did not prevent some participants from engaging in unprotected sex and many echoed the sentiments, "I know it's bad but…" In the moments preceding sexual intercourse, respondents shared that they were thinking of using condoms, but instead of raising the issue themselves they waited for their partners to suggest condoms, even though some of the time participants knew or assumed that their partner would not

suggest condoms. In the case that participants' sexual partners did not suggest condoms, participants engaged in unprotected sex. As one participant, Leon, shared:

> "I thought about it…it was in the back of my mind, you know? But (he) never said nothing, so I didn't."

This passivity revealed an overall general trend of sexual safety not being a priority for some men in this study. Leon also shared:

> "I wanted to see if he was going to bring it up. He didn't, so I just left it as it may not have been a big deal…(I waited) for him to bring it up, if not, then it was no, we wouldn't use a condom."

5.5b.3 Contextualizing attitudes: Drivers and consequences of apathetic and passive attitudes to condom use

Apathetic and passive attitudes to condom use served as important barriers to participants engaging in protected sexual behaviors. It is worth noting that some participants were more proactive in their approach and suggested condom use to their partners. If partners agreed, condoms were used, but if partners displayed any resistance or simply preferred unprotected sex, participants with passive attitudes agreed to unprotected sex. Michael shared,

> "(T)here was actually this guy who I had hooked up with last Wednesday and who I had hooked up with before, and I had put a condom on him part of the time and he said that he couldn't stay hard with the condom on, and I said ok and let him do it without it…then he ran into me again (at the bathhouse), he started fucking me and I didn't care that there was no condom."

Of course, within the scope of men's attitudes toward sexual protection, power dynamics in negotiating condom use must be considered. Some partnerships featured imbalanced power dynamics that left some participants unable to insist or

at the very least negotiate condom use. One participant, Cary, shared,

> "I said do you have protection? And he was like no. And then I was like don't you need some, and he was like, no, let me go in there raw…can I hit it raw? And I was like are you serious? And he was like shut the fuck up, let me just hit it raw. And we had sex. I told him right before he was entering me. I said when it's time for you to ejaculate, please take that out. He was like yeah, if I want to. But right now, I'm just like really really nervous, because I don't know who he's been with, I don't know who he's been with before, what he did with that person, I don't know with who he's been with."

Indeed, power imbalances figured prominently in some participants' narratives of unprotected sex. For men in this study, imbalances most often occurred as a result of some form of indebtedness. For participants who were being financially or otherwise supported (e.g. living at partner's home) by their partner, participants may have felt obligated to accept their partners' wishes for unprotected sex (see Section 5.5b.3a in Table 5.3). Moreover, a consequence of the childhood emotional or physical abuse that many participants reported experiencing may have rendered them less able to protest a partner's desire for unprotected sex or may have led them to believe in the futility of their actions in controlling the outcome of different situations, including practicing protected sexual behaviors (Briere 1992, Freshwater et al. 2001, Genuis et al. 1991, Liem & Boudewyn 1999, Paul et al. 2001).

It is noteworthy that participants with apathetic and passive attitudes consistently held these attitudes regardless of partner type or the environmental/situational context of the sexual episode. This may be a consequence of participants not perceiving their sexual partners to pose different levels of risk. That is, regardless of how participants came to know of and interact with newly met sexual partners, their narratives suggest that they perceived the sexual health risks associated with having sex with that partner to be uniform. For instance, participants perceived that

sexual partners met at a nightclub posed the same level of HIV risk as one met through online hookup websites or through a friend or acquaintance. Passive and apathetic participants rarely shared narratives of having sex with partners that they perceived to pose different levels of risk, including ongoing casual or occasional sex partners.

Both, participants with apathetic attitudes, who did not prioritize sexual safety, and participants with passive attitudes who either thought about safe sex at the time of intercourse but did not raise the topic, or who did in fact suggest condom use but were met with resistance, described approaches to protective sexual behaviors that resulted in inconsistent condom use. Indeed, both apathetic participants who implicitly accepted sexual safety as being their partner's responsibility and passive participants who had a reliance or expectation of their partners initiating protected sexual behaviors had sexual lives characterized by inconsistent condom use. For example, one participant, Dwight, with a passive approach to condom use described how one of his ongoing casual sexual relationships often volleyed between unprotected and protected sexual behaviors.

> "Yeah, I slept with him a few times with a condom. But there were a large amount of times when I just like laid there and just threw my legs up in the air and was like just give it to me."

As highlighted in the introduction to this section, it was not a lack of HIV prevention knowledge that drove men's unprotected sexual behavior. Jerry, an HIV+ participant who was living with his primary partner, acknowledged that despite his awareness of the risks of unprotected sex, at the moment of sexual encounter, he did not prioritize this knowledge and chose to have unprotected sex with someone other than his primary partner.

> "I wanted to beat myself up the next day, I really did, because I know sleeping with someone unprotected I could get a different strain which causes my

> medicine not to work and then it also brings in ways I could affect (my main partner) and ways of hurting his health and this whole thing just came down on me, I [thought about it] but I didn't care."

When asked to reflect on the consequences of apathetic or passive attitudes toward protected sex, participants acknowledged both the risks inherent to their behaviors and attitudes as well as the fact that this knowledge did not lead them to refrain from engaging in unprotected sex. Cary, a participant with a strong history of inconsistent condom use with multiple anonymous and casual ongoing sexual partners admitted to understanding the risks associated with his behaviors:

> "(I was) taking chances…yeah, basically, I mean, if they didn't want to use it, I didn't care."

In this sample, overcoming men's indifferent or passive attitudes toward condom use in the face of their own strong basic HIV prevention knowledge will be required before a change in approach to condom use will occur. Interestingly, those participants with passive attitudes who did suggest condom use but ultimately engaged in unprotected sex (excluding those with a lack of power to negotiate condom use) were driven to suggest condoms oftentimes because using condoms was the 'expected thing to do,' not necessarily because of personal beliefs on condom use. Ironically, Keenan, a participant who had previously always insisted on using condoms—due to his own understanding of caring for one's sexual health as a cultural value—describes why he decided to not initiate discussions of condom use:

> "We were just like, like petting each other and kissing and everything and then I gave him oral sex and then he gave me oral sex and then he got on top of me, like, I could feel him getting in the position, and so I knew that he wasn't going to use (a condom), and I don't know. Like, before him, I've always used condoms, like with every person….but the main reason why I did

it 'cause, I don't know. One of my friends said, like... I don't know quite how to describe it. I've always been raised like use a condom every time, no matter what, even if you love them to death and stuff like that. I was raised to use condoms and everything, but I remember a discussion with a friend, and he had said he didn't use a condom with somebody. I was like, 'oh my gosh,' I made this huge deal. He was like, 'I'm grown-ass man,' you know… I was thinking about that."

This alludes to the complexities of men's HIV risk behaviors. This data suggests that in spite of HIV prevention knowledge, a history of low risk sexual behaviors, and personal beliefs regarding sexual health responsibility, men may still engage in high risk behaviors.

The results of the previous chapter are useful when considering the potential causes and pathways leading to apathetic and passive attitudes to condom use. Participants who reported adverse childhood experiences described many high-risk sexual behaviors. Negative attitudes towards condom use may fuel these high-risk behaviors. Narratives suggested that participants who perceived their childhood experiences to be adverse (particularly with respect to poor socioeconomic status) grew into adults that reported apathetic and passive attitudes toward condom use. Narratives suggested two main driving factors for these attitudes:

a) *Childhood familial approaches to health promotion*. In participants' childhood home, narrowed priorities were often focused on the immediate or near future (e.g. securing food or shelter), at the expense of priorities considered to be in the distant future (e.g. sexual health and condom use) and not as pressing. This may have set up a life trajectory that found this approach to priorities extended into participants' adult lives, that is, participants employed a time frame that prioritized immediate needs and benefits over those in the future. Within this context, preventing STDs is not a pressing need and therefore not prioritized, leading to apathetic or passive attitudes

toward condom use (see Section 5.5b.3 in Table 5.3).

b) *Social networks*: Apathetic and passive attitudes were reinforced in the present day by participants' social networks. Narratives revealed that members of participants' social networks shared similar life histories and approaches to sexual health. This may have served to reinforce and perpetuate participants' own attitudes to condom use and unprotected sexual behaviors.

Understanding and addressing the underlying factors informing the low priority that some participants place on minimizing their own sexual risk behaviors will be critical to enhancing men's self efficacy toward condom use and engaging in sexually protective behaviors.

5.5c "Heat of the Moment"

Several participants shared stories of sexual encounters that progressed so quickly that thoughts of condom use did not enter their mind at any point during the sexual encounter. While this pattern was observed in participants with sexual histories characterized by frequent episodes of unprotected sex, it predominately occurred in participants reporting very limited experiences of unprotected sex, often with the episode in question being the first instance ever of unprotected sex. Clear differences existed between these two types of participants, with the latter often reporting clear protective sexual health strategies, while the former did not. Participants for whom unprotected sexual behaviors were rare, often described their unprotected sexual encounters as a 'mistake,' 'slip-up,' or 'accident,' that would not happen again in the future. As described by one of these respondents, Jonathan, during the sexual encounters condoms were often readily available but as a result of being caught up in the "heat of the moment," not used.

> "Yeah, I had (condoms), but in the heat of the moment…you know? It was in the back of my mind but at the time, you know… They were available but we

> just didn't use them… after it was done, I was like (oh my god). I felt so bad. I stayed in the shower for like an hour after. Oh my god. I freaked out. I went to the doctor the next day and got tested. He was like 'You know it takes a couple of weeks before that shows up'. I was like 'I don't care!'"

Many participants spoke of condoms being in the same room as the room where sexual intercourse took place (i.e. in a book bag or nearby dresser drawer or night table), or on their person (i.e. clothing pockets) as indicated by the quote below. However, participants had great difficulty articulating why even in the heat of the moment, condoms were not used if they were within arms reach. Here, Anthony, a participant who intended to use condoms with his partner described a fast-moving sexual encounter in which thoughts of condom use were quickly forgotten.

> "Some (condoms) were in my pocketbook, I'm quite sure, I usually keep them, I can reach right in there and ka-boom… I thought about it in the beginning, and knew it was the intention of it, and then forgot about it totally that quick."

Participants with similar sexual histories marked by rare occurrences of unprotected sex conceded that in the moment, they were overtaken by sexual desire which led to a rapid sequence of events leading to unprotected sex, often leaving them shocked at their own unprotected behaviors and regretful that they allowed lust and desire to trump deeply ingrained knowledge of sexual safety. Many of these participants reported being under the influence of alcohol at the time of the unprotected sexual encounter, but firmly did not believe that excused their unprotected sexual behaviors. They were mostly young, middle/upper-middle class, college students, who generally reported strong family support networks, and belonged to social networks that placed similar emphasis on the importance of protective sexual behaviors (see Section 5.5c in Table 5.3). Since most of these participants had been living away from the family home for a relatively short amount of time, they were still heavily influenced by parental expectations of them living responsible adult lives, which included health-conscious sex lives. However, it

is important to note that there were several participants who despite being caught up in the moment did make the effort to use condoms and engage in protected sexual behaviors.

In contrast, participants who engaged in unprotected sexual behaviors with higher frequency did not report similar feelings of guilt or shock as those with rare instances of unprotected sexual encounters. Their narratives tended to reflect their beliefs that 'mistakes happen,' but did not encourage a rethinking of sexual health strategies toward more sexually protective behaviors. The majority of participants reporting these behaviors did not attend college, came from childhoods they perceived as low income, and living adult lives they characterized as being of a low socioeconomic status. These individuals also perceived limited family support and were part of social networks that shared similar approaches to sexual health.

These results suggest that participants' sexual behaviors are influenced by multiple factors acting across the course of participants' lives, culminating in approaches to sexual health that determine participants' engagement in protected and unprotected sexual behaviors.

5.5d Poor emotional health

Due to perceived challenges in personal, family, housing, employment, or other life circumstances, many participants described 'feeling down' or depressed, and this functioned through numerous internal/psychological mechanisms to result in unprotected sex. These are depicted in Figure 5.1.

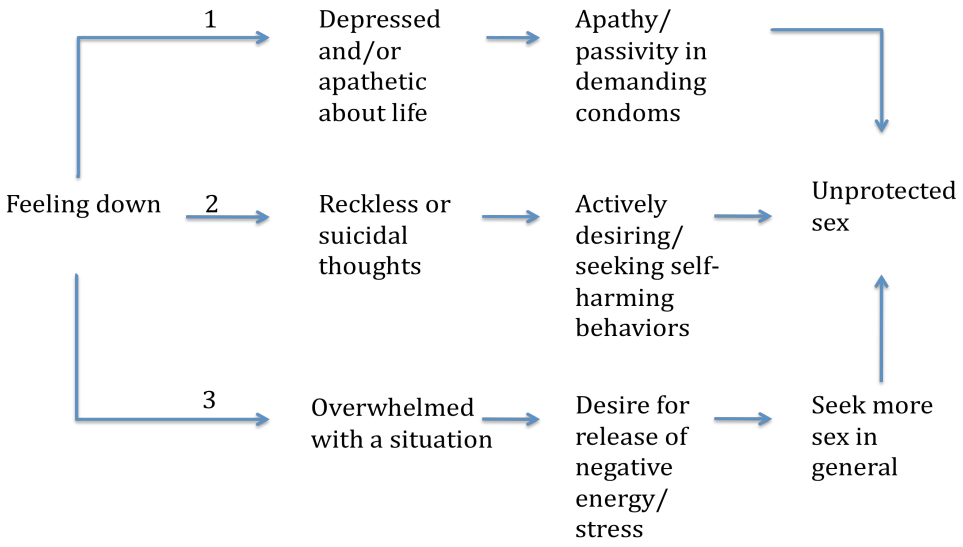
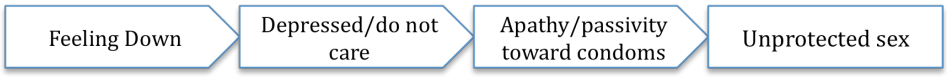


Figure 5.1: Mechanisms by which poor emotional health led to unprotected sex among participants.

This section will now explore these mechanisms by which poor emotional health among participants may have been linked to unprotected sexual behaviors.

5.5d.1 Poor emotional health leading to apathy towards sexual safety



When asked to reflect on the happenings of their life in the time period surrounding the unprotected sexual encounter described for this study, some participants shared that they were in the midst of particularly difficult personal circumstances. This led many to report that they were feeling depressed at the time of unprotected sex. For example, one participant, Martin, spoke of his mother's illness and his difficulty in emotionally managing the situation, and how he believed this led him to engage in behaviors that he otherwise may not have:

> "I was going through a lot of emotional stuff, and I was kind of like a loner. I had a lot of stuff that was going on with me…Well, she was dying and I stayed

with her everyday, it just was tearing me apart. Then at that time, when all this was going on with my mother, then I would go home, I didn't care, I called some friends over…I was behaving not myself."

This quote was typical of participants who believed that their depressive symptoms had led to indifference toward many critical areas of their lives. This included being apathetic and/or passive about maintaining family and friendship ties, addressing employment and/or housing concerns, as well as indifference toward sexual health protection. Participants who were feeling down reported not caring enough to initiate or demand condom use from their partners. In the light of their own poor emotional health, sexual protection was not a priority for men, with narratives suggesting that general indifference dictated many of their decisions (see Section 5.5d.1 in Table 5.3).

5.5d.2 Poor emotional health leading to recklessness and self-harming behaviors

Many participants who reported depressive symptoms around the time of the discussed sexual episode described a tendency toward recklessness as manifested through actively seeking to engage in self-harming behaviors, such as unprotected sexual behaviors. For example, Clinton, a participant who was very depressed as a result of ongoing difficulties in an on-again, off-again relationship with a primary partner engaged in many reckless behaviors, such as excessive alcohol and drug use, dangerous driving, and many episodes of unprotected anal intercourse. When asked to reflect on why he engaged in high risk behaviors, he shared:

"I, like I was saying, I don't… maybe I do have a death wish, I don't know. I know I should care, but I just don't. And he obviously doesn't, so…we have (condoms)…I have a whole drawer full of condoms."

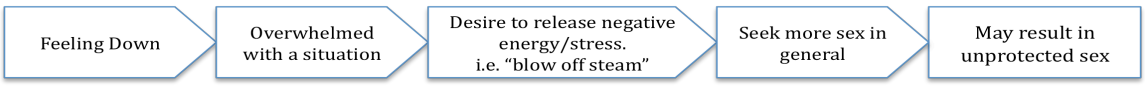
This example demonstrates the complex nature of factors driving sexual risk

behaviors. While the previous section described a general apathy by participants towards sexual health, this participant revealed a particular apathy driven by a depressive period in his life. In retrospect many participants recognized their own self-harming behaviors but shared that during those moments of their lives "nothing mattered," or that they "didn't give a fuck" about their lives, or "just wanted (everything) to (go) away," and as a result may have subconsciously sought out and engaged in self-harming behaviors such as unprotected anal intercourse, including with partners that were either known to be HIV+ or engaging in high risk behaviors such as injection drug use. Just under one half of participants in this study reported that they had contemplated suicide during these difficult life periods. Indeed, some participants had made several suicide attempts and were hospitalized as a result, while others were temporarily hospitalized for fear they may be considering suicide or may attempt suicide. Many participants described needing a respite from the difficult life circumstances in their lives:

> "I was depressed for a variety of reasons. I was taking a lot of drugs. I intentionally took too much of something so that I would go to the hospital, my intention was to go to the hospital so that I could have a time-out sort of thing."

Many participants that described challenging life circumstances—whether it be in their relationships with intimate partners or family members, or employment or housing difficulties—conveyed the need or desire for a "time-out," a temporary or permanent reprieve from the realities of their lives; for some, this need was realized through self-harming processes.

5.5d.3 Feelings of being overwhelmed leading to desire for emotional escape



Some instances of unprotected sex occurred during a period in which participants were feeling overwhelmed by a particular situation, such as being unhappy at their

workplace or unable to secure independent housing. Some participants described that these situations led them to experience high levels of anxiety, which they sought to counteract through increased participation in activities they found to be pleasurable or calming or activities that distracted them from their overwhelming situations, such as, increased marijuana smoking or socializing with friends, or seeking/having more sex in general. Participants that handled their emotional anxiety through increased sexual relations also tended to be participants with histories of inconsistent condom use who often did not prioritize sexual safety. Consequently, their increased number of sexual partnerships inevitably resulted in some episodes of unprotected sex. Jermaine, a participant who was experiencing difficulties in his relationship with his children's mother, as well as his primary male partner, reflected on how the multiple pressures he faced led him to engage in unprotected sex.

> Jermaine: Shit was chaotic. My baby's mother was acting crazy, you know? Making my kids hate me and shit, but I…didn't want to go back to [my primary partner] without money, a job, so shit was just crazy. I wanted out. I was at the bar, saw the dude and was like 'fuck it'.
>
> Interviewer: Why do you think you thought that?
>
> Jermaine: I don't know. Shit was just getting to be too much. I wanted to be away from all that, you know? Have a good time.

This escape theme common among participants in this study has been reported before (Operario et al. 2008). When faced with stressful life factors—whether it be homelessness, dissolution of a relationship, or troubles within one's family, to name just a few—participants sought to escape, which was often manifested as participation in behaviors that could be deemed reckless, such as unprotected sexual behaviors. As respondents shared, this allowed them to momentarily "not think" about the troubles they were experiencing in their personal lives.

In conclusion, participants' perceived that their poor emotional or mental health influenced their unprotected sexual behaviors. Challenging life circumstances or difficulties in personal relationships were the most commonly reported contributors to poor mental health. However, it is important to note that not all participants with poor emotional health engaged in high risk behaviors, and not all participants with good emotional health engaged in low risk behaviors. This suggests that emotional health may be just one aspect of an interactive framework guiding risk behaviors in this population. In addition, narratives suggested that participants who reported poor mental health in adulthood also perceived more challenging childhood experiences than those who reported limited mental health issues. Childhood and adult experiences may have constructed a life-course trajectory in which continuous lifelong challenges negatively impacted participants' resiliency, coping skills, or their ability to negotiate or prioritize their own sexual health.

5.5e Reliance on visual and behavioral cues

Some participants actively sought to determine whether a potential partner was in good health and did not have a promiscuous history; they used visual and behavioral cues, not necessarily accurate ones, to help determine these things. These cues were used to ascertain a partners' STD/HIV status and in the case that cues led them to believe a partner was HIV negative, it allowed participants to give themselves permission to have sex with these partners without using a condom. Visual cues included prospective partners appearing to be well groomed as indicated by clean, well-manicured fingernails, pleasant body odor, absence of bodily sores or scabs, as well as the cleanliness of their home. Participants' overall impression of prospective partners guided decisions regarding their sexual behaviors, specifically whether they would have sexual relations with that individual, and if so, whether it would be protected or unprotected. Here, one participant, Richard, explained how his intuition, based on perceptible cues, guided his behaviors:

> "Depends on the mood, on the feeling I'm getting from the other guy. Okay, I'll just use those two examples. The guy two months ago seemed like a clean cut guy, he seemed like he was pretty clean. But the other guy was grimy, rough, dirty kind of guy, and that kind of thing. And he was intense. Even though the guy two months ago was persistent, the other guy was really intense and kept going after it, which led me to think 'what makes me that special, that he would pursue me so strongly. Is he like this with everybody? And if so, what are the chances that he wouldn't have something.'"

Some participants conveyed that visual cues sometimes led them to be suspicious of their partner's sexual history. Participants commented that if their partners started behaving differently, or as one participant phrased it "not acting right," they would usually insist on using condoms. This demonstrates that visual cues were employed not just to determine whether to engage in sexual intercourse with someone, but also whether to use a condom with that person.

Similarly, participants also used behavioral cues as an indication of a partner's sexual history (i.e. is this person promiscuous?) and acceptability of unprotected sexual relations with that partner (i.e. is this person 'safe' to sleep with?). Several participants described Providence's gay social scene as relatively small, and that consequently, it was not unusual to observe the same individuals or group of individuals patronizing Providence's relatively few gay or gay-friendly bars/nightclubs. One participant, Marcus, shared:

> "(Rhode Island) being such a small state with such a small city, of the fact that even though we don't talk about, like we don't discuss, have like full-blown discussions of who they may or may not have had sex with, or whom I have or whoever, it's not like we don't know, so yes. Considering that, for the most part, the same single circle, or the same single circle of gay men that I know of, tend to have sex with the same people, from that same circle."

As a result, if prospective partners appeared to socialize at social venues too frequently, respondents deduced that they were promiscuous, and therefore not a 'safe' sexual partner. For example, one participant, Lawrence, discussed how using social and situational cues allowed him to determine that it was safe to sleep with an ongoing partner for the first time:

> "When I realized that he wasn't at the bar…you know sometimes you go to the bar and see someone every week, they party, they drink… he wasn't like that…not a ho, so the risk factor went down."

Lawrence recounted that the first several weeks of this ongoing sexual relationship was characterized by protected sexual behaviors, but eventually graduated to unprotected anal intercourse. When asked if he or his partner had been HIV tested prior to this change, the participant again relied on behavioral cues:

> "I didn't take his word (on his HIV status), I watched how he was, what he did… I know how he is. I knew [a former partner who was HIV+] med routine, so I would see if (this partner) was trying to sneak something. I wasn't there all the time, but I would spend a weekend…."

Thus, participants' judgments of partner's behavioral cues led men in this sample to make determinations of how 'safe' a partner was to sleep with. Interestingly, when verbalizing these patterns of assessing HIV risk, many participants made statements along the lines of "I mean, obviously it sounds stupid when you say it and when you think about it, but…," thus acknowledging that their means of sexual risk assessment was flawed. However, while participants demonstrated adequate basic HIV-prevention knowledge, many demonstrated limited general HIV-related knowledge. When informed by the interviewer that HIV+ men may not necessarily need medication or that many men were unaware of their status, participants expressed surprise and became anxious and worried over their past actions.

> Interviewer: Okay. So there are some people that have HIV but you would never know and they don't have to take medication. What do you think of

that?

Wilson: Something to think about. I didn't even think…

Adrian, a participant who expressed strong general opinions about questioning prospective partners' sexual history throughout the course of the interview ultimately relied on visual and behavioral cues to decide whether to sleep with the participant with or without a condom in the case of the sexual episode described for this study.

> "Oh, no, I was, I was definitely grilling, I've challenged their responses and I ask questions… they looked clean, they seemed like the type of people that would look after themselves…."

Similar contradictions between beliefs and actions were observed in many respondents' narratives. Moreover, several men expressed similar experiences of determining a partner's sexual safety based on a partner's apparent lack of being on an antiretroviral drug regimen, as described above. Thus, several cues acting in concert (e.g. behavioral cues of not frequenting bars too often and not appearing to be on medication regimen) may turn an otherwise innocuous observation into one in which participants feel comfortable making decisions regarding a prospective partner's sexual status and may consequently dictate their actions regarding condom use. In general, narratives revealed that visual and behavioral cues guided prospective partner risk assessment. Moreover, discrepancies existed between participants' personal approaches to sexual safety/HIV-related knowledge and their risk assessment processes and sexual behaviors.

5.5f History of unprotected sex

Studies have shown that MSM are more likely to use condoms with casual or anonymous partners than with their main partners or those with whom they are in committed relationships (Dawson et al. 1994, Doll et al. 1991, Fitzpatrick et al. 1990,

McKusick et al. 1985, Myers et al. 1992, Valdisseri et al. 1988). However, our study results suggest that participants not only did not use condoms with their main sexual partner, many also did not use condoms with their casual partners. Many described sexual episodes with ongoing partners, with whom a history of unprotected sex had already developed. These ongoing partners fell into one of two groups, 1) primary partners with whom monogamy was expected, and 2) casual sexual partners with whom no expectations of monogamy existed.

5.5f.1 Ostensibly monogamous relationships

Participants who reported being in ostensibly monogamous relationships reported that condoms were not used because of trust within the relationship, however, in reality, many study participants admitted to sleeping with someone other than their primary partner, and some of these times without condoms. Participants acknowledged that they could "be bringing something back" (i.e. an STD) to their partners, but found it difficult to explain their lack of condom use, demonstrating a disconnect between knowledge and behavior. Perhaps as a result of their own infidelity or that of their peers', many participants in monogamous relationships expressed doubts of their partner's faithfulness: "you never know what he is doing when you not around." An underlying suspicion of infidelity appeared to be a general theme among respondents in monogamous relationships, but many reflected that broaching the subject of condom use with their primary partner would likely raise suspicions of their own faithfulness. As a result, it became important for some participants to demonstrate a trust in their partners, often through unprotected sex, as shared in the following quote by Matthew, a participant who described otherwise strict sexual safety rules:

> "I just didn't use it. I thought about it and I wanted to show him that I trust him, and that was the way for me to show him that I trust him and taking his word for stuff. He tells me all the time that he doesn't really trust a lot of people, and I'm one of the ones he trusts with everything. So I just wanted to, I don't know, let him know that I do trust him."

In this study, the majority of participants in committed relationships did not use condoms with their primary partners. Thus when condom use was practiced within these relationships, it was usually the result of infidelity or suspicion of infidelity on the participant's or partner's part. For example, Richard, a participant who had previously engaged in ongoing unprotected sex within his monogamous relationship described how his partner's unfaithfulness led him to become distrustful of his partner, and insist on condom use.

> "I told him, I was like, it's going to take me a long time (before we stop using condoms again). Once I get that trust back then I can say that I'm with you 100%, because until then it's not going to be the same."

It is important to note that most participants who suspected their partners of infidelity did not ask their partner to be HIV tested, but instead focused on assessing and reestablishing emotional trust through their partners' words and actions. Another participant, Anthony, who had caught his partner in a sexual indiscretion began insisting on condoms as a way to protect himself:

> "Well, I'll put it like this: when he's ended up being with somebody else, and I heard about it, that's when I'm using condoms…Right, to save myself."

Some participants commented that it was their partners that began insisting on condom use, mostly due to their partner's suspicion of their own faithfulness.

> Interviewer: So was there a reason that you used a condom one time but not the other?
>
> Jamar: Well that's because he kinda has….he's a big health freak, he likes to make sure that everything in order and good and the way it's supposed to be. We ended up using a condom that day because one of his friends told him that I was sleeping around on him…One of my so called friends, ran to him and told him that I was cheating…so we ended up (using a condom), I told him that 'it really doesn't matter, but if you want to have use a condom, I'll use a condom. but I'm giving you my word that I didn't cheat on you'. He

ended up realizing that it was a lie and so my boyfriend said 'sorry, I didn't know what to believe'.

This participant's comment about his partner being a 'health freak' was echoed by a small number of participants. Narratives of respondents with partners concerned about their sexual safety and general wellbeing suggested they were less likely to engage in unprotected sex with anonymous partners, indicating the important influence that a partner's sexually-protective approaches can have on participants' own sexual behaviors. This is particularly important since studies have suggested that most HIV transmission among MSM occurs through individuals' main sex partners (Sullivan et al. 2009).

5.5f.2 Casual sexual relationships

In contrast to the literature, narratives suggested that slightly more participants engaged in unprotected sex (n=11) than protected sex (n=9) with casual partners. Many participants were involved in one or more ongoing casual sexual relationships, with some of these participants also involved in committed relationships. These casual relationships ranged from a few months to up to 6 years. Among participants who engaged in unprotected sex with casual partners, narratives suggested two main factors as driving these behaviors. First, as patterns of continued sexual relations within casual partnerships were established, participants became relaxed about their condom use practices. That is, participants would use condoms regularly when in early sexual encounters with the casual partner, but as time went on, they reported using condoms less often, eventually reaching a point where condoms were not used at all. Participants acknowledged that their casual partners were likely sleeping with other men, but were unable to reconcile this knowledge with their continued unprotected sexual behaviors with these partners. Thus, these changes in sexual safety practices did not necessarily reflect increased trust in the partner, but instead was more related to comfort, and

"laziness," and was often time-dependent (see Section 5.5f.2 in Table 5.3). We observed that the longer participants had been carrying on sexual relationships with casual partners, the less often they described condom use with that partner. When asked if he would consider starting to use condoms, one participant who had already stopped using condoms within his casual sexual relationships commented, "Umm, I guess…(but) why start now?"

Participants' narratives tended to be reflective of past behaviors and the consequences of those behaviors. However, participants had difficulty negotiating their future sexual health, in other words, participants believed that since they had already stopped using condoms, there was no point in restarting condom use. They tended not to consider condom use within the context of protecting themselves from future STDs. This alludes to the second factor driving unprotected sexual behaviors, a feeling of immunity against STDs. As a result of having remained "safe" and "clean" (i.e. HIV negative) while not using condoms, participants conveyed a sense of invincibility (i.e. they believed they were unlikely to ever contract an STD). As one participant, Nathan, who was involved in multiple casual ongoing sexual relationships phrased it:

> "I've been lucky so far…don't see that changing."

Researchers have suggested cognitive-behavioral approaches, such as the Information-Motivation-Behavioral Skills Model, as a way to understand why individuals engage in unprotected sex with casual partners in order to change the behavior. However, these models often do not take to into account the wider social context informing these behaviors. For Black MSM, casual partnerships may satisfy sexual needs within an uncommitted context, and provide participants with a temporary escape from their lives. As reported throughout this chapter, many participants described difficult social realities, and casual partnerships characterized by emotionally-detached sexual encounters may have provided fleeting moments of escape and enjoyment (Operario et al. 2008). For men in this study, early interactions with casual partners were marked by caution and

protected sexual behaviors, but over time gave way to unprotected sexual behaviors for many participants.

Table 5.3 Representative participant quotes demonstrating perceived situational and partner factors implicated in sexual risk behaviors

Relevant Section	Theme	Quote
5.5a	Life experiences of participants who engaged in transactional sex	"My dad was locked up for most of the time that I was a kid. He was a crackhead. My mom also did crack, but wasn't as bad as him."
		"I can't find any good jobs. I go from place to place. At my last job, I quit because my manager was an asshole and wasn't fair."
5.5b.3	Power imbalances and sexual risk behaviors	"I had gotten into a fight with my girlfriend. So she went home and I was by the bus stop cooling off. And the guy who lived in the house right by the bus stop invited me in…we had drinks…[I didn't want to go home, so] he was going to let me stay the night. After watching tv, he kinda started unzipping his pants…I gave him a blow-job. We had sex. He didn't have condoms so…"
5.5b.3	Priorities focused on the immediate or near future	"I'm thinking about today. Right now."
		"I ain't worried about tomorrow. It ain't guaranteed, you feel me?"
5.5c	Unprotected sexual behaviors attributed to the "heat of the moment" among lower risk participants:	"I couldn't believe that I did that. I mean, I knew him so he wasn't a stranger or anything, but still!"
		"I had been drinking. It was a [college African American club] party. That's no excuse. I still know what's right and wrong. It hasn't happened again."
5.5d.1	Poor emotional health leading to apathy toward sexual safety	"That was a hard time. I just didn't care about much. When I got out of the hospital [following a suicide attempt], things were just ugh, you know?...if he wanted to use a condom okay, otherwise, it was whatever."
		"I was feeling alone, like no one cared about me…just really alone. I wasn't that interested in sex…[condoms] wasn't really even on my radar. Didn't think about them."
5.5f.2	Casual sexual relationships and sexual risk behaviors	"When we first met, we used condoms most of the time, we might have slipped once or twice but you know, we used condoms. And then I don't know how it happened, but then eventually we just stopped."
		"I mean, I don't know what he's doing when he's not with me. I'm not with…We just messing around…so yeah, he probably is fucking other [men]."

5.6 Discussion

This chapter explored the situational and self/partner-related factors that study participants described as driving their HIV risk behaviors. Participants' narratives suggested several important factors driving HIV risk behaviors. In summary:

- *Imbalanced power dynamics:* Participants who participated in ongoing sex work engaged in unprotected anal intercourse because clients resisted condom use or offered higher rates for unprotected sex, while those who engaged in transactional sex (i.e. sex in exchange for housing or food) feared that refusal of unprotected sex would result in an end to the exchange relationship, i.e. partners would no longer provide for them.

- Participants' *apathetic or passive attitudes toward condom use* often resulted in sexual behavior decisions becoming their partner's responsibility. If partner suggested condom use, participants agreed to use condoms, but if condoms were not suggested, participants had unprotected sex.

- Some sexual episodes progressed so quickly that participants reported being so caught up in the "*heat of the moment*" that condom use did not come up in conversation, despite condoms sometimes being within arms reach. Participants who reported very limited histories of unprotected sex most frequently described being caught up in the moment as the driver of unprotected sex.

- *Poor emotional health* as a result of difficult personal relationships or challenging life circumstances led participants to a) become apathetic or passive in demanding condoms, b) actively seek and engage in self-harming behaviors such as unprotected sex, or c) feel so overwhelmed by these difficult situations that sex—often unprotected—functioned as an escape.

- Participants used *visual and behavioral cues* to make potentially inaccurate assumptions of a prospective partner's sexual history and STD status. These assumptions guided sexual behavior decisions, specifically, whether they would sleep with the individual, and if so, whether a condom would be used.

- Participants involved in *ostensibly committed and monogamous relationships* engaged in unprotected sex with their partners because of trust within the relationship or a fear that suggesting condom use may lead their partner to be suspicious of their fidelity. However, a considerable number of these men reported unprotected sex outside the relationship. Casual sexual relationships often began with condom use but in many cases gave way to unprotected sex; this progression reflected a relaxation of participants' sexual safety strategies.

The results reported in the previous chapter suggested that adverse childhood experiences have an important influence on sexual behavior decision making later in life. This chapter extends that data to also implicate participants' present day (i.e. adult life) social, economic, and mental health circumstances in their decisions regarding sexual safety. Many participants' narratives of unprotected sex were heavily influenced by life circumstances perceived to be challenging, such as housing instability, unemployment, and problematic family relationships, while narratives of protected sex were contextualized by favorably perceived living conditions and healthy relationships. I observed that participants who described

socioeconomic disadvantage in childhood often also described socioeconomic disadvantage (and the accompanying poor mental health effects) in adulthood. This continuing thread of disadvantage from childhood to adulthood has been previously described and has important health implications (Pagani 2007). Our findings suggest that participants' early life experiences—often contextualized by socioeconomic status and family dynamics—more often than not initiated a life trajectory that led participants to a lived experience of similarly adverse or positive adult experiences; this ultimately dictated positive or negative sexual health approaches (i.e. protected or unprotected sexual behaviors, respectively.)

Basic HIV prevention knowledge was widespread among men in this study; participants understood that condom use prevented the transmission of HIV. This may be indicative of the success of Rhode Island State's CDC-funded public health initiatives, all of which are based within agencies and community based organizations in the greater Providence area. Many participants in this study were recruited from these organizations and accordingly may have been influenced by the programs. For example, Crossroads Rhode Island—a temporary shelter for the homeless where several study participants were residing—coordinated the delivery of HIV counseling, testing and referral services throughout Providence, and the Department of Corrections ran several testing, education, and counseling programs, which may have also benefited participants who had recently been released from incarceration. Participants' involvement with local HIV/AIDS resources was a limitation of this sample. Future studies will need to explore the risk behaviors of Black MSM who have had no contact with such organizations. While the vast majority of participants acknowledged that condom use prevented the transmission of HIV, many also recognized the risk associated with some of their own behaviors such as having sex with multiple partners or engaging in transactional sex. In short, participants' knowledge of HIV prevention did not translate to their behaviors, with participants engaging in multiple sexual risk behaviors, including unprotected anal intercourse.

The risk factors for unprotected sexual behaviors described in this chapter are best understood when examined from a life course perspective and contextualized by the Social Epidemiological Model of HIV Risk and the Syndemic Production of Disease described in Chapter 2. Narratives supported the Social Epidemiological Model, which locates risk at the individual, social, and structural levels. High risk participants described problematic partner characteristics and low socioeconomic position (*individual factors*), low social capital, living in poor neighborhoods, challenging family dynamics, and homophobia (*social factors*), all nested within *structural factors* such as higher reported rates of incarceration, and more stigma and discrimination. Many low risk participants described contrasting experiences marked by higher income and education levels (*individual factors*), as well as positive gay-related support, and social and sexual networks sharing similar sexual health approaches (*social factors*), and limited experience with law enforcement and incarceration, and increased access to prevention messages (*structural factors*).

While this model provides a general overview of the ways in which HIV risk is created in a society, the Syndemic Production of Disease allows for a better understanding of how patterns of illness are perpetuated within certain populations. Among the most important risk factors to emerge from the data involved participants' mental health and apathetic/passive attitudes to condom use—both of which narratives suggest are tied to and informed by participants' life circumstances. Syndemic Theory holds that "the cluster of interacting epidemics that exist among gay men (are) largely socially produced." (Stall et al. 2008, pg. 254) This not only provides insight on the social conditions that contextualize the narratives of HIV+ participants, but precisely underscores that social context is also important for understanding decision-making processes among those at high risk for HIV. High-risk participants described interacting epidemics of poverty, unemployment, and poor family relationships (family relationships described in Chapter 6), which participants' believed to have led to their poor emotional health and apathetic and/or passive attitudes to condom use. Narratives suggested that these factors ultimately contributed to increased unprotected sexual behaviors. In

comparison, low risk participants did not describe similar challenging life circumstances, instead they described middle class/upper middle class status, strong relationships, and post-secondary education, which narratives suggested led to stricter rules guiding sexual safety, more stringent risk assessment, and fewer discrepancies between knowledge and behavior. These theories of understanding HIV risk confirm the complex, interactive, and cumulative nature of factors implicated in unprotected sexual behaviors of the Black MSM in this study.

Findings reported here make important contributions to the field of HIV risk among MSM in general and Black MSM in particular. It is one of few qualitative reports to explore how participants' lived experiences lead to high risk or low risk sexual behaviors; the results contribute improved understandings of Black MSM's risk behaviors to the qualitative literature, and support existing quantitative data demonstrating linkages between childhood and adult experiences (Ben-Shlomo & Kuh 2002), as well as the influence of each type of experience independently as well as cumulatively. The analyses also suggest that contextualizing behaviors by single stand-alone theories may be inadequate for capturing the nuances inherent to men's risk taking behaviors; instead, using the inherently complementary nature of multiple sociostructural theories of HIV risk may provide novel insight into Black MSM's unprotected sexual behaviors, and better reveal points for intervention.

In addition to the results reported in this chapter, important non-normative patterns also emerged from participants' narratives. While poor emotional health did drive many participants to engage in unprotected sexual behaviors, there were several participants who reported low risk, protective sexual health strategies despite having poor emotional health. Reciprocally, we also observed a few participants with good emotional health engage in high-risk behaviors. Moreover, while many participants who reported that the fast pace of a sexual encounter resulted in condom use not being raised and condoms consequently not used, several other participants who also got caught up in "heat of the moment" did describe being able to interrupt the sexual encounter to raise the issue of condom use, and consequently use condoms. Unfortunately, the number of participants

describing these patterns were insufficient for an in-depth analysis, but does highlight the need to further examine non-normative pathways from lived experiences to behaviors. However, it is clear that in the face of challenging personal circumstances—social or economic—these participants were able to employ positive coping strategies that saw them avoid poor sexual behavior decision making. Future studies will need to examine Black MSM's coping strategies in the face of differing life circumstances, and the consequences of those strategies for HIV prevention activities.

As described in the introduction, previous studies have also demonstrated that men use condoms more often with casual partners than with their main partners, but this study found that participants reported more unprotected sex than protected sex with casual partners, including single participants and those who reported being in committed relationships. The sexual health consequences of these behaviors are both apparent and significant. Importantly, studies of condom use patterns across different partner types have mostly used mixed-race samples, often with Black MSM making up a small proportion of the sample, thus presenting an important area of future study. Examining Black MSM's sexual relationships, and the cultural context of sexual behaviors and sexual safety within those relationships may provide greater insight on Black MSM's condom use patterns. Participants in this study almost exclusively described sexual histories characterized by sexual relations with partners that were Black—usually a consequence of their social environment rather than any prioritization of race in prospective partners. It is possible that Black MSM may exhibit differences in sexual risk behaviors and attitudes toward sexual safety when partnered with someone of a different race. This warrants further study.

Future research will benefit from further consideration of Black MSM's HIV risk from a life course perspective. Research efforts should focus on ways to intervene in the socioeconomic and social trajectories of risk behaviors that begin in childhoods and extend into Black MSM's adult lives. This necessitates greater understanding of pathways that lead to both negative and positive health behavior outcomes, particularly for Black MSM populations that have been shown to experience greater

socioeconomic disadvantage and mental health difficulties (Mimiaga et al. 2009). Understanding the differences in health behavior outcomes for those who have had similar childhood and adult experiences is critical to designing tailored HIV prevention interventions that are effective in reducing HIV incidence in this population. This includes further research in resilience and coping strategies among Black MSM—a population that has been understudied.

Finally, it should be reiterated that the qualitative nature of this study does not allow for causal links to be drawn between participants' experiences and their sexual health behaviors, but does allow for a greater appreciation of the ways in which quantitatively-reported risk drivers are contextualized in participants' lives. It is also important to note that the factors driving participants' risk behaviors are not mutually exclusive. The categorical listing of these risk factors is not intended to convey the belief that these factors act independently; indeed, in keeping with Syndemic Theory of Disease Production, the Social Epidemiological Model of HIV Risk, and the life course perspective, it suggests that it is the interaction and synergistic effects of these factors that guide the health behavior profile observed in Black MSM.

CHAPTER 6: SOCIAL SUPPORT AND SEXUAL RISK BEHAVIORS

6.1 Overview

The previous chapter examined participants' perceived drivers of unprotected and protected sexual behaviors. This chapter extends that data to examine how the presence and quality of social support influenced sexual risk behaviors. The overarching theme in this analysis was that, in general, men recollected personal histories characterized by limited positive encouragement and emotional support, as well as the absence of meaningful personal relationships. Narratives suggested that these factors resulted in some participants having difficulty trusting others, which often led them to avoid forming close friendships or sexual relationships, leaving their need for emotional connections with others unfulfilled. Consequently, the absence of fulfilling social relationships led some participants to seek physical and emotional intimacy through unprotected sexual encounters with anonymous and casual sex partners. Notably, some participants described having satisfying social relationships, and described sexual health strategies and approaches to sexual relationships that were conducive to lower risk sexual behaviors. Distinctions in the sexual risk behavior between participants who reported supportive relationships versus those who do not might indicate potential areas for intervention.

6.2 Background

Social relationships are a significant part of the lives of most people, and inform important emotional, psychological and behavioral functions (Uchino et al. 1996). Social support has been implicated in HIV risk behaviors, though not consistently (Darbes & Lewis 2005). Low levels of family social support has been associated with increased levels of problematic behaviors (e.g. alcohol and drug use) known to increase HIV risk behaviors (Brook et al. 1990, El-Bassel et al. 1997, Maton & Zimmerman 1992, Wills 1986, Windle 1992). Low overall social support (i.e. from

all sources of support) has been shown to be associated with increased participation in risk behaviors such as unprotected anal intercourse in men who have sex with men and women (MSMW), and some MSM populations (Dilley et al. 1998, Folkman et al. 1992, Peterson et al. 1992, Strathdee et al. 1998), but not others (Mayne et al. 1998). Reported findings also suggest race/ethnicity-specific effects. While social support is associated with improved mental health and fewer problem behaviors in Caucasian populations (Maton et al. 1996, Windle 1992), other studies have reported that Black MSM with lower levels of social support participate in fewer HIV risk behaviors than White MSM with similar levels of support who engaged in more HIV risk behaviors (Ostrow et al. 1991). These results suggest that the relationship between social support and negative (or positive) outcomes may depend on several factors, such as the type of support (e.g. family vs. peer), individual characteristics (e.g. race and gender; MSM vs. MSMW) and the types of outcomes being evaluated (e.g. substance use vs. depression vs. UAI) (Peterson & Jones 2009, Zimmerman et al. 2000). Qualitative research has the potential to further explain the influence of these potential factors on the relationships between social support and HIV risk behaviors.

More broadly, extensive research has examined the role of social support in reducing multiple health risks, such as the likelihood of becoming ill, the course of recovery for those already ill, the general risk of mortality, as well as maintaining overall wellbeing (Broadhead et al. 1983, Cohen 1988, Cohen & McKay 1984, Cohen & Syme 1985, House et al. 1988, Seeman 1996, Uchino et al. 1999, Dixon et al. 1998, 1999, Penninx et al. 1998, Repetti et al. 2002). Evidence shows that social support from family or peers can protect against adverse psychological and health consequences associated with stressful social conditions (Allgower et al. 2001, Coker et al. 2002, Hefner & Eisenberg 2009, Moak & Agrawal, 2010), with interpersonal relationships shown to play an integral role in social, psychological, and behavioral outcomes across one's lifetime. The mental health effects of social support have been implicated in HIV prevention in Black men (Brotman et al. 2002, Elizur & Mintzer 2001). When emotionally substantial relationships are lacking,

individuals report higher levels of depression and low self-esteem, which can influence HIV risk taking behaviors (Mays et al. 2000). Moreover, higher perceived levels of support are associated with lower reported levels of depression, negative mood states, stress, anxiety, and higher levels of coping efficacy and self esteem (Antoni et al. 1990, Antoni & Schneiderman 1998, Dixon et al. 2006, Hays et al. 1990, Hays et al. 1992, Kelly et al. 1993, Miller et al. 1997, Nott et al. 1995, Penninx et al. 1998, Turner et al. 1993).

In the United States, Black men and women consistently experience adverse social and economic conditions across their lifetime. As described in Chapter 1, members of the Black community are more likely to live in poverty and experience higher levels of morbidity and mortality than other populations. For Black MSM, these socioeconomic conditions are exacerbated by cultural norms of masculinity that is often at odds with homosexuality and provides limited support for MSM. Social support and close personal relationships may allow men to better cope with these adverse conditions and buffer against risk behaviors associated with such conditions (e.g. high risk sexual behaviors, poor mental health, etc.). The mechanisms by which social support influences coping with stressful life events has been described by two main theoretical frameworks: the main-effect hypothesis and the stress-buffering hypothesis (Cohen & Wills 1985). The main-effect hypothesis (also known as the direct-effects hypothesis) suggests that social support is able to directly impact mental health because social networks provide individuals with regular positive experiences and stable and socially rewarding roles in their community—this direct effect occurs regardless of the amount of stress individuals may experience (Cohen & Wills 1985, Joseph 1999). Thus, individuals with strong social support perceive stronger feelings of being appreciated and cared for, and this influences their psychological health (Compas et al. 1986, Frey & Rothlisberger 1996), which in the context of this dissertation can contribute to fewer HIV risk behaviors. The stress-buffering hypothesis maintains that social support functions as a coping mechanism in which perceived social support indirectly buffers against the negative effects of a stressful event (Cohen & Wills 1985, Frey & Rothlisberger

1996, Williams & House 1991) by influencing individuals' choice of coping strategy when faced with a stressful event (Schreurs & de Ridder 1997), and fostering adaptation skills (Tak & McCubbin 2002, Thoits 1995, Uchino et al. 1996), thereby indirectly affecting health outcomes such as HIV risk behaviors. Evidence for the buffering effect of social support is found when correlations between stress and health are examined. A systematic review reported a stronger association between stressful events and poor health in those with weaker social support systems than those with stronger social support systems (Uchino et al. 1996). The buffering impact of social support has been supported by data on physiological outcomes. A literature and meta-analytic review found strong evidence linking social support to cardiovascular, endocrine, and immune system functioning (Uchino et al. 1996).

The literature on the relationship between social support, health, and HIV risk should be contextualized by evidence that suggests that sexual minorities experience social support differently than their heterosexual counterparts (Kimberly & Serovich 1999), with many relying on nontraditional family support systems (Pequegnat & Bray 1997). Due to cultural ideologies that promote masculinity norms and discourage homosexuality in the Black community the availability of support networks for Black MSM might be limited. Family and peer networks might serve as contexts of stress for Black MSM who might have to conceal their sexual identity or sexual behaviors to avoid stigma (Mays et al. 2000). A qualitative examination of non-gay-identified Black MSM reported that African American cultural norms reinforced traditional gender roles and secrecy surrounding same-sex behaviors thereby hindering solicitation of support from family or friends (Operario et al. 2008). While a number of studies have examined the role of support networks on HIV risk behaviors in general populations (Darbes & Lewis 2005, Reilly & Woo 2004) and medication adherence in HIV-positive Black MSM (Wohl et al. 2010a, Wohl et al. 2010b), a significant gap remains on the influence of social support networks on Black MSM who are HIV negative. Thus, while quantitative studies have demonstrated an association between social support and health outcomes, an understanding of *how* and *in which ways* social support

might affect health outcomes, particularly HIV risk for Black men is critical, and perhaps most achievable through qualitative methods. To date, very limited qualitative research has examined this relationship between social support and HIV risk. Published studies of the mental health mediators of social support on HIV risk behaviors have largely not focused on Black MSM populations. Indeed, the sociocultural context of social support among minority populations may require unique consideration. To this end, Meyer's (1995, 2003) work on explaining the increased prevalence of poor mental health in LGBT populations, and the coping strategies (i.e. social support) employed to attenuate the relevant stressors are important (Cochran 2001, Gilman et al. 2001, Herrell et al. 1999, Sandfort et al. 2001), but may be limited in its generalizability to Black MSM populations who may be facing multiple sources of stress in addition to sexual identity-related stress. Minority stress was described in Chapter 2.

6.3 Research questions

Psychological and public health interventions for Black MSM, particularly HIV prevention programs, must consider the sources and quality of social support in men's lives. In particular, interventions must consider the social support characteristics necessary to providing a compassionate and encouraging context for improving Black MSM's wellbeing. To achieve this, qualitative data was collected on the nature of participants' sources of support, and how participants perceived the presence or absence of support to influence their mental health and sexual risk behaviors. Specifically, this chapter aimed to explore the following questions:

1. How do participants describe the quality of social support from their family, peer, and community networks?

2. How do participants perceive the social support in their lives to impact their psychological wellbeing?

3. How do participants perceive the presence or absence of social support to influence their sexual risk behaviors?

In general, thematic analysis aimed to capture the importance of social support on the psychological and sexual lives of Black MSM. This chapter first reports the characteristics of participant's social networks, followed by the perceived quality of social support from family, peer, and sexual partners, and concludes with the perceived psychological consequences of this support and its effects on participants' sexual risk behaviors.

6.4 Social networks

Participants described a range of social network compositions. Narratives suggested that the social networks of participants who engaged in lower risk behaviors were more diversified than those would have engaged in higher risk behaviors, with lower-risk participants more likely to describe networks consisting of immediate family members and a wide circle of peers. The social networks of higher risk participants were primarily composed of family members, including both immediate and extended family members, with some including peers as part of their social network. Notably, higher risk participants were more stringent in their definition of friendship. They perceived many members of their peer networks to be "associates," (i.e. acquaintance) instead of "friends," and were unlikely to view them as a potential source of support. As LeVar shared,

> "I'm a simple person and don't have a lot of friends, and don't keep a lot of associates around me…a lot of people call a lot people friends, but they're really not their friends, that I do not call people friends unless I know you for X amount of time and you're good enough to be my friend, worthy. I call most people associates."

When participants were asked to specifically describe those who they considered to be a source of support, lower risk participants perceived immediate family members and multiple close friends to serve as sources of support. By contrast, higher risk participants described family members as a source of support, and often did not perceive friends to be a reliable source of support. These differences in social support networks between higher and lower risk participants may have been related to socioeconomic and cultural factors. As will be discussed later in this chapter, narratives suggested that lower risk participants often described having middle or higher income households, and higher risk participants described low-income households. Middle/high income participants described wider social support networks, and low-income participants described more limited support networks. Income differences may limit opportunities for ongoing sexual health education, and result in differences in participants' sexual networks (i.e. differences in risk behaviors and sexual health approaches). For instance, college friends served as an important source of peer support among middle/higher income participants, participants shared that these friends usually held similar beliefs on sexual health and safety. However, this avenue (i.e. college) for creating close friendships was not available to many low-income participants. In addition, narratives suggested differences in the emphasis participants placed on family ties. Higher risk participants were more likely to perceive family ties to be the most and only important social ties in their lives, whereas lower risk participants perceived family and peer ties to both be of importance. As this chapter will show, this may have led to differences in participants' desires to form and maintain close friendships. Overall, while participants described their social support networks to ostensibly consist of family and friends, in reality, narratives suggested that for many participants these sources of support were limited or nonexistent, and instead served as sources of stress. In addition, few participants in this study perceived a sexual partner or boyfriend to be an important source of support.

6.5 Family support and expectations

6.5a Limited social support

A dominant theme to emerge from the data was participants' perceptions of limited emotional support from family members. Men in this sample described limits to which they believed they could rely on others and limits to the material and emotional support that they could expect. Narratives revealed a common sense of resignation regarding the willingness and capacity of family members to provide assistance, guidance, or advice, as described by participants Cary, Leon, and Christopher, respectively:

> "They've helped me here and there, 50/50, but when I mostly need help…when I'm hungry and I'm cold and I'm upset, they're not there."

> "No, no, there was no one I could tell anything…I could never tell them anything, never."

> "Believe it or not…I had no help from no one. And everything I had obtained…I had obtained on my own. No one helped me. Everything, clothes, apartment, car. No one gave me anything. "

This generalized lack of support had adverse psychological effects, as described by Leon:

> "I don't know, I feel like there's some security in [deciding] what you wanna do when you're still at home, but you still have the parents there to talk about it and I think a lot of it has to do with like if your parents talk to you about stuff, too, but my mother never really did and so I had to just learn everything by myself…that has had a huge [influence] on my life, it's made

me feel like shit for most of my life."

In general, men in this sample believed that family members provided little to no encouragement for their personal or professional success. Indeed, many believed that family members were not only critical of their desire for success and skeptical of their personal goals, but actually wished to see them fail. For example, Jamar, a homeless participant in his early 20s recalled a recent instance of informing his family about his enrollment in a Certified Nursing Assistant course as a means by which to become self-sufficient, and the skepticism by which his endeavor was met by family members. He described how his mother and aunts listed the multiple obstacles preventing him from attending or completing the course, including a perceived lack of intelligence, low likelihood of finding employment as a nursing assistant, and lack of transportation to and from class. He described the psychological effects of this lack of support and encouragement:

> Jamar: "I ended up quitting [my job] 'cause, well, I quit, went to Boston, came back, got the job back. I ended up quitting cause I got depressed. I didn't want to be around anybody."
>
> Interviewer: What were you depressed about?
>
> Jamar: "I'm trying to build and people in my life are trying to tear down what I'm trying to build. It was just, I just got totally depressed… No one was being supportive (of) me being successful in life. Period. Believe it or not."
>
> Interviewer: Not being supportive of you in terms of what?
>
> Jamar: "They just thought negative shit about me and was trying to stop me from progressing, and trying to change me instead of trying to understand me, and make me do what they want, instead of letting me be me."

Other participants echoed similar sentiments of limited family support. Another young man, Cary, a recent high school graduate, who was raised in a home in which most family members did not graduate from high school, described how instead of encouraging his goal of graduating from high school his mother mocked him and actually expected him to fail. He perceived a consistent lack of support throughout his education, which included his graduation—a significant moment in the participant's life.

> "[My mother] would always want to see someone do bad instead of seeing them do good, and she told me I wasn't going to graduate high school…but I did. I graduated high school, and when I did, I brought my cap and gown and I fucking bought a ticket for her and I mailed it to her, and I said 'oh congratulations, but by the way I'm graduating, you're invited.' She didn't even come."

In response to a history of consistently limited family support, many participants described feelings of hopelessness and depression. One young participant, a freshman in college, recalled how his mother's ongoing gambling addiction rendered her unable to help him in his college application process the previous year. He believed that his mother's lack of support and consideration of his future goals contributed to his feelings of depression and isolation, which ultimately led to a suicide attempt and hospitalization.

> "[O]ne of the things that sent me into the depression that made me want to send myself to the hospital was when I found out that my mother gambled heavily and that she spent all her earnings on gambling. So when I tried to get financial aid from [my university]… they didn't give me any aid… After that happened, I sort of didn't care about anything and felt very depressed, mainly because I felt that she didn't care about me. Cause when I asked her why it seemed like we had a lot of money but she couldn't afford to send me to school, she avoided the topic and I could tell that she was so wrapped up in

> her gambling that she didn't have enough concern for me to give me the information that I needed, which is why I had to steal it—so that made me depressed. I felt abandoned…"

Overall, participants' narratives suggested a sense of social alienation as a result of limited family support and positive encouragement. As will be shown throughout this chapter, the effects of this limited social support and consequent psychological effects may have had important implications for men in this sample, particularly with respect to feeling interpersonally whole (i.e. feeling "complete" as an individual), valuing oneself, and being able to make healthy adult emotional and behavioral choices.

6.5b Positive social support

Notably, not all men in this study experienced limited sources of support or the absence of emotionally substantial relationships with family. A subset of participants described positive, encouraging, and meaningful relationships, with parents/guardians as their "number one fan," who encouraged them to "reach for [their] potential," and "follow [their] dreams." This included both generalized and gay-identity related support. For instance, Jonathan, an openly gay participant in his early 20s who described always having a loving, supportive family dynamic, shared that his family members were:

> "Absolutely amazing. Oh, yeah, they're really supportive. Everyone [in my family has] always been very supportive, really, really supportive."

Indeed, the importance of gay-related family support was a recurrent theme amongst participants who described positive family support, as demonstrated by participant Xavier's words,

> "[My mother] used to always tell me, 'whatever it is you like…'. I always liked art and everything else that everyone else in the neighborhood didn't really like and I started to notice that I was a little different so to speak. Boys would come play with me and I would play with them and I wouldn't want them to leave. I want to play house with the boys and not just the girls and that's pretty much how I came to know that I liked my sexuality. And like I said, I had a supportive family so whichever direction I chose to go I knew that I would be accepted. And it's been like that with everything."

Some participants perceived gay-related family support as tacit and implied. Thus, while not necessarily open and explicit, participants shared that their family households did not feel oppressive, negating the need for extreme measures to conceal their same sex desires and behaviors. For instance, one participant, Michael, shared,

> "It never came up…I'm sure [my parents] knew, but they didn't bring it up, so I didn't bring it up. They're old school…so I wasn't expecting them to invite my boyfriend over for dinner. It worked for us."

Participants acknowledged the limited context of this support and did not perceive conversations about their sexuality and same-sex behaviors to be welcomed or discussed encouragingly. Often, this type of support was more readily acceptable and expected by low-income participants than higher income participants.

Interestingly, participants who described strong supportive family relationships were mostly men from middle or higher socioeconomic groups. These participants, many of whom were college students, portrayed a family dynamic characterized less by the struggle for basic necessities such as food or housing than did men from socio-economically disadvantaged backgrounds. These strong family support structures provided men with long-term expectations about life and the aspiration of personal or familial goals, such as a college education. Narratives suggested that

involved, attentive, and supportive parents or guardians had high expectations of their children and encouraged high goal setting, including college attendance and overall responsibility in their approach to finances, relationships, education, and career. One senior college student, with positive family dynamics shared that his parents had high expectations of him, including many expectations that were assumed. When asked of his parents' general expectations of him, the participant shared:

> "That I graduate…and pass my classes. They put a lot of faith and trust in me. They know that I'll do what I need to do to succeed…they're both bankers."

In this case, "succeed" implied graduating college, securing 'good' employment, and living a traditionally successful life (i.e. being a fiscally and socially responsible adult).

Another participant, Lawrence, in his mid twenties described his parents as:

> "the type of parents that if I tell them there's something I want to do, they know that I'm going to strive for it, go and try and do it to the best of my knowledge."

In general, participants reflected on how family members held high expectations of them, encouraged their goals, and discussed specific plans on how to meet those goals. As Anthony shared:

> "I feel that my family is really proud of me and supportive of me. I've always been a hard worker, so as long as I'm doing something, they're okay with it. If I was sitting around the house all day smoking weed, then that would be a different story…[My family expects that] I graduate well. They don't really bug me 'cause we already talked about what my future plans are and that I make sure that I work towards meeting my goals."

Positive family support narratives were not limited to students and those of higher socioeconomic statuses, but were also recalled by men from lower-income backgrounds. However, the emotional support and encouragement received by men from lower income groups reflected the realities of their social contexts – e.g. being encouraged to graduate from high school, to get an hourly-wage job, to find an apartment. The narratives on family support from lower-income participants tended to focus more on achieving independence (i.e. school, employment, housing) rather than on deeper emotional connections. For instance, Christian, a participant in his late 30s who had spent approximately half of his life incarcerated described a supportive family structure, as characterized by his family's desire and encouragement for him to establish a stable life for himself:

> "My father, he's a good guy. He just wants me to have some kind of life. To get a job…to be settled, to see me stable."

Narratives suggested that the emotional support and encouragement available to these lower-income participants tended to be more tenuous and superficial, many times lacking the deep emotional ties described by middle/higher-income participants. However, it may be that while emotional support is present among lower-income participants, it is less openly expressed than support among middle/higher-income participants.

Overall, we observed variability in participants' descriptions of family support. Some described supportive family backgrounds which facilitated participants' abilities to think highly of themselves and to anticipate goals for the future. By contrast, the majority described non-supportive family backgrounds which led participants in this sample to feel isolated and have low expectations about interpersonal relationships.

6.6 Peer and sexual partner social support

6.6a Peer social support

A recurrent narrative theme was the lack of supportive peers in whom participants believed they could confide in and rely upon, and the resulting perceptions of emotional isolation participants shared. Narratives suggested that participants' had few close friendships and an absence of emotionally intimate relationships with sexual partners, as described by Harold and Martin, respectively:

> "I would say that I have no friends…yeah, me on my own, me against the world."

> "Nah, I don't really have friends like that. There are people I know…friends, friends? No."

This is particularly important because participants shared that their homosexuality often resulted in close family relationships existing within a limited context, in which the participant's homosexuality was not acknowledged or discussed. Narratives suggest that lifetime experiences of low social support, frequently beginning in early family contexts, led to ongoing feelings of social isolation, alienation, and the anticipation of rejection by others.

As one participant, Adrian, stated, "I rely on myself a lot. I do what I need to do for myself," and this self-reliance was largely related to a belief that others would ultimately "let [him] down". Participants articulated several reasons for having few close relationships. Adrian stated:

> "Whatever I need, like as far as clothing, food, housing, I do on my own. I don't, I don't ask anybody for anything…because, like I said, people can throw things in your face… I can't really rely on the people that I know because they'll tell you one thing and do another. And I learned that years ago."

Another participant, Raymond, shared:

> "I don't really associate with anybody. I just stay to myself. I just don't really feel like sharing myself with other people or sharing my time with others."

However, not all participants described limited peer networks. In particular, narratives suggested that the social support networks of lower-risk, higher-income participants included close friendships, most often friends met through college. This subset of participants perceived these social relationships to be an important part of their lives, and critical to their happiness. Robert, a participant with close friendships commented: "I have great friends. They're very loyal, always there for me." In relation to a recent stressful event, one participant shared that his "friends tried to cheer [him] up," and allowed him to better cope with the situation. The significance of peer networks was also suggested through the importance participants placed on friends' opinions of potential partners:

> "And most of the time [me and the potential boyfriend] hung out, it was with other people, which is important because I wanted to see how he interacted with my friends, which was important to me."

A college student, Devon, characterized his social networks as:

> "I have a really mixed group of good friends, actually. I definitely have a good number of friends that are black and a good number that are white."

He continued on to explain how these friendships were formed:

> "In freshman year I went to [student] parties, Black cultural group events. I loved the people in my freshman dorm. I think over time, I made a greater effort to reach out and make more friends that were students of color, it was something that I thought was lacking. I major in Africana study and I met a lot of people in that department."

However, not all participants who engaged in lower risk behaviors described fully supportive relationships with friends. For instance, another college student, Jonathan, who described many close friendships did not believe that these otherwise supportive friends would accept his homosexuality. As a result, he concealed his same-sex behaviors:

> "I see people that are very liberal [at my college] and I know that perhaps [name of College] as an institution and the types of students that [this college] attracts are very liberal students. But then they attract some that are not and for some reason, as far as accepting sexuality goes, the students that I seem to be—that I associate with for some reason are those people…they assume that I'm straight."

6.6b Sexual partner support

In addition to close family relationships and friendships, a few participants also described close relationships with sexual partners. When asked to describe a meaningful relationship with another individual, one participant, Anthony, described his relationship with a current sexual partner and noted his appreciation for being valued for his company, instead of simply as a sexual partner:

> "He's a good person to talk to and he's like, the thing about, I like him because we can sit and we can talk, have a drink, we can go to his house and have a drink and it doesn't have to always be about sex."

However, narratives suggested that most participants did not perceive supportive relationships with sexual partners, and did not consider them to be a part of their social network. This may reflect the nature of many higher risk participants' sexual networks, i.e. multiple anonymous and casual partners, with few committed, monogamous, sexual relationships. The impact of few supportive relationships on participants' emotional wellbeing was profound and far-reaching. Participants described intensified needs for emotional connection and support. Indeed, the significance of emotionally close relationships with sexual partners was particularly pronounced in the absence of strong family and friendship networks. Those who did find themselves in close sexual relationships described a heightened sense of pain and loneliness upon losing an intimate sexual partner, either through the partner's death or the dissolution of the relationship. For many men, the end of a meaningful relationship with a sexual partner led to feeling "alone in the world," and without many close friendships, men often were left with no one with whom to discuss their feelings. For several respondents, this led to feelings of depression and considering suicide. As one participant. Richard, stated:

> "I usually hold [my feelings] in…When it does come out, I explode…I do something, try to take myself out. I've been in [the] hospital three times."

Nonetheless, these participants turn to available sources of support in times of need. For example, one participant. Marcus, reflected on the support structures he turns to when feeling depressed:

> "I have close friends and that's just, the only one I have that, is my baby's mother. [When I want to talk to someone] I go to my daughter and my son.

> When I have [suicidal] thoughts like that, I go to see them. They're the ones that put a smile on my face."

Overall, most respondents described limited social support networks, with few close personal relationships with friends and sexual partners. This led participants to express feelings of emotional and social isolation, and often resulted in participants preferring to be alone and avoid pursuing new friendships. By contrast, a subset of participants, often college students, described mostly strong, supportive peer networks in which their same sex behaviors were accepted, and did not share similar feelings of loneliness and isolation. These participants emphasized the general importance of maintaining their close friendships and pursued opportunities to form new friendships.

6.7 Psychological consequences of limited social support

As a consequence of limited emotional intimacy with the people in their lives, many men in the study described a strong general desire for deeper emotional connections, and to be loved and appreciated by others. Here, two participants, Nelson and Christian, respectively describe the reasons underlying their need to emotionally connect with others:

> "I needed love. I needed affection. I just needed to feel safe, [someone] to say 'you're doing a good job.' You know, for someone to see my worth. "

> "Even if we don't have any sex, what makes me feel good, if I can, someone that I know, we hang out, watch TV, just to lay in the bed together and talk. Nothing else going on, I'm happy with that. "

However, narratives suggest that in keeping with their description of having weak relationships with family, friends, and intimate sexual partners—as well as

challenging childhoods, which for some were characterized by physical, sexual and emotional abuse (as described in Chapter 4)—many participants in this study expressed difficulty trusting others or being emotionally vulnerable. One participant, Robert, recalled how the experience of informing family members of his childhood molestation was met with derision and contributed to his inability to trust others.

> "I saw the reaction I got when I said somebody was touching me, instead of being like who's touching my little brother, they were like you little faggot, and I was just like wow, these are really my relatives? Am I really a part of them? I can't trust nobody."

Difficulties trusting others led many participants to avoid entering close intimate partnerships and forming friendships. In fact, many participants echoed one man's characterization of close relationships as being "more trouble than it's worth." For example, one participant, Christian, reflected on the shallow nature of his past friendships with individuals with whom he had previously engaged in illicit activities. Following a period of incarceration, he recalled that when he declined requests to join his peers in illegal activities, they taunted him and questioned his loyalty to them. He concluded that it was best to avoid forming any close friendships.

> "I have no friends…[it's] too complicated. I've been screwed over a lot. The…friends that I had…it takes for you to get older to realize that they're not your friends, they're your boys…and you've known them for 10 years and if you don't want to do [something illegal] they start saying 'what are you, scared now?' I'd rather just be by myself."

Participants described a desire to avoid the perceived complications inherent to maintaining friendships, and made themselves unavailable to meeting new people by not "putting [themselves] out there." Wilson, a participant, who described a

particularly stressful place of employment described his avoidance of new relationships and preference for being alone as a way to manage his stress:

> "I watch DVDs at home, that relaxes me. I'm usually by myself because I don't know a lot of people… I think in a way it's better for me because it helps me calm down after work, being by myself. It gives me some peace."

Many participants in this sample shared the belief that allowing themselves to be emotionally vulnerable would inevitably result in being hurt by friends, partners, and family. Narratives also suggested that troubling lifetime experiences led participants to describe a lack of significant emotional connection with the people in their lives, which led participants to crave the emotional support and encouragement ostensibly found in close relationships. Paradoxically, expectations of being hurt by others, particularly by intimate partners, led to considerable difficulties trusting others and prevented respondents from being able to attain the type of emotional connection they desired. They described a cycle of isolation that made the attainment of the desired emotional connections problematic, and oftentimes, ultimately unachievable. For example, Dwight, a participant who had experienced many troubling life experiences including childhood sexual abuse and adulthood rape, reflected on his desire to be emotionally connected with a sexual partner and the personal obstacles preventing this from occurring:

> "Because when, having sex for me, it's always been, when I'm doing it, I always feel like I'm always observing it, not really, you know how people give themselves over to their passion, they're like having passion, you're like wow they really love each other, this is, I've never been able to just do that. I always try to think I'm doing it…but I know it's not real. And then I'm doing this because I'm scared, or I'm doing this because I'm angry, I've never had that connection. It's hard for me to connect. I'm just afraid to let anyone get too close, and I'm afraid to get too, I'm afraid to get too close to anybody."

Overall, narratives revealed tensions between participants' desire for emotional closeness and efforts to achieve this closeness. Participants acknowledged that while they wished to emotionally connect with others, their inability to trust others made it difficult, and impeded their ability to establish meaningful relationships.

6.8 HIV risk and protective behaviors

6.8a Limited support and sexual behaviors

Narratives suggested that sources of support are implicated in sexual risk behaviors. These findings support previous studies (described in the introduction of this chapter) and are able to nuance the current literature on social support and HIV risk in Black MSM populations. The quality of supportive relationships with friends and sexual partners emerged as a more important influence on participants' sexual health strategy than the effects of (non)supportive family relationships. Participants tended to describe their risk behaviors in terms of their strong or weak relationships with friends and ongoing casual or monogamous sexual partners. Indeed, in the absence of strong supportive family relationships, support from peers and partners may be of particular importance. Many participants perceived their primary sexual partner to be their only source of support, and attributed high risk behaviors to difficulties in this relationship. In keeping with the cycle of social and emotional isolation described earlier, respondents without primary partners believed that entering into an intimate sexual relationship would eventually conclude in the loss of the partner, either through the partner leaving them, or the death of the partner due to drugs, illness, or violence. The fear of emotional

connection may prevent men from entering into stable partnerships, and consequently may exacerbate the needs for emotional intimacy, ultimately leading men to have unprotected and anonymous sexual encounters to provide immediate yet temporary intimacy. One respondent, Nelson, recalled how his desire for a meaningful emotional relationship with a sexual partner led him to seek out an anonymous sexual partner:

> "I was lonely, horny. In my head I wanted a relationship. I wasn't looking for a relationship with this particular person. I felt lonely, not in a sad, depressed way, but I just wanted to be intimate with someone."

Other participants (Robert, Harold, and Martin, respectively) also showed that the loneliness and emotional disconnect they experienced served as an important driver to seek sex:

> "The loneliness, the loneliness, the being in a relationship with someone, a monogamous relationship, and then losing that person."

> "I was lonely. I felt betrayed. I needed a friend. Oh my god, I'm going to start crying…but at that time, [name deleted] was a perfect gentleman. He did everything that he said he was going to do for me, and he did it."

> "I was on my internet and there's a website called [website name for soliciting anonymous partners], and it's a gay male website. I just went on there 'cause I was lonely and hadn't had a relationship in a long time, and like I said, depressed. I don't know, I felt really mentally sick…so I went on this website and I met this guy and we got drunk and…"

Several participants also commented on the aftermath of a relationship break-up. Robert shared how the end of his relationship with his primary partner and only source of support left him yearning for physical contact and a desire to feel that

someone cared for him—a desire that the participant perceived to lead to his own unprotected sexual behaviors:

> "I was in such a, not negative place, but a hurt place and just something about having someone just touch you in that way is just very comforting."

Another respondent, Michael, described how the emotional pain resulting from the recent end of a long-term relationship led him to engage in unprotected sex with an anonymous partner:

> "I've fell in love, completely I believe it's the first time I ever fell in love, with this guy…but me and him ended up breaking up, and that was hurtful, it was crazy hurtful. I was like sobbing, crying, crazy, and I was at the time I started just wanting to feel something, because I just felt so numb from the crying and anger and pain, and I went online and met this guy and it was pretty much a hook up and we both didn't have condoms and I don't know why I did it, but I was like you know what, fuck it, I don't care, I trust you, just let's get this over with, and it was, it was sex, just to have sex, and actually no it wasn't sex just to have sex, it was sex to just to be human for five minutes."

Thus, a heightened need for physical contact and emotional intimacy frequently motivated high-risk sexual encounters. Respondents explained that they would often seek sexual partnerships in convenient and anonymous venues to satisfy immediate needs for intimacy. This often meant using online dating/sex websites, having casual sex partners, or patronizing bars, clubs, bathhouses, or street locations where partners could be easily found.

> John: I went on one of those dating websites, found someone that seemed alright, and messaged him.
>
> Interviewer: Was this the first time you had used the site?

John: Yeah

Interviewer: Why do you think you went on it?

John: I don't know… I guess, I don't know, I hadn't felt anything good for anyone in so long. I just wanted to feel something, feel someone, and this was wham bam. No questions asked, know what I mean? I don't have to take him out for a date and do all that. We both knew what [was up].

Participants with limited social support networks described having multiple concurrent sexual partners. Jamar, a participant who engaged in high risk behaviors described a connection between his approach to anonymous sexual encounters and a fear of interpersonal intimacy and anticipatory rejection:

"I'm in several relationships at all times. It's not a nice thing, it's just the way I protect myself because I feel like if I, I've tried being with just one person, and I always got devastated, so I just figured like if I see a few people, it's fine, as long as…if I don't really put any real, all love into it…I'll be safe like that."

Thus, participants' narratives revealed potential interconnections between the quality of personal relationships and their sexual risk behaviors. Specifically, participants who lacked socially and emotionally fulfilling relationships expressed feelings of depression, loneliness, isolation and an anticipation of future rejection, and these factors led them to satisfy their need for interpersonal connection through sexual intercourse, which often took the form of unprotected high-risk sex with anonymous partners. This occurred despite participants having knowledge of the risk for HIV and STD transmission, often as a result of prioritizing their need for sexual and emotional intimacy above sexual safety. Often these unprotected sexual episodes occurred while under the influence of alcohol or drugs, particularly cocaine and inhalant nitrites (i.e. "poppers"), which participants described using to

feel more sexually uninhibited and to enhance sexual performance. For instance, one participant, Michael, shared:

> "I just needed sex, so in order to allow myself to have sex with this person was to drink…I didn't even know how old he really was. I just wanted to be penetrated."

Robert, another participant with an extremely limited support network described how inhaling poppers led him to knowingly and repeatedly engage in high risk behaviors.

> "[I met him] at a park, a year ago. He had performed oral sex on me. So I was in my apartment, I call him, he comes over, so then a couple weeks ago we ended up getting into anal, he wanted me to penetrate, and I just did it, and he said it's not safe, we gotta use a condom, and we both agreed, but then we were sniffing this thing, poppers. Yeah, I gotta get away from that, because all my inhibitions just go. All my fear about HIV, it all goes when I sniff it. When I'm with him it's like I don't care, and this other guy brings poppers and it's like I'm not thinking clearly when I'm doing it…I gotta go get tested soon."

In contrast, few participants with strong social support networks described using alcohol and/or drugs during unprotected sexual encounters; of those who did, the substances of choice were mostly alcohol and marijuana. Overall, participants' perceptions of limited support and the resulting psychological vulnerability they experienced may have functioned interactively to lead participants to engage in high risk sexual behaviors.

6.8b Positive support and sexual behaviors

Notably, the presence of strong peer and partner support networks did not completely buffer men in this study from engaging in unprotected sex. However, narratives suggested that the more fine-tuned characteristics of sexual risk behaviors differed between participants with strong and weak social support networks, with respect to partner-seeking venues, types of sexual partners, positive self-identity, and the use of alcohol or drugs. In particular, participants with stronger support networks more frequently described unprotected sexual episodes occurring in the context of established partnerships—i.e. with partners they had dated previously, with boyfriends, etc. They also frequently described partner-selection strategies centered on participants' friendship networks, at house parties, or through virtual media, including social networking websites, such as Facebook, and internet dating services where they could establish deeper relationships. There were fewer reports of meeting partners at bars, nightclubs, or online 'hook-up' websites, as well as strong views disfavoring these venue-based selection strategies. These ways of meeting partners provided greater opportunities to screen potential sex partners. For instance, one participant, Xavier, reasoned that he would not engage in unprotected or protected sexual intercourse with a partner met at a nightclub, bar or similar venue because it did not allow enough time to become familiar with the person:

> "I feel like if I want to have that special bond with someone, I have to get to know them before I give them (sex)….that something sacred to me, you don't just give it up."

Thus, participants with strong support systems shared beliefs that sex should occur within the context of prolonged familiarity with a potential partner, or as part of an established relationship. Participants with weaker support systems did not share similar beliefs, and described meeting sexual partners at clandestine spaces, such as bars, nightclubs, video arcades, bookstores, and bathhouses, as well internet sex websites used for finding immediate and anonymous sexual partners. These potential differences in partner selection opportunities and venues may contribute

to differences in sexual risk behaviors. For example, more prolonged in-person or online conversations may allow for greater communication between prospective partners regarding relationship potential, HIV risk and condom use, whereas individuals meeting at anonymous sex websites, bathhouses or bars/nightclubs may be more prone to immediate and higher risk behaviors, i.e. may be less likely to discuss condom use and more likely to be intoxicated. However, it is important to note that these differences in partner selection were not always consistent with quality of social support. For instance, some participants with stronger support systems did not share beliefs that sex should occur within the context of an established relationship, while some participants with weaker social support networks did not describe meeting sexual partners at venues associated with anonymous partners.

Narratives also suggested that participants with strong, supportive peer friendships perceived their social network to be supportive of their gay identity and same-sex behaviors. This may have led to greater self-acceptance of participants' own same-sex behaviors, which may have resulted in lower risk behaviors. These participants reported a reduced need to be overly secretive of their same-sex behaviors. Studies have shown that internalized homophobia and not having a gay-identity are associated with increased HIV risk behaviors (Lye Chng & Géliga-Vargas 2000, Ramirez-Valles 2002, Waldo et al. 1998). In keeping with this, these participants perceived their sexual networks to include other like-minded gay men*;* that is, a larger pool of 'suitable' sexual partners to choose from, those who practiced lower-risk behaviors and shared similar attitudes toward sexual health. One participant, Lawrence, shared:

> "I mean, most of my friends, the people I chill with, are into safe sex. I mean, we don't really talk about it, I guess its kind of what everyone just does, like no one goes around sleeping with [a lot of] dudes [unprotected]. That's just crazy."

Another participant shared that his sexual network consisted of other men with similar approaches to sexual safety, so "even though [they] didn't talk about condoms, everyone always [took] care of themselves…and [were] smart" about engaging in low HIV risk behaviors. Thus, engaging in sex with partners sharing similar attitudes towards safe sex may have reduced opportunities to engage in high risk sexual behaviors, and fostered norms that encouraged lower risk behaviors.

Overall, participants with limited social support networks described patterns of multiple, concurrent sexual episodes, with mostly anonymous and casual on-going sex partners. Participants who perceived strong social support networks described patterns of consecutive, monogamous sexual relationships. However, participants with strong support networks, as well as those with weak social support networks described participating in unprotected sex.

6.9 Discussion

This chapter explored the social support systems available to participants and examined how levels of social and emotional support are implicated in their sexual risk behaviors. The majority of participants in this sample revealed emotional and psychosocial vulnerability due to limited family and peer support networks. Participants described lives lacking in strong emotional connections and encouragement, with a few participants sharing positive narratives of strong emotional support from family relationships and close friendships. The dominant narrative theme identified in this analysis suggests that lack of emotional support and meaningful personal relationships were linked with sexual risk behaviors. Specifically, it was observed that a) participants who perceived weak social and emotional support described high risk behaviors, prioritizing immediate sexual

gratification over sexual safety; b) participants who perceived stronger social support systems found sex partners through their social networks and in venues geared toward establishing longer relationships, whereas participants who described having weaker emotional support typically found sex partners through anonymous venues that catered to finding no-strings-attached partners.

Notably, participants lacking the social and emotional support provided through close family and peer relationships described intense feelings of loneliness and depression, and shared a desire to be emotionally connected to others. However, the poor emotional wellbeing cultivated over the course of their lives may have led many participants to have extraordinary difficulties trusting others, and contributed to expectations of being hurt by peers, friends, and sex partners. Consequently, participants appeared to have developed strategies to prevent themselves from being hurt by others, while still fulfilling their need for physical intimacy. These strategies included forming few friendships and avoiding meaningful, emotionally intimate sexual partnerships. Paradoxically, these "emotionally protective" strategies can increase risk for HIV and STIs, and can further exacerbate feelings of isolation by obstructing opportunities for deeper levels of intimacy.

The findings have important implications for current and future HIV prevention strategies. Many researchers have criticized studies in the HIV prevention literature that measure individual-level risk behaviors in Black MSM but which do not include sociocultural and psychosocial factors (Malebranche 2003, Mays et al. 2004, Millett et al. 2006). This study's findings support this argument, indicating that stronger consideration of the holistic wellbeing and sources of family/social support available to Black MSM is needed in HIV prevention literature. Specifically, HIV prevention strategies for Black MSM must better address emotional health and expectations about intimate relationships in order to understand the motivations and contexts for men's sexual behaviors. Moreover, the limited social support participants described in this chapter must be considered as existing along a continuum, and not unique to their adult lives. Rather, within the context of

childhood experiences characterized by challenging family relationships, poverty and abuse (as described in previous chapters) which led many participants to feel uncared for and unloved, the significance of positive, consistent support over the course of one's life becomes evident. Social support may allow Black MSM to address earlier childhood adversity, and cope with the stresses of their present day lives, and in doing so reduce the associated high risk sexual behaviors. However, to date, much of the research on HIV within the Black MSM community has been epidemiological in nature; a stronger consideration of the emotional wellbeing and sources of family/social support available to Black MSM is needed. Diaz's work on Latino MSM reveals that psychological symptoms of distress are more prevalent among those who are socially isolated and have low sense of self worth (2001). Studies have also shown the significance of social support for HIV prevention in Black men (Brotman et al. 2002, Elizur & Mintzer 2001). Research on African American's friendship networks reveal that when emotionally substantial relationships are lacking, individuals report higher levels of depression and low self-esteem, and this may influence HIV risk taking behaviors (Mays et al. 2000). This suggests that HIV prevention strategies must address the limited social support networks, as well as the social alienation that men like those included in this study experience. Poor emotional wellbeing can lead to problems with self regulation and increase self-defeating behaviors, which in turn, can increase the possibility of participating in HIV risk behaviors such as unprotected sexual intercourse, having multiple partners, and substance use (Cole et al. 1996a, Cole et al. 1996b, Twenge et al. 2002). Kimberly and Serovich's (1999) study of the social supports and risk-taking behaviors of HIV positive gay men determined that the more supportive men perceived their family members to be, the lower their intentions were to engage in sexual risk behaviors, and sources of support from family members were more predictive of reduced risk behaviors than sources of support from friends. It is important to note that much of the research investigating the influence of family/support networks on HIV risk taking behaviors has not focused specifically on Black MSM; rather, these studies have mostly focused on HIV-positive mixed-race populations (with the majority of participants usually being Caucasian), and Black

women. Future research will need to specifically explore the role of family and social support networks on the risk taking behaviors of HIV-negative and positive Black MSM.

More generally, this sample of Black MSM displayed a high degree of critical consciousness about the linkages between family background, social contextual factors, and sexual risk behavior. Men were open to disclosing their personal issues and were clear in their descriptions about feelings of vulnerability, family dynamics, and expectations about the future. This indicates a possible promising opportunity for counseling interventions with Black MSM aiming to address deep-seated psychosocial factors associated with HIV risk. The inclusion of culturally sensitive psychological counseling may enhance public health strategies aiming to reduce the incidence of HIV/AIDS in Black MSM.

In addition to the methodological limitations listed in Chapter 3, several limitations specific to this chapter must be considered. First, this analysis of social support, loneliness, and interpersonal networks relied on men's subjective narratives; I was not able to assess these as quantitative variables and, consequently, was unable to draw quantitative conclusions about these associations. Second, this qualitative analysis might be affected by recall or self-presentational demands. Third, the interview protocol may have bias study participants to share mostly negative narratives; however, all efforts were made to avoid doing this and it is meaningful to note that some participants were more likely to report positive or optimistic narratives. Fourth, findings must also be interpreted with caution due to limitations in generalizability and the non-representative nature of the sample. Finally, as outlined by the Syndemic Theory and the Socio-epidemiological Model, the influence of support systems on risky sexual behaviors is likely to interact with other factors in the lives of participants. Consequently, the conclusions in this chapter must be considered within the context of multiple individual- and social-level factors that are implicated in the sexual behaviors of Black MSM. Despite these limitations, the chapter findings are important and enhance understandings of how complexities of

participants' social support networks might affect their decisions to engage in risky or protective sexual behaviors.

In conclusion, the dominant models of HIV risk and prevention may not appreciate the significance of social support—among other factors suggested in Chapters 4 and 5—in influencing HIV risk behaviors of Black MSM. The need for holistic, integrated approaches to HIV risk is critical to addressing the burden of HIV infection in this population. The next chapter will summarize and critically analyze current effective HIV prevention interventions for Black MSM, highlight limitations and gaps in the current research, and suggest recommendations for future HIV prevention research and interventions.

CHAPTER 7: DISCUSSION AND CONCLUSIONS

7.1 Summary and interpretation of key study findings

This qualitative study examined the social context of HIV risk in the lives of Black MSM. It extends knowledge on the current qualitative and quantitative literature on the nature of risk behaviors in this population at high risk for HIV infection, and provided valuable insight into the factors that Black men perceive to drive their own unprotected and protected sexual behaviors. While findings corresponded with aspects of the major theoretical frameworks described in Chapter 2, specifically, the Socio-epidemiological Model, Syndemic Theory, and the life course approach, it also suggested that no single theory can explain risk behaviors—rather, a combination of these theories must be used to understand Black MSM's risk. In summary:

1) Narratives suggest that a range of structural and environmental characteristics, including interpersonal, internal/psychological, and episodic factors contributed to respondents' participation in high risk behaviors. Interpersonal factors included imbalanced power dynamics that do not allow for condom negotiation with partners, and trust within the context of ostensibly committed and monogamous relationships leading to unprotected behaviors. Internal/psychological factors included apathetic or passive attitudes toward condom use, and poor emotional health as a result of difficult personal relationships or challenging life circumstances leading men to participate in potentially self-harming behaviors or not prioritize sexual safety. Episodic factors included participants becoming caught up in "the heat of the moment," as well as a reliance on visual and behavioral cues to determine suitability of having unprotected sex with a prospective partner. These findings support the multi-level and mutually reinforcing nature of HIV risk as suggested by the Socio-epidemiological Theory and Syndemic Theory.
2) Narratives suggest the impact of cumulative trajectories on risk behaviors, as supported by the life course approach. Participants' recollected childhood experiences—particularly socioeconomic status, family characteristics, and abuse—may have influenced adult sexual behaviors. Long lasting effects of adverse childhood experiences may have impacted participants' self-esteem, self-efficacy, coping skills, social networks, emotional health, and life prospects, in turn impacting individual sexual health strategies.
3) Participants perceived limited social support networks and few close personal relationships. This led participants to describe feelings of loneliness and to desire emotional connections; however, difficulties trusting others made these connections unattainable. Narratives suggested that participants with little social support described higher risk sexual behaviors (e.g. concurrent sexual episodes with mostly anonymous and casual on-going sex partners), and participants with stronger social support described lower risk sexual behaviors (e.g. unprotected sex within 'monogamous' sexual relationships). Narratives suggested that social support across participants' life time had pervasive effects on many aspects of their lives (e.g. social/emotional, relationships, etc.), which in turn impacted their sexual risk

behaviors. This supports the Socio-epidemiological theory and life course approach to understanding HIV risk behaviors in Black MSM, and highlights the need for future prevention efforts to address social support needs.

4) An emergent narrative theme centered on participants' various coping strategies for stress related to the experience of being Black and MSM. Some participants described negative coping strategies that included engaging in high risk sexual behaviors or activities that had the potential to lead to high risk behaviors (e.g. alcohol or drug use). This was often accompanied with decision-making processes focused on immediate outcomes and the near future. Other participants described coping strategies or "ways of living" centered on activities unlikely to result in high risk behaviors (e.g. exercise or spending time with friends), with decision-making processes focused on long-term outcomes and future consequences. Participants with negative coping strategies also described "giving-in" to their sexual desires despite have knowledge of the associated health risks. Narratives of participants with positive coping strategies suggested that they were more deliberate in their actions and behaviors. Prevention strategies will need to shift poor coping strategies away from risk taking behaviors toward health promotion activities.

These four narrative themes suggest that the multiple socioeconomic, cultural, and personal factors driving HIV risk among Black MSM are interactive, reinforce one another, and are implicated in many aspects of participants' lives. As major narrative themes suggest, for participants in this sample, HIV risk is best understood from a syndemic and life course perspective, in which experiences and challenges across participants' lives interacted to guide protected or unprotected sexual behaviors. The Socio-epidemiological model that theorizes HIV risk as existing at the individual, social, and structural levels, supports these findings.

7.2 Theoretical implications of study findings

As suggested by this study's findings, traditional theories of health behavior change commonly used in HIV prevention models do not adequately capture the dynamic and holistic factors driving HIV risk in this population of Black MSM. To varying extents—these models [Theory of Reasoned Action (Fishbein & Ajzen 1975), Health Belief Model (Janz & Becker 1984), Social-Cognitive Model (Bandura 1994), and AIDS Risk Reduction Model (Catania et al. 1990)]—do not recognize the ongoing effects of life experiences, family and peer relationships, and social support on men's sexual risk behaviors or self-efficacy for engaging in protected sexual behaviors. By contrast, several other contextual theories are better suited for understanding HIV risk among Black MSM, including the Socio-epidemiological Model and the Syndemic Production of Disease. These theories incorporate the individual-, community-, cultural-, and structural-level drivers of HIV risk. Minority stress emphasizes that the stresses associated with occupying a dual-minority status, such as stigma, discrimination, and internalized homophobia, may lead to HIV risk behaviors. Some participants' narratives supported these processes through which minority stress is considered to function through. Indeed, narratives suggested that the stigma, discrimination, and harassment experienced by participants created psychological barriers to using condoms.

In the face of extraordinary challenges to addressing some of the cultural and structural drivers of HIV risk, a greater theoretical focus on the resiliency factors and coping techniques of Black MSM may be a pragmatic approach to HIV risk reduction. For instance, while intervening in the poor socioeconomic status of Blacks or homophobia within the Black community may be difficult (Adimora & Auerbach 2010), renewed emphasis on understanding and improving the resiliency and coping mechanisms men use to address the adversity in their lives may be a more feasible way forward. As described in Chapter 2, resilience refers to the process of overcoming risk as evidenced by healthy development, through the avoidance of negative outcomes (e.g. HIV infection) or positive adjustment to adverse experiences (Fergus & Zimmerman 2005). Studies have suggested that resiliency-based theories will be most successful when focused on the development

of resources for those at risk, rather than risk reduction *per se* (Cauce et al. 2003, Luthar & Cicchetti 2000, Yates et al. 2003). As suggested by this study, the lives of many Black MSM are characterized by adverse life challenges that may interfere with emotional, mental or physical health. Understanding how individuals are able to not only positively cope, but thrive under these circumstances may be critical to reducing men's participation in high risk behaviors (Mutanski et al. 2007). Participants' narratives suggested several potentially integral components to future theories of resiliency for Black MSM. It is important to acknowledge that implementing these suggestions presents a formidable challenge to the intervention community. These suggestions include:

1. *Understand men's experiences*. For reasons described throughout this thesis, using both qualitative and quantitative techniques to understand the life experiences of Black MSM will be necessary to fully capturing its effects on men's HIV risk behaviors. Men's experiences are diverse and change over the course of their lives, therefore incorporating their voices into these theories are critical to the development of effective interventions targeted to this population. Moreover, understanding men's experiences will allow for a richer comparison between the experiences that lead to high versus low risk behaviors.

2. *Understand the effects of these experiences on men's psychological and emotional health*. Narratives suggested that positive and adverse childhood and adult experiences impacted participants' mental health and lead to feelings of loneliness, isolation, and inadequacy. Consequently, any model of resiliency should aim to appreciate the impact of these experiences on men's mental and emotional health. They should also explore whether it is in fact possible to reduce adverse impacts of such experiences and/or prevent such experiences in future underserved populations.

3. *Identify vulnerabilities that impact sexual risk behaviors*. Poor emotional or mental health may facilitate poor sexual behavior decision making processes. Resiliency

frameworks should seek to identify and address the ways in which poor or strong mental and emotional health may lead to high or low risk behaviors. Moreover, studies of coping and resiliency should explore other potential vulnerabilities that may impact men's approach to sexual health and safety, sexual partner dynamics, self-efficacy, and ultimately sexual risk behaviors. This may include potentially modifiable factors, such as expectations from relationships or poor HIV knowledge or misconceptions.

4. *Identify potential resiliency factors and create opportunities for the promotion of these coping techniques.* For example, in this study several participants described particularly important personal relationships or hobbies that they perceived to help them cope with the adversity of their childhood. Therefore, creating a framework that allows for the identification of a range of potential resiliency factors or coping techniques that men may call upon when dealing with stress or adversity may help reduce participation in future risk-taking behaviors. For example, this may include identifying, improving or encouraging specific skills, characteristics, or beliefs, such as problem solving skills, seeking help when necessary, and identifying potential sources of social support. Resiliency frameworks should also aim to identify and tailor coping techniques to best suit the individual (i.e. is a particular individual more suited to an individual, partner, group, or community-level approach to developing resiliency and coping) at different stages of their life, since coping needs may change over the course of an individual's life, such that the techniques used in childhood may differ than those used in adulthood.

5. *Ongoing support for the maintenance and continued development of these resiliency factors*. This actionable component of a resiliency model is important for the development of potential future interventions. Though it may change in nature, stress and challenging life experiences are present throughout the course of one's life, therefore, ongoing support for the continued maintenance or support of these skills or activities is important. These services should be low-cost, readily accessible, and easily manageable, so as to not deter Black MSM.

7.3 Current effective evidence-based interventions

In 1996, the Prevention Research Branch of the Division of HIV/AIDS Prevention at the Center for Disease Control and Prevention launched the HIV/AIDS Prevention Research Synthesis (PRS) Project to systematically review and summarize the HIV behavioral prevention research literature. The most recently updated (August 2011) version of the *2009 Compendium of Evidence-based HIV Prevention Intervention* (published by the PRS) identified one best-evidence intervention (Many Men, Many Voices) for reducing HIV risk behaviors in Black MSM (Wilton et al. 2009). This intervention has been identified by the PRS through a series of efficacy reviews, and represents the strongest HIV behavioral intervention in the literature to date that has been rigorously evaluated and has demonstrated efficacy in reducing HIV incidence or HIV-related risk behaviors, and/or promoting safer behaviors. Two additional randomized control trails (Jones et al. 2008, Peterson et al. 1996)—that did not meet the PRS' methodological criteria for inclusion—have also been identified as reducing HIV risk behaviors among the same population.

Many Men, Many Voices (3MV) was an integrated group-level HIV intervention carried out in New York City between 2005 and 2006 in a sample of 338 Black MSM, and aimed to 1) reduce insertive and receptive unprotected anal intercourse; 2) reduce number of sexual partners; 3) increase consistent condom use during anal intercourse; and 4) increase testing for HIV and other STDs. The intervention aimed to incorporate behavioral and social determinants of risk and protective behaviors including cultural, social, and religious norms; Black MSM identity and degree of connectedness to the Black and gay communities; HIV/STD interactions; sexual relationship dynamics; and the social influences of racism and homophobia. The intervention was delivered through 6 consecutive 2 to 3 hour sessions over the course of a 2.5 day weekend retreat, and did not prioritize a singular emphasis on condoms use, instead opting to utilize a 'menu of behavior change options' for HIV

prevention. The first session helped participants recognize the linkages between racism/homophobia and HIV risk behaviors. The second session explained the sexual relationship dynamics of being the insertive or receptive partner and the associated HIV/STD risks. The third session sought to personalize participants' own risk by building a menu of behavioral options (e.g. abstinence, mutual monogamy between 2 HIV-negative partners, consistent condom use) in order to reduce HIV transmission risk. The fourth session enhanced participants' intentions to change their own high risk behaviors and guided them toward protective sexual behaviors. The fifth session encouraged participants to choose and implement a relationship-focused risk reduction behavior change option with their partner(s). The final session employed role-playing communication and negotiation strategies, and provided peer support to promote problem solving and identified effective risk-reduction strategies if relapse should occur. Wilton et al. (2009) reported that at the 3 month followup, participants had significantly fewer main or casual sex partners (25%), and at 6 month followup fewer episodes of any UAI (66%) and insertive UAI (51%) with casual partners but not main partners. However, these results should be considered within the context of several limitations. 3MV was unable to show a statistically significant protective effect on UAI and condom use outcomes in participants with primary sexual partners, which may have resulted from an underpowered sample of participants (one-third of overall sample) with long-term primary partners. In addition, this intervention struggled with implementation difficulties. For instance, in addition to the 2.5 day intervention delivery described in the study, the authors suggest that the intervention could also be delivered over the course of 6 weekly sessions; however, the efficacy of this mode of delivery has not been tested. Moreover, a weekend retreat may be cost prohibitive.

One intervention that did not meet the PRS' methodological criteria but did show effects on reducing risk behavior was Defend Yourself (*d-up!*). Based on previous popular opinion leader studies (Kelly et al. 1991, Kelly et al. 1992, Kelly et al. 1997, Miller et al. 1998, Sikkema et al. 2000, Somerville et al. 2006), this community-level intervention sought to use existing social networks of Black MSM to shift social

norms toward increased condom use and improved sense of self-worth in a sample of approximately 300 men (sample size varied across different study phases) (Jones et al. 2008). *d-up!* used popular opinion leaders from within these social networks, who were respected and trusted by fellow network members, to encourage consistent condom use and increase self-worth, pride, and confidence as black men who have sex with men. This was achieved through casual one-on-one conversations with their friends and acquaintances. In general, *d-up!* aimed to create an environment in which Black MSM felt comfortable making the decision to practice safer sex. The authors outlined 10 core elements of the intervention. The first and second core elements involved identifying a high-risk population in well-defined community venues, and using key informants and systematic observation to identify the target population's social networks, and identify the most respected, credible and trustworthy people in each network. The third and fourth core elements detailed the recruitment and training of these respected social network members into opinion leaders, and to educate these leaders on the relationship between negative social and cultural factors and sexual risk behaviors, in order to promote positive self-worth in their social networks and to teach social network members how to address biases in their conversations with sexual partners. The fifth and sixth core elements trained opinion leaders to introduce risk reduction and protective sexual behavior messages into everyday conversations with friends and acquaintances. It also provided training on the specific elements of effective behavior change messages that target attitudes, social norms, intentions to change behavior, and self-efficacy related to HIV risk, as well as offer practical steps to begin practicing protective sexual behaviors. The seventh core element involved ongoing, weekly training sessions for opinion leaders to help improve their skills and build confidence in delivering effective HIV prevention messages to others. The final core element had opinion leaders set goals to hold risk-reduction conversations between weekly intervention sessions with high-risk friends and acquaintances, review and discuss outcomes of these conversations at later training sessions, and use logos, symbols, or other appropriate conversation starters between opinion leaders and other members of their social networks.

The authors reported significant reductions in receptive UAI at 4 months (23.8%) and 8 months (24.7%) following intervention, and in insertive and receptive UAI at 12 months (35.2% and 44.1%, respectively). In addition, at 12 month followup, mean number of partners for receptive or insertive UAI decreased by 40.5% and 53.0%, respectively. However, several important limitations restrict the applicability of these findings. First, this intervention did not include a control group to which the intervention could be compared, and instead made comparisons to participants' baseline behaviors. Consequently, it is possible that the changes in risk behaviors may have occurred even in the absence of the intervention. Second, the sample population included men aged 18 to 30, thus limiting the generalizability of results to those under 18yrs of age—the risk group experiencing the highest HIV incidence (CDC 2012)—and Black MSM aged above 30 years. Moreover, results cannot be generalized to settings with abundant HIV prevention messages and resources. This study also utilized convenience samples recruited from venues (e.g. nightclubs) at which individuals may be more likely to engage in high risk sex, and may have ultimately recruited a sample overrepresented by high-risk Black MSM. For instance, Black MSM that do not patronize nightclubs may have been underrepresented in this sample.

An early RCT that showed efficacy but was not classified as a best evidence intervention by the CDC was Peterson et al.'s (1996) intervention aimed at reducing high-risk sexual behaviors among Black MSM. The intervention consisted of either 1 or 3-session small groups. Both intervention groups delivered similar types of activities/messages, except that one was completed in one session, while the other was completed over the course of 3 sessions. These sessions consisted of four main components. 1) Self-identity and development of social support: facilitators reinforced participants' self-identity as dual minority individuals, and promoted self-pride in this status, and described the possible consequences of poor self-identity on sexual risk behaviors. 2) AIDS risk education: respondents participated in awareness building activities to increase knowledge of HIV risk behaviors,

including the transmission routes and importance of HIV testing, as well as had any questions answered. 3) Assertiveness training: participants were trained to be assertive in the negotiation of condom use and other low-risk sexual behaviors, or refusal of high-risk activities within new and established sexual partnerships. 4) Behavioral commitment: to strengthen commitment to risk reduction, participants shared strategies they used to reduce their own risk behaviors and were encouraged to make a verbal commitment before the group to change their risk behaviors. Authors reported that participants in the 3-session group had reduced UAI at 12 and 18 months following the intervention. The single session group experienced a slight decrease in UAI at 12 and 18 months, but the change was not significant. However, a high attrition rate at the 12 and 18 month followup makes interpretations of these results difficult. Authors reported that one-third of participants did not attend 12 and 18 month follow-up appointments. Moreover, a "sizeable" number of participants did not attend all sessions of the 3-session intervention. A high attrition rate affects the ability to accurately assess intervention effects and detect differences across intervention conditions (Fowler 2009). Study authors were also unable to eliminate group differences at baseline due to failure of the randomization procedure that resulted in imbalanced number of participants in different intervention conditions. Differences in groups characteristics at baseline may have also occurred as a result of multiple recruitment strategies, the focus of which differed across time and locations.

To date, only 3MV has been classified as a best-evidence intervention for reducing HIV risk behaviors in Black MSM. Methodological difficulties in Jones et al.'s (2008) and Peterson et al's (1996) interventions—specifically, lack of a control group and a high attrition rate, respectively—make the intervention results promising, but not definitive. All three interventions addressed the influence of racial bias and views of homosexuality in the Black community on participants' HIV risk behaviors. Moreover, all interventions included a component focused on participants' intention to change their high risk behaviors and increase low risk behaviors, and encouraged participants to make behavioral commitments to change their behaviors.

Interestingly, only 3MV sought to personalize participants' HIV risk, through the development of a menu of behavior options, in which participants' were encouraged to select realistic pathways to lower their own risk behaviors (e.g. monogamous relationships or consistent condom use). For instance, a participant who enjoys sex with many sexual partners may not view mutual monogamy as a realistic or viable option, but may find consistent condom use among his multiple sexual partners as reasonable. Indeed, these menu of behavior options varied across participants, highlighting the importance of allowing men's beliefs and perceptions to be heard and incorporated into interventions targeted to them. This may increase participants' self-efficacy for engaging in lower-risk behaviors, and ultimately reduce HIV risk behaviors.

7.4 Potential implications for future HIV intervention approaches

This study has been able to give voice to a population of men not often heard, and as a result, gained important insight into the factors men perceive to influence their own risk behaviors. Our findings suggest that several important factors have not been given the prominence they deserve in the HIV prevention literature. The psychological vulnerabilities that some men face as a result of limited social support and adverse childhood experiences, as well as personal expectations and outlooks for the future, and the priority placed on sexual safety emerged as clear trends in participants' high risk behaviors, and indicates important steps toward a refreshed approach to HIV prevention interventions. While the interventions described above, offered, to varying degrees, integrated approaches to HIV prevention, our study findings suggest that prevention scientists will need to strengthen this integrated approach and offer more fully holistic interventions that address the major factors men perceive to influence their risk behaviors. The application of a life course

approach may offer new pathways to reducing risk behaviors. This study is among the first qualitative studies to use the life course perspective to specifically examine *Black MSM*'s sexual behaviors. While other studies have used the life course perspective to mostly study suicide risk, delinquency and recidivism, anti-social behavior, and health behaviors in general (as described in Chapter 2), this study extends that field of knowledge to consider men's sexual behaviors, factoring in the unique sociocultural context in which these behaviors are borne. Our findings suggest that an individual's risk for participating in high risk behaviors cannot be divorced from experiences across the course of their lives. A greater understanding of these lifetime experiences, may improve future intervention design.

Interventions that address psychosocial, emotional, and interpersonal factors in addition to individual-level sexual behaviors may be more likely to bolster preventative effects for Black MSM. For example, the Bruthas Project, an intervention to reduce sexual risk behavior in Black men through four intensive counseling sessions, demonstrated reduced participation in sexual risk behavior and fewer overall sexual partners, as well as increased sense of social support and self-esteem, and less loneliness (Operario et al. 2010). Findings also highlighted a need for programs that can address challenges in forming intimate relationships and maintaining satisfying partnerships. These findings call for more complex programmatic approaches to HIV prevention that go beyond condom usage, safer sex information, and HIV testing. Indeed, the majority of validated HIV prevention interventions are brief in duration and generally focus on the individual alone rather than on the social, psychological, and interpersonal context of that individual's risk behaviors. However, it is acknowledged that community-based organizations and HIV prevention providers are limited in their capacity to provide more in-depth psychological counseling to high-risk MSM clients, due to staffing, resources, time, and funding constraints. Establishing linkages between HIV prevention educators, HIV/STD testing services, clinical treatment and care providers, and culturally sensitive psychological counseling may offer a useful

'bundle' of complementary yet necessary strategies for reducing the burden of HIV infections in Black MSM.

Complex pathways to risk suggest complex interventions. Adapting previous interventions that were targeted to non-Black MSM populations may be insufficient. A clear approach, focused on targeting risk factors affecting Black MSM will require prevention researchers to go beyond traditional approaches to HIV risk, and incorporate components directly applicable to men's experiences. For instance, this may include addressing the socioeconomic conditions of Black MSM (e.g. improve literacy among poor Black MSM or increase access to job skills training), *as well as* the cultural view of homosexuality (e.g. greater tolerance and discussion of same sex behaviors within the Black Church), *as well as* acknowledging and addressing Black MSM's mental health and emotional problems that can lead to high risk behaviors (e.g. depression and feelings of loneliness as a result of adverse lifetime experiences). These suggestions have been made before (Adimora & Auerbach 2010, Saleh & Operario 2009), but it is the integrated use of these approaches that are necessary as HIV intervention research moves forward. This study's findings suggested a particularly important need for future interventions to use a socio-epidemiological and syndemic approach for understanding and addressing the psychological effects of participants' adult and childhood experiences, as well as its effects on later sexual risk behaviors. These need not be directly related to HIV, but perhaps more importantly address the social conditions leading to increased risk of participating in high risk behaviors. As suggested by Bronfenbrenner's ecological perspective, mitigating risk in some domains may occur by buffering others in the systems of interaction that make up an individuals' world (1979, 2005). For instance, this may necessitate partnerships between multiple agencies responsible for child and adult welfare. Ensuring positive and nurturing childhood experiences free from maltreatment cannot be divorced from programs focused on improving adult mental health, which in turn cannot be divorced from HIV prevention interventions targeted to Black MSM. Just as interrelated as the risk factors

informing individuals' sexual behaviors are, so must HIV prevention approaches be in order to effectively address those factors.

Indeed, our findings suggest that future HIV interventions may need to target high risk populations at younger ages—not only young Black MSM, but more broadly those raised in poor socioeconomic circumstances and/or experiencing challenging family life or abuse—and may benefit from fostering close relationships between adolescents and responsible members of their community, as well as increasing access to group-level resources, in general. Since interventions targeting the larger socioeconomic and structural forces that drive participants' adverse childhood experiences are more costly, face political and economic obstacles, as well as lengthy to implement and effect change (Adimora & Auerbach 2010), interventions focused on improving community level resources may provide an alternative, and more timely effect on HIV risk behaviors. These intervention approaches may ameliorate the impact of adverse childhood experiences on mental health, self-efficacy for condom use, and decision-making processes regarding sexual safety and partner selection strategies, as well as allow participants to develop and maintain healthy relationships. Previous community-level interventions with mixed populations have shown success in reducing HIV risk behaviors and attitudes (CDC 1999, Kegeles et al. 1996, Kelly et al. 1997, Sikkema et al. 2000, Sikkema et al. 2005). Such interventions may not only curtail HIV risk taking behaviors among sexually-active adolescents, but may also interrupt the processes that lead participants with challenging childhoods to engage in high risk sexual behaviors as adults.

A recent qualitative study asked Black and Latino MSM to suggest future intervention approaches and characteristics for reducing HIV risk in similar populations of MSM (Rhodes et al. 2011). It is noteworthy that despite the direction of recent research on the multi-faceted nature of factors driving HIV risk, many of these 'common-sense' suggestions—that were also echoed by participants in our study—are not common practice. Participants called for the use of mentors and role models to spread HIV prevention and risk reduction messages, as well as help

change the image of Black MSM in the community. Indeed, in our study, participants articulated beliefs that within the Black community, men who have sex with men are disparaged and considered an affront to Black masculinity. Participants also shared that interventions should build on men's informal social networks and encourage "community building," with members of a social network helping one another become more knowledgeable about HIV/AIDS, risk and protective behaviors, and gaining access to community resources. Some participants in our study described social network norms of risky sexual behaviors; future interventions can focus on changing these norms toward promoting lower risk behaviors.

Participants described the importance of identifying men with the potential to be trained to disseminate these risk reduction messages, and provide advice about sensitive topics while maintaining discretion. These leaders should fill knowledge gaps and correct misconceptions. For instance, in our study, some participants used visual and behavioral cues to make potentially inaccurate assessments about partner's sexual risk. Addressing these types of misconceptions are important. These individuals should also provide practical guidance on how to access resources, such as HIV/STD testing and free condoms. Several participants in our study shared that while they would like to be tested more often but did not know of readily available discreet testing facilities.

Participants also identified the need for safe spaces for facilitated supportive men's group dialogue around issues of masculinity, family, religious and societal expectations, as well as intimacy among men. Our findings suggested that many men believed that they were unable to discuss their sexuality with family members, or sometimes within their close friendships. Even in cases where participants perceived positive family support (or more accurately, the absence of explicit gay-related harassment and disapproval), it was often the result of not discussing or being overtly obvious about their sexuality (e.g. by not bringing boyfriends to the family home). Thus, interventions that allow for an open and safe space to discuss these issues are necessary.

Interventions should also provide practical guidance on managing triggers and coping, such as equipping participants with the tools to avoiding certain bars or video arcades that have previously resulted in high risk behaviors, or helping men determine the best placement of condoms in their home. However, this may not always be successful, our findings have suggested that even when condoms were readily available (e.g. in pant pocket), they may not be used. Therefore, interventions that provide participants with multiple potential pathways to safer sexual behaviors (e.g. similar to 3MV's 'menu of behavior change' options) may be more successful in encouraging behavior change.

The inclusion of social media (e.g. Twitter, Facebook) was suggested, in addition to other interactive technology/media known to facilitate sexual relationships (e.g. telephone hotlines, 'hookup' websites). This may be able to target different demographics of Black MSM, and potentially be used as a source of social support (i.e. particularly for men with limited social support networks) and risk prevention messages, as well as practical information on testing sites, and where to obtain free condoms. Many participants in our study used social media and the Internet to meet sexual partners. Prevention messages posted on these websites may be able to reach populations at high risk for HIV infection, particularly, young Black MSM who have the highest HIV incidence and are the most prolific users of virtual media (Jones & Fox 2009, Mustanski et al. 2011).

The promotion of condom use and HIV testing within the context of men's relationships was also suggested. Participants argued against blanket prevention messages for consistent condom use. Instead, they asserted that condom use should be contextualized according to participants' relationships. That is, during the early stages of a relationship condom use and HIV testing and status knowledge should be emphasized but as the relationship progresses and condom use become less likely prevention messages should shift their focus to emphasize condom use when having sex with men other than a main partner as a way to protect a primary partner.

Finally, participants called for a focus on developing culturally congruent programming to reach MSM who live in rural communities, do not patronize gay bars/clubs, or are otherwise considered to be a hidden MSM population.

These suggestions reveal the important contributions that MSM of color can make toward the development of culturally-appropriate HIV prevention interventions. Many of the above suggestions were in keeping with the observations made in this study, including the significance of incorporating social support into interventions, using appropriate sexual safety messages that mirror the changes in men's primary sexual relationships, the need to address misconceptions when making HIV risk assessments in prospective partners, and practical advice on managing triggers of high risk behaviors. This reflects men's understanding of their own behaviors and suggests the need for their inclusion in all steps of future interventions, from design and development, to delivery and dissemination, to implementation.

7.5 Future research recommendations

The findings of this study revealed important areas for further research. Increased qualitative research will be necessary to understand the lifetime experiences of Black MSM and to uncover the underlying factors driving high risk and low risk sexual behavior. It may also reveal differences between the lifetime experiences of men who engage in high risk versus low risk behaviors. Understanding these mechanisms can lead to the development of more specific intervention designs targeted specifically to these different populations of Black MSM. Moreover, a similar larger scale qualitative study is needed. While Providence is an urban center, its small size may lead findings to be un-generalizable to Black MSM living in larger urban centers in the Northeast such as New York or large urban centers in the South such as Atlanta that may have access to more resources and a greater pool of Black MSM (DiClemente & Peterson 1994). A similar larger scale qualitative study should

also be carried out in rural areas, as our findings are not generalizable to Black MSM living in rural areas. The quantitatively testable aspects of this qualitative research should also be examined. This includes a rigorous examination of the factors suggested by this research to potentially influence HIV risk in Black MSM, such as social support, adverse childhood experiences, apathy toward condom use, passivity in demanding condoms, and reliance on visual or behavioral cues to determine partner's sexual risk—all of which can be tested through quantitative methodologies, such as surveys or questionnaires. Indeed, a fully mixed-methods approach is overdue. Qualitative research is able to nuance quantitative findings and provide insight into detected patterns and statistical findings. Conversely, quantitative research is necessary to statistically identify those patterns and themes that qualitative research can explore in greater detail, and is able to examine the testable hypotheses generated from qualitative research.

Moreover, larger-scale statistical studies examining the mechanisms by which poor and good mental health affects downstream HIV risk behavior, including condom use, condom negotiation, and partner selection, is needed. Quantitative studies will also be able to provide further information on the role of Black MSM's self-esteem, self-pride, confidence, and self-efficacy for condom use and other low risk behaviors. Rigorous quantitative research is needed to determine the relationship between mental health and varying sociodemographic and social conditions, and risk behaviors. For example, the effect of poor mental health on risk behaviors in lower versus higher income populations; the impact of college attendance on social networks and attitudes toward practicing high or low risk behaviors; and particularly for young Black MSM, the effect of family attitudes toward sexual safety on one's own sexual risk taking behaviors.

In-depth studies are needed to understand the coping mechanisms that Black MSM use to overcome difficult personal experiences. These include both positive and negative coping mechanisms. In this study, participants described several coping mechanisms, but as this was not a primary focus of the study, further research on

this topic is necessary and important. In keeping with this, future research may benefit from a shift away from a deficit-based model to a strength-based model, in which the focus moves toward better understanding the factors that mediate resilience among men who experience socioeconomic and psychosocial hardship in childhood. Understanding why and how men who have experienced similar childhood adversity have different adult sexual health outcomes may be the most important and effective way forward.

Finally, this study included both HIV negative and positive MSM. While this study did not report findings according to HIV status, previous research has suggested differences in risk behavior between these two populations, with HIV-positive MSM engaging in higher risk behaviors than HIV-negative MSM (Forney & Miller 2012, Grov et al. 2010); however, it has also been reported that HIV-positive Black MSM engage in fewer high risk behaviors than their HIV-negative counterparts (Robinson et al. 2011). Due to difficulties in recruiting Black MSM in a small city, men were not excluded based on HIV status. A similar study comparing HIV positive and negative populations is warranted. To date, the few studies that use a life course approach to examining risk behaviors in HIV-positive men have almost exclusively focused on experiences of child abuse in early life (Kang et al. 2002, O'Leary et al. 2003, Paul et al. 2001, Zierler et al. 1991), without focusing on other potentially adverse (or positive) childhood experiences. These studies have also focused on HIV positive MSM's current social support networks, with little attention paid to the preceding conditions (including social support) that drove the risk behaviors that may have ultimately resulted in HIV infection.

7.6 Methodological limitations of this study.

While specific chapter limitations have already been described, an overall summary of study limitations is useful. Methodological limitations of this study included the use of self-reported data and subjective recall of life experiences. This may have

resulted in an over-representation of normative behaviors and underrepresentation of stigmatized behaviors, resulting in the omission of potentially important data. Recollected narratives may have also been subject to recall bias, in which they may have inaccurately reported or misremembered experiences or events. However, as described in Section 3.2, a narrative approach to data collection gives power to men's voices and allows for a more nuanced understanding of men's risk factors to emerge. Researcher bias may have also been in effect, but as addressed in Section 3.14, all efforts were taken to minimize its effects. Moreover, this study may be subject to self-selection bias, as the Black MSM who were willing to participate in a research study on sexual behaviors may not represent other Black MSM.

An additional important limitation is the relatively small size of 34 participants. The recruitment of any hidden population is difficult, but is particularly difficult in a city the size of Providence. However, the aims of qualitative studies are different than quantitative studies, and often do not need large samples to collect analyzable data. Thirty-four participants was sufficient to reach data saturation, such that the inclusion of more participants could not guarantee any new data (Guest et al. 2006). Increased number of HIV+ participants would have allowed for within-group comparisons of the drivers of HIV risk behaviors. However, it is noteworthy that HIV positive participants described similar life histories to HIV negative participants.

Of note, this qualitative study does not allow for causal links to be made between participants' life experiences and their subsequent high or low risk behaviors. However, it does allow for the complexities of individual experiences to emerge and provides insight into the potential mechanisms and processes driving high and low risk behaviors. Moreover, the experiences that narratives suggest as influencing sexual risk behaviors (e.g. adverse childhood experiences, poor social support, etc.) cannot be parsed out individually. It may be that the additive effects of these interactions impacted HIV risk, rather than these childhood factors individually. Indeed, as a defining theme of this thesis, the consistently interactive nature of participants' risk reflects the realistic nature of HIV risk in men's lives. HIV risk is

likely due to the reinforcing linkages between many aspects of Black MSM's lives, which culminate to lead to high risk or low risk behaviors. Therefore, to consider these potential risks or drivers of risk individually may be inaccurate and not representative of risk in men's lives.

Finally, the conclusions drawn from this study may not be generalizable to other populations of MSM, Black men, or Black MSM, men living in different geographic regions (e.g. rural), or those in larger cities.

7.7 Conclusion

This thesis set out to explore the drivers of HIV risk in Black MSM in Providence, Rhode Island. It examined men's risk from a socio-epidemiological and life course perspective, beginning with participants' formative years and continuing into their present day lives. Participants' perceptions of their risk behavior and the drivers of these behaviors were complex and insightful. The findings suggest that risk behavior is not a singular action, rather it is the outcome of a lifetime of experiences, ranging from socioeconomic experiences, to the receipt of social support, to family dynamics, and the effects of these experiences on attitudes and beliefs toward sexual safety, mental and emotional health, and self-efficacy for condom use. This study included 34 Black MSM, in one of the first known qualitative studies of this population in Providence, the city with the highest prevalence and incidence of HIV in the State of Rhode Island.

The Socio-epidemiological Model and Syndemic Production of Disease were used as conceptual guides for understanding the multiple drivers of HIV risk behaviors in this population. This context-specific approach was critical to exploring and understanding how one's cultural and economic milieu, and personal challenges or successes were implicated in the decision-making trajectory leading to high or low risk behaviors. This is also important for the development and implementation of

culturally relevant, context-driven interventions.

This study suggests many possible avenues through which risk behaviors function, and can be intervened upon. It drew attention to men's own perceptions of their lives and risk behaviors, as well as the acute awareness that they have of the factors driving these behaviors. Prominently including Black MSM in the development of future interventions may result in novel and innovative prevention programs targeted to this population. It is hoped that the intensely personal experiences shared by the men in this study will be further explored through rigorous qualitative and quantitative studies, with the ultimate goal of identifying and disrupting the pathways from challenging life circumstances to high risk behaviors, and reducing the burden of HIV infection amongst Black MSM.

LIST OF REFERENCES

Avison WR & Turner RJ. (1988). Stressful life events and depressive symptoms: disaggregating the effects of acute stressors and chronic strains. Journal of Health and Social Behavior; 29(3): 253-64.

Baltes PB, Lindenberger U, & Staudinger UM. (1998). Life-span theory in developmental psychology. In Damon W & Lerner RM. (Eds.) Handbook of child psychology (Vol 1): Theoretical models of human development (pg. 1029-1143). New York: Wiley.

Bandura A. (1994). Social cognitive theory and the exercise of control over HIV infection. In DiClemente R & Peterson J (Eds.). Preventing AIDS: Theories and methods of behavioral interventions(pg. 25–59). New York: Plenum Press.

Barker DJP. (1998). Mothers, babies and health in later life. Edinburgh: Churchill Livingstone.

Bartholow BN, Buchbinder S, Celum C, Goli V, Koblin B, & Para M et al. (2005). HIV sexual risk behavior over 36 months of follow-up in the world's first HIV vaccine efficacy trial. JAIDS; 39: 90-101.

Baum A, Singer J, & Baum CS. (1981). Stress and the environment. Journal of Social Issues, 37(1): 4–35.

Beck A, McNally I, & Petrak J. (2003). Psychosocial predictors of HIV/STI risk behaviors in a sample of homosexual men. Sexually Transmitted Infections; 79:142-146.

Becker MH. (1993). A medical sociologist looks at health promotion. Journal of Health and Social Behavior; 34(1): 1-6.

Beitchman JH, Zucker KJ, Hood JE, DaCosta GA, Akman D, & Cassavia E. (1992). A review of the long-term effects of sexual abuse. Child Abuse and Neglect;16(1):101–118.

Belsky J & Cassidy J. (1994). Attachment: Theory and evidence. In Rutter M. & Hay D. (Eds.), Development through life (pg. 373-402). Oxford, UK: Blackwell Scientific.

Ben-Shlomo Y & Kuh D. (2002). A life course approach to chronic disease epidemiology: conceptual models, empirical challenges, and interdisciplinary perspectives. International Journal of Epidemiology; 31(2):285–93.

Bensley LS, Van Eenwyk J, & Simmons KW. (2000). Self-reported childhood sexual and physical abuse and adult HIV-risk behaviors and heavy drinking. American Journal of Preventative Medicine, 18(2): 151-158.

Berger AM, Knutson JF, Mehm JG, & Perkins KA. (1988). The self-report of punitive childhood experiences of young adults and adolescents. Child Abuse and Neglect; 12(2):251-262.

Berscheid E & Reis HT. (1998). Attraction and close relationships. In Gilbert DT, Fiske ST, & Lindzey G. (Eds.). Handbook of social psychology, Vol. 1, 2nd Ed. New York: McGraw-Hill.

Bingham TA, Harawa NT, Johnson DF, Secura GM, MacKellar DA, & Valleroy LA. (2003).The effect of partner characteristics on HIV infection among African American men who have sex with men in the Young Men's Survey, Los Angeles, 1999-2000. AIDS Education and Prevention;15(1 Suppl A): 39-52.

Binson D, Woods WJ, Pollack L, Paul J, Stall R, & Catania JA. (2001). Differential HIV risk in bathhouses and public cruising areas. American Journal of Public Health; 91(9): 1482-1486.
Bolding G, Davis M, Hart G, Sherr L, & Elford J. (2005). Gay men who look for sex on the Internet: is there more HIV/STI risk with online partners? AIDS; 19(9): 961-968.
Bornstein M. (Ed.) (2002). Handbook of parenting (2nd ed.). Mahwah, NJ: Lawrence Erlbaum Associates.
Bosga MB, de Wit JBF, de Vroome EMM, & Houweling EMM. (1995). Differences in perception of risk for HIV infection with steady and non-steady partners among homosexual men. AIDS Education and Prevention; 7(2): 103–11.
Bowleg L. (2004). Love, sex, and masculinity in sociocultural context: HIV concerns and condom use among African American men in heterosexual relationships. Men and Masculinities; 7(2): 166-186.
Branscombe NR & Ellemers N. (1998). Coping with group-based discrimination: Individualistic versus group- level strategies. In Swim JK, Stangor C (Eds). Prejudice: The Target's perspective (pg. 243-266). New York: Academic Press.
Branscombe NR, Schmitt MT, & Harvey R. (1999). Perceiving pervasive discrimination among African Americans: Implications for group identification and well-being. Journal of Personality and Social Psychology; 77(1): 135–149.
Branscombe NR & Wann DL. (1992). Role of identification with a group, arousal, categorization processes, and self-esteem in sports spectator aggression. Human Relations; 45(10): 1013-1033.
Braveman P & Barclay C. (2009). Health disparities beginning in childhood: A life-course perspective. Pediatrics; 124(Suppl 3): 163-175.
Briere JN. (1992). Childhood abuse trauma: Theory and treatment of the lasting effects. Newbury Park, CA: Sage Publications.
Briere J & Runtz M. (1990). Differential adult symptomatology associated with three types of child abuse histories. Child Abuse and Neglect; 14(3):357-364.
Briere J & Runtz M. (1988). Multivariate correlates of childhood psychological and physical maltreatment among university women. Child Abuse and Neglect; 12(3):331-341.
Broadhead WE, Kaplan BH, James SA, Wagner EH, Schoenbach VJ, & Grimson R, et al. (1983). The epidemiologic evidence for a relationship between social support and health. American Journal of Epidemiology; 117(5): 521-537.
Brodsky BS, Malone KM, Ellis SP, Dulit RA, & Mann JJ. (1997). Characteristics of borderline personality disorder associated with suicidal behavior. American Journal of Psychiatry; 154: 1715-1719.
Bronfenbrenner U. (2005). Making human beings human: Bioecological perspectives on human development. Thousand Oaks, CA: Sage Publications.
Bronfenbrenner U. (1979). *The Ecology of Human Development*. Cambridge, MA: Harvard University Press.

Brook JS, Brook DW, Gordon AS, Whiteman M, & Cohen P. (1990). The psychosocial etiology of adolescent drug use: A family interactional approach. Psychology

Monographs; 116: 111–267.
Brooks VR. (1981). Minority stress and lesbian women. Lexington, MA: Lexington Books.
Brooks RA, Etzel MA, Hinojos E, Henry CL, & Perez M. (2005). Preventing HIV among Latino and African American gay and bisexual men in a context of HIV-related stigma, discrimination, and homophobia: Perspectives of providers. Aids Patient Care and STDs; 19(11): 737-744.
Brotman S, Ryan B, Jalbert Y, & Rowe B. (2002). The impact of coming out on health and health care access: The experiences of gay, lesbian, bisexual and two-spirit people. Journal of Health and Social Policy;15(1): 1-29.
Bryant SL & Range LM. (1995). Suicidality in college women who were sexually and physically punished by parents. Violence and Victims; 10(3):195–201.
Bull SS & McFarlane M. (2000). Soliciting sex on the Internet: what are the risks for sexually transmitted diseases and HIV? Sexually Transmitted Diseases; 27(9): 545-50.
Bull SS, Lloyd L, Rietmeijer C, & McFarlane M. (2004). Recruitment and retention of an online sample for an HIV prevention intervention targeting men who have sex with men: the Smart Sex Quest Project. AIDS Care; 16(8): 931-43.
Cassidy J & Shaver PR. (Eds.) (1999). Handbook of attachment: Theory, research, and clinical applications (pg. 89-111). New York: Guilford.
Catania JA, Coates TJ, & Kegeles S. (1994). A Test of the AIDS Risk Reduction Model: Psychosocial correlates of condom use in the AMEN cohort survey. Health Psychology; 13(6): 548-555.
Catania JA, Kegeles S, & Coates T. (1990). Towards an Understanding of Risk Behavior: An AIDS Risk Reduction Model (ARRM). Health Education & Behavior; 17(1):53-72.
Catania JA, Paul J, Osmond D, Folkman S, Pollack L, Canchola J, Chang J, & Neilands T. (2008). Mediators of childhood sexual abuse and high-risk sex among men-who have sex with men. Child Abuse & Neglect; 32:925-940.
Cauce AM, Stewart A, Rodriquez MD, Cochran B, Ginzler J. (2003). Overcoming the odds? Adolescent development in the context of urban poverty. In Luthar SS (Ed). Resilience and Vulnerability: Adaptation in the Context of Childhood Adversities (pg. 343-363). New York: Cambridge University Press.
Cavaiola AA & Schiff M. (1988). Behavioral sequelae of physical and/or sexual abuse in adolescents. Child Abuse & Neglect;12(2): 181–188.
Cazenave N. (1984). Race, socioeconomic status, and age: The social context of American masculinity. Sex Roles; 11(7/8):639-656.
CDC AIDS Community Demonstration Projects Research Group. (1999). Community-level HIV intervention in five cities: final outcome data from the AIDS community demonstration projects. American Journal of Public Health; 89(3):336–345.
Centers for Disease Control and Prevention. (2012). HIV in the United States: At a glance. Retrieved from: http://www.cdc.gov/hiv/resources/factsheets/us.htm.
Centers for Disease Control and Prevention. (2011). Estimates of new HIV infections in the United States, 2006-2009. Retrieved from:

http://www.cdc.gov/nchhstp/newsroom/docs/HIV-Infections-2006-2009.pdf
Centers for Disease Control and Prevention. (2011). Characteristics Associated with HIV Infection Among Heterosexuals in Urban Areas with High AIDS Prevalence --24 Cities, United States, 2006—2007. Morbidity and Mortality; 60(31):1045-1049.
Centers for Disease Control and Prevention. (2008). HIV/AIDS Surveillance Report, 2006 (pg. 1-55). US Department of Health and Human Services.
Centers for Disease Control and Prevention. (2008). MMWR analysis provides new details on HIV incidence in U.S. Populations, in CDC HIV/AIDS Facts (pg. 1-5).
Centers for Disease Control and Prevention. (2008). Subpopulation estimates from the HIV incidence surveillance system--United States, 2006. Morbidity and Mortality Weekly Report; 57(36): 985-989.
Centers for Disease Control and Prevention. (2005). HIV prevalence, unrecognized infection, and HIV testing among men who have sex with men--Five U.S. cities, June 2004-April 2005. Morbidity and Mortality Weekly Report; 54(24): 597-601
Centers for Disease Control and Prevention. (2003). HIV/STD risks in young men who have sex with men who do not disclose their sexual orientation—six U.S. cities 1994-2000. Morbidity and Mortality Weekly Report; 52(5): 81-86.
Channon S. Executive dysfunction in depression: the Wisconsin card sorting test. Journal of Affective Disorders. 1996; 39(2):107-114.
Chauncey G. (1994). Gay New York: Gender, urban culture, and the making of the gay male world 1890–1940. New York, NY: Basic Books.
Chng L & Geliga-Vargas J. (2000). Ethnic identity, gay identity, sexual sensation seeking and HIV risk taking among multiethnic men who have sex with men. AIDS Education and Prevention; 12(4):326-339
Clandinin DJ & Connelly M. (2004). Narrative inquiry: experience and story in qualitative research. San Francisco: Jossey-Bass.
Clark R, Anderson NB, Clark VR, & Williams DR. (1999). Racism as a stressor for African Americans: A biopsychosocial model. American Psychologist; 54(10):805–816.
Clatts MC, Goldsamt LA, & Yi H. (2005). An emerging HIV risk environment: a preliminary epidemiological profile of an MSM POZ Party in New York City. Sexually Transmitted Infections;. 81(5):373-376.
Claussen AH & Crittenden PM. (1991). Physical and psychological maltreatment: relations among types of maltreatment. Child Abuse and Neglect; 15(1-2):5–18.
Clements-Noelle K, Marx R, Guzman R & Katz M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. American Journal of Public Health; 91(6): 915-921.
Cochran SD. (2001). Emerging issues in research on lesbians' and gay men's mental health: Does sexual orientation really matter? American Psychologist; 56(11):931–947.
Cochran M, Larner M, Riley D, Gunnarsson L, & Henderson CR. (1990). Extending

families: The social networks of parents and their children. New York: Cambridge University Press.
Cohen S. (1988). Psychosocial models of the role of social support in the etiology of physical disease. Health Psychology;7(3):269-97.
Cohen DA, Mason K, Bedimo A, Scribner R, Basolo V, & Farley TA. (2003). Neighborhood physical conditions and health. Am J Public Health, 2003. 93(3): p. 467-71.
Cohen S & McKay G. (1984). Social support, stress, and the buffering hypothesis: A theoretical analysis. In Baum A, Taylor SE, Singer JE (Eds). Handbook of psychology and health, Vol. 4 (pg. 253-267). Hillsdale, NJ: Erlbaum.
Cohen S & Syme S (Eds.) (1985). Social support and health. New York: Academic Press.
Cohen S & Wills TA. (1985). Stress, social support, and the buffering hypothesis. Psychological Bulletin, 98(2):310–357.
Coker AL, Smith PH, Mckeown RE, & King MJ. (2000). Frequency and correlates of intimate partner violence by type: Physical, sexual, and psychological battering. Am Journal of Public Health; 90(4): 553-559.
Cole SW, Kemeny ME, Taylor SE, Visscher BR. (1996). Accelerated course of human immunodeficiency virus infection in gay men who conceal their homosexual identity. Psychosomatic Medicine, 58(3), 219-231.
Cole SW, Kemeny ME, Taylor SE, & Visscher BR. (1996). Elevated Physical Health Risk Among Gay Men Who Conceal Their Homosexual Identity. Health Psychology; 15(4): 243-251.
Collins P. (2005). Black sexual politics: African Americans, gender, and the new racism. New York: Routledge.
Collins WA & & Laursen B. (1999). Relationships as developmental contexts. The Minnesota Symposia on Child Psychology, Vol. 30. Mahwah, NJ: Lawrence Erlbaum Associates.
Compas BE, Slavin LA, Wagner BM, Vannatta K. (1986). Relationship of life events and social support with psychological dysfunction among adolescents. Journal of Youth and Adolescence, 15(3):205–221.
Conger RD, Cui M, Bryant CM, & Elder GHJ. (2000). Competence in early adult romantic relationships: A developmental perspective on family influences. Journal of Personality and Social Psychology; 79(2):224-237.
Connell RW. (1987). Gender and Power. Stanford, California: Stanford University Press.
Connelly FM & Clandinin DJ. (2006). Narrative inquiry. In Green JL, Camalli G, & Elmore PB. (Eds.), Handbook of complementary methods in education research. Washington, DC: American Educational Research Association.
Corcoran M. (1995). Rags to riches: Poverty and mobility in the United States. Annual Review of Sociology; 21: 237-267.
Council on Scientific Affairs. (1993). Adolescents as victims of family violence. JAMA; 270(15):1850-1856.
Crawford I, Allison KW, Zamboni BD, & Soto T. (2002). The influence of dual-identity development on the psychosocial functioning of African-American gay and bisexual men. Journal of Sex Research; 39(3): 179-189.

Crepaz N & Marks G. (2001). Are negative affective states associated with HIV sexual risk behaviors? A meta-analytic review. Health Psychology; 20(4):291–299.
Critical Appraisal Skills Programme (CASP). Public Health Resource Unit, Institute of Health Science, Oxford.
Crocker J & Major B. (1989). Social stigma and self-esteem: The self-protective properties of stigma. Psychological Review; 96(4): 608-630.
Cunningham RM, Stiffman AR, & Dore P. (1994). The association of physical and sexual abuse with HIV risk behaviors in adolescence and young adulthood: implications for public health. Child Abuse and Neglect; 18(3):233-245.
Danis M, Kotwani N, Garrett J, Rivera I, Davies-Cole J, & Carter-Nolan P. (2010). Priorities of low-income urban residents for interventions to address the socio-economic determinants of health. Journal of Health Care for the Poor and Underserved; 21(4): 1318-1339.
Darbes LA & Lewis MA. (2005). HIV-specific social support predicts less sexual risk behavior in gay male couples. Health Psychology; 24(6): 617-622.
Dawson D & Fischer KW (Eds.) (1994). Human behavior and the developing brain. New York: Guilford Press.
Dawson G & Ashman DB. (2000). On the origins of a vulnerability to depression: The influence of the early social environment on the development of psychobiological systems related to risk of affective disorder. In Nelson CA. (Ed.), The effects of early adversity on neurobehavioral development (pg. 245-279). Mahwah, NJ: Lawrence Erlbaum Associates.
Dawson JM, Fitzpatrick RM, Reeves G, Boulton M, & McLean J, et al. (1994). Awareness of sexual partners' HIV status as an influence upon high-risk sexual behavior among gay men. AIDS; 8: 837-841.
Dawson G, Frey K, Panagiotides H, Yamada E, Hessl D, & Osterling J.(1999). Infants of depressed mothers exhibit atypical frontal electrical brain activity during interactions with mother and with a familiar, nondepressed adult. Child Development; 70(5): 1058-1066.
DeBellis MD, Keshavan MS, Clark DB, Casey BJ, Giedd JN, & Boring AM. (1999). AE Bennett Research Award. Developmental traumatology. Part II: Brain development. Biological Psychiatry; 45(10):1271–1284.
Denizet-Lewis B. (3 Aug 2003) Double lives on the down low. New York Times. Accessed online: http://query.nytimes.com/gst/fullpage.html?sec=health&res=9F0CE0D61E3I 930A3575BC0A9659C8B63.
Denning P & Campsmith M. (2005). Unprotected anal intercourse among HIV-positive men who have a steady male sex partner with negative or unknown HIV serostatus. American Journal of Public Health, 95(1): 152-158.
Deren S, Oliver-Velez D, Finlinson A, Robles R, Andia J, & Colon HM, et al. (2003). Integrating qualitative and quantitative methods: Comparing HIV-related risk behaviors among Puerto Rican drug users in Puerto Rico and New York. Substance Use & Misuse; 38(1): 1-24.
Diaz R. (1999). Trips to Fantasy Island: contexts of risk sex for San Francisco gay men. Sexualities; 2(1): 89-122.

Diaz R. (1998) Latino gay men and HIV: Culture, Sexuality and Risk Behavior. New York and London: Routledge.
Diaz R & Ayala G. (1999). Love, passion and rebellion: ideologies of HIV risk among Latino gay men in the USA. Culture, Health, and Sexuality; 1(3): 277-293.
Diaz R, Ayala G, & Bein E. (2004). Sexual Risk as an Outcome of Social Oppression: Data From a Probability Sample of Latino Gay Men in Three U.S. Cities. Cultural Diversity and Minority Psychology; 19(3): 255-267.
Diaz R, Ayala G, Bein E, Henne J, & Marin BV. (2001). The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: findings from 3 US cities. Am J Public Health; 91(6): 927-932.
Diaz R, Peterson JL, & Choi KH. (2008). Social discrimination and health outcomes in African American, Latino, and Asian/Pacific Islander gay men. In Unequal opportunity: Health disparities among gay and bisexual men in the United States, Wolitski Rj, Stall R, Valdiserri R (Eds). Oxford University Press: New York.
DiClemente RJ & Peterson JL. (Eds) (1995). Preventing AIDS: Theories and methods of behavioral interventions. New York, NY: Plenum Press.
Diez Roux AV. (2002). Invited commentary: places, people, and health. American Journal of Epidemiology; 155(6): 516-519.
Dilley JW, McFarland W, Sullivan P, & Discepola M. (1998). Psychosocial correlates of unprotected anal sex in a cohort of gay men attending an HIV-negative support group. AIDS Education and Prevention; 10(4):317–326.
Dixon D, Antoni M, Kilbourn K, Wagner S, Schneiderman N, & Klimas N, et al. (1998). Social support buffers PTSD symptoms and HHV-6 antibody titers in HIV+ gay men following Hurricane Andrew. Neuroimmunomodulation;5:15. Presented at the 1998 meeting of the PsychoNeuroImmunology Research Society.
Dixon D, Cruess S, Kilbourn K, Klimas N, Fletcher MA, & Ironson G. (2006). Social support mediates loneliness and human herpesvirus type 6 (HHV-6) antibody titers. Journal of Applied Social Psychology; 31(6): 1111-1132.
Dohrenwend BP & Dohrenwend BS. (1969). Social status and psychological disorder: A casual inquiry. New York: Wiley.
Doll LS, Byers RH, Bolan G, Douglas JM, & Moss PM, et al. (1991). Homosexual men who engage in high risk behavior: A multicenter comparison. Sexually Transmitted Diseases; 18(3): 170-175.
Drossman DA, Leserman J, Nachman G, Li ZM, Gluck H, & Toomey TC, et al. (1990). Sexual and physical abuse in women with functional or organic gastrointestinal disorders. Annals of Internal Medicine;113(11): 828 –833.
Dube SR, Anda RF, Felitti VJ, Edwards VJ, Croft JB. (2002). Adverse childhood experiences and personal alcohol abuse as an adult. Addictive Behaviors; 27(5):713–725.
Dube SR, Anda RF, Felitti VJ, Edwards VJ, Williamson DF. (2002). Exposure to abuse, neglect, and household dysfunction among adults who witnessed intimate partner violence as children: implications for health and social services. Violence and Victims. 17(1): 3-17.
Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH, & Anda RF. (2003). Childhood

abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. Pediatrics; 111(3): 564-572.
Dunn J. (1993). Young children's close relationships: Beyond attachment. Newbury Park, CA: Sage Publications.
Dyson ME. (2001). When you divide body and soul, problems multiply: The black church and sex (pg. 116-117). In Byrd R & Guy-Shetfall B. (Eds.), Traps: African American men and gender and sexuality (pg. 308-326). Bloomington: Indiana University Press.
Edwards VJ, Holden GW, Felitti VJ, & Anda RF. (2003). Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: results from the adverse childhood experiences study. American Journal of Psychiatry; 160(8): 1453-1460.
Egelend B, Sroufe LA, & Erickson M. (1983). The developmental consequence of different patterns of maltreatment. Child Abuse and Neglect; 7(4):459-469.
el-Bassel N, Schilling RF, Irwin KL, Faruque S, Gilbert L, & Von Bargen, et al. (1997). Sex trading and psychological distress among women recruited from the streets of Harlem. American Journal of Public Health; 87(1): 66-70.
Elder GH. (1998). The life course and human development. In: Damon W & Lerner RM, (Eds.), Handbook of child psychology (Vol 1): Theoretical models of human development (pg. 939-991). New York: Wiley.
Elford J, Bolding G, Maguire M, & Sherr, L. (2000). Combination therapies for HIV and sexual risk behavior among gay men. Journal of the Acquired Immune Deficiency Syndromes; 23(3): 266–271.
Elford J, Bolding G, & Sherr L. (2002). High-risk sexual behavior increases among London gay men between 1998 and 2001:What is the role of HIV optimism? AIDS; 16(11): 1537–44.
Elford J, Bolding G, & Sherr L. (2001). Peer education has no significant impact on HIV risk behaviours among gay men in London. AIDS; 15(4): 535-538.
Elford J, Bolding G, & Sherr L. (2001). Seeking sex on the Internet and sexual risk behaviour among gay men using London gyms. AIDS;15(11):1409-1415.
Elford J, Whincup P, & Shaper AG. (1991). Early life experience and adult cardiovascular disease: longitudinal and case-control studies. International Journal of Epidemiology; 20(4): 833-844.
Elizur Y & Mintzer A. (2001). A framework for the formation of gay male identity: Processes associated with adult attachment style and support from family and friends. Archives of Sexual Behavior; 30(2):143-167.
Elliott R, Sahakian BJ, Herrod JJ, Robbins TW, & Paykel ES. (1997). Abnormal response to negative feedback in unipolar depression: evidence for a diagnosis specific impairment. Journal of Neurology, Neurosurgery & Psychiatry;63(1):74-82.
Elliott R. The neuropsychological profile in unipolar depression. (1998). Trends in Cognitive Sciences;2(11): 447-454.
Elwood W & Greene K. (2005). Risks both known and unknown: A qualitative method to assess the role of situation in HIV/STD risk and prevention. Journal of Homosexuality; 50(1): 135-154.

Elwood WN & Williams ML. (1999). The politics of silence: Communicative rules and HIV prevention issues in gay male bathhouses, in Power in the blood: A handbook on AIDS, politics, and communication (pg. 121-132). Elwood WN (Ed), Lawrence Erlbaum Associates: Mahwah, New Jersey.

Elwood WN & Williams ML. (1998). Sex, drugs, and situation: attitudes, drug use, and sexual risk behaviors among men who frequent bathhouses. Journal of Psychology and Human Sexuality; 10(2): 23-44.

Ewart C & Suchday S. (2002). Discovering how urban poverty and violence affect health: Development and validation of a neighborhood stress index. Health Psychology; 21(5): 254–262.

Ewick P & Silbey SS. (1995). Subversive stories and hegemonic tales: Toward a sociology of narrative. Law & Society Review; 29(2): 197-226.

Farina A, Allen J, Saul B. (1968). The role of stigmatized person in affecting social relationships. Journal of Personality; 36(2):169-182.

Farmer P. (1999). Infections and inequalities: The modern plagues. Berkeley: University of California Press.

Felitti VJ. (2002) The relationship between adverse childhood experiences and adult health: Turning gold into lead; 6(1): 44-47.

Felitti VJ. (1993). Childhood sexual abuse, depression and family dysfunction in adult obese patients: a case control study. South Med Journal;86(7):732–736.

Felitti VJ. (1991). Long-term medical consequences of incest, rape, and molestation. South Med Journal;84(3):328–331.

Felitti VJ, Anda RF, Nordenberg D, Wiliamson DF, Spitz AM, & Edwards V, et al. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventative Medicine; 14(4): 245-258.

Ferber A. (2007). The construction of Black masculinity: White supremacy now and then. Journal of Sport and Social Issues; 31(1): 11-24.

Fergus S & Zimmerman MS. (2005). Adolescent Resilience: A Framework for Understanding Healthy Development in the Face of Risk. Annual Review of Public Health; 26:399–419.

Fields SD, Malebranche D, & Feist-Price S. (2008). Childhood sexual abuse in black men who have sex with men: Results from three qualitative studies. Culture Diversity & Ethnic Minority Psychology; 14(4): 385-390.

Finkelhor D & Browne A. (1985). The traumatic impact of child sexual abuse: A conceptualization. American Journal of Orthopsychiatry;55(4):530–541.

Finkelhor D, Hotaling G, Lewis IA, & Smith C. (1990). Sexual abuse in a national survey of adult men and women: prevalence, characteristics, and risk factors. Child Abuse and Neglect; 14(1):19 –28.

Fishbein M & Ajzen I. (1975). Belief, attitude, intention, and behavior: An introduction to theory and research. Reading, MA: Addison-Wesley.

Fisher J, Fisher WA, Bryan AD, & Misovich SJ. (2002). Information-motivation-behavioral skills model-based HIV risk behavior change intervention for inner-city high school youth. Health Psychology; 21(2): 177-186.

Fitzpatrick R, McLean J, Boulton M. (1990). Variation in sexual behavior in gay men.

In Aggleton P, Davies P, Hart G. (Eds.), AIDS: Individual, cultural and policy dimensions (pg. 121-132). Lewes: Falmer.
Flowers P. Knussen C, & Duncan B. (2001). Reappraising HIV testing among Scottish gay men: The impact of new HIV treatments. Journal of Health Psychology; 6(6): 665–678.
Flynn HA, Walton MA, Curran GM, Blow FC, & Knutzen S. (2004). Psychological distress and return to substance use two years following treatment. Substance Use and Misuse; 39(6): 885-910.
Fogel A. (1993). Developing through relationships: Origins of communication, self, and culture. Chicago: University of Chicago Press.
Folkman S, Chesney M, Pollack L, & Phillips C. (1992). Stress, coping, and high risk sexual behavior. Health Psychology; 11(4): 218-222.
Ford C, Whetten KD, Hall SA, Kaufman JS, & Thrasher AD. (2007). Black sexuality, social construction, and research targeting 'the down low' ('the DL'). Annals of Epidemiology; 17(3): 209-216.
Forney JC & Miller RL, & The City Project Study Team. (2012). Risk and protective factors related to HIV-risk behavior: A comparison between HIV-positive and HIV-negative young men who have sex with men. AIDS Care; 24(5): 544-552.
Fowler FJ. (2009). Survey Research Methods. (4Th Ed.) Thousand Oaks, California: Sage Publications, Inc.
Freimuth VS, Quinn S C, Thomas SB, Cole G, Zook E, Duncan T. (2001). African Americans' views on research and the Tuskegee Syphilis study. Social Science & Medicine; 52(5): 797-808.
Freimuth VS, Hammond SL, Edgar T, McDonald DA, & Fink EL. (1992). Factors explaining intent, discussion and use of condoms in first-time sexual encounters. Health Education Research; 7(2):203-215.
Freimuth VS, Quinn SC, & Thomas SB. (2001). African Americans' views on research and the Tuskegee syphilis study. Social Science and Medicine; 52: 797-808.
Freshwater K, Leach C, & Aldridge J. (2001). Personal constructs, childhood sexual abuse and revictimization. British Journal of Medical Psychology; 74(3): 379–397.
Frey CU & Rothlisberger C. (1996) Social support in healthy adolescents. Journal of Youth and Adolescence; 25(1): 17–31.
Frye V, Latka MH, Koblin B, Halkitis PN, Putnam S, Galea S, Vlahov D. (2006). The urban environment and sexual risk behavior among men who have sex with men. J Urban Health; 83(2): 308-324.
Galtung J. (1969). Violence, peace, and peace research. Journal of Peace Research; 6(3 167-191.
Garnets LD, Herek GM, & Levy B. (1990). Violence and victimization of lesbians and gay men: Mental health consequences. Journal of Interpersonal Violence;5(3): 366–383.
Garnets LD & Kimmel DC. (1991). Lesbian and gay male dimensions in the psychological study of human diversity. In Goodchilds J (Ed.), Psychological perspectives on human diversity in America (pg. 143-192). Washington, DC: American Psychological Association.
Genuis M, Thomlison B, & Bagley C. (1991). Male victims of child sexual abuse: A

brief overview of pertinent findings. Journal of Child and Youth Care; 6:1–6.
Gibbs JT & Fuery D. (1994). Mental health and well-being of black women: toward strategies of empowerment. American Journal of Community Psychology; 22(4): 559–82.
Giele JZ & Elder GH. (1998). Life course research: development of a field. In Giele JZ, Elder GH (Eds.). Methods of life course research: qualitative and quantitative Approaches (pg. 5-27). Thousand Oaks, CA: Sage Publications.
Gilgun J. (2010). Reflexivity and qualitative research. Current Issues in Qualitative Research; 1(2): 1-8.
Gilman SE, Cochran SD, Mays VM, Hughes M, Ostrow D, & Kessler RC. (2001). Risks of psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey. American Journal of Public Health; 91(6):933–939.
Glaus O. (1988). Alcoholism, chemical dependency and the lesbian client. Women and Therapy*; 8:* 121–214.
Glesne C. (1999). Becoming qualitative researchers: An introduction (2nd ed.). Don Mills, Ontario, Canada: Longman.
Goffman E. (1986). Stigma: Notes on the management of a spoiled identity. New York, NY: Simon & Schuster.
Gold RS, Karmiloff-Smith A, Skinner MJ, & Morton J. (1992). Situational factors and thought processes associated with unprotected intercourse in heterosexual students. AIDS Care; 4(2): 305-323.
Gold RS & Skinner MJ. (1992). Situational factors and thought processes associated with unprotected intercourse in young gay men. AIDS; 6(9): 1021-30.
Goldin CS. Stigmatization and AIDS: Critical issues in public health. Social Science and Medicine; 39(9):1359–1366.
Golding J, Pembrey M, & Jones R. (2001). The Avon longitudinal study of parents and children: 1. Study methodology. Paediat Perinat Epidemiology; 15(1): 74-87.
Gonsiorek JC. (1988). Mental health issues of gay and lesbian adolescents. Journal of Adolescent Health Care; 9:114-122.
Gould DA, Stevens NG, Ward NG, Carlin AS, Sowell HE, & Gustafson B. (1994). Self-reported childhood abuse in an adult population in a primary care setting. Archives of Family Medicine; 3(3): 252–256.
Graham H. (2002). Building an inter-disciplinary science of health inequalities: the example of lifecourse research. Social Science and Medicine; 55(11):2005–2016.
Green AH, Voeller K, Gaines RW, & Kubie J (1981). Neurological impairment in maltreated Children. Child Abuse Neglect;5(2):129-134.
Grov C, Golub SA, & Parsons JT. (2010). HIV status differences in venues where highly sexually active gay and bisexual men meet sex partners: results from a pilot study. AIDS Education and Prevention;22(6):496-508.
Grov C, Parsons JT, & Bimbi DS. (2007). Sexual risk behavior and venues for meeting sex partners: an intercept survey of gay and bisexual men in LA and NYC. AIDS and Behavior; 11(6): 915-926.
Gubrium J. & Holstein JA. (1997). The New language of qualitative method.

New York: Oxford University Press.
Guest G, Bunce A, & Johnson L. (2006). How Many Interviews Are Enough? An Experiment with Data Saturation and Variability. Field Methods; 18(1): 59-82.
Hall HI, Song R, Rhodes P, Prejean J, An Q, & Lee LM, et al. (2008). Estimation of HIV incidence in the United States. JAMA; 300(5): 520-529.
Hallfors DD, Waller MW, Bauer D, Ford CA, & Halpern CT. (2005). Which comes first in adolescence: sex and drugs or depression? American Journal of Preventative Medicine;29(3):163-170.
Halkitis PN & Parsons JT. (2003). Recreational Drug Use and HIV-Risk Sexual Behavior Among Men Frequenting Gay Social Venues. Journal of Gay & Lesbian Social Services; 14(4): 19-38.
Hallqvist J, Lynch J, Bartley M, Lang T, & Blane D. (2004). Can we disentangle life course processes of accumulation, critical period and social mobility? An analysis of disadvantaged socio-economic positions and myocardial infarction in the Stockholm Heart Epidemiology Program (SHEEP). Social Science and Medicine; 58(8): 1555-1562.
Hamilton CJ. & Mahalik JR. (2009). Minority stress, masculinity, and social norms predicting gay men's health risk behaviors. Journal of Counseling Psychology; 56(1): 132-141.
Hammer JC, Fisher JD, Fitzgerald P, & Fisher WA. (1996). When two heads aren't better than one: AIDS risk behavior in college-age couples. Journal of Applied Social Psychology; 26(5): 375-397.
Han C. (2008). A qualitative exploration of the relationship between racism and unsafe sex among Asian Pacific Islander gay men. Archives of Sexual Behaviors, 2008. 37(5): 827-837.
Hanson KL, Luciana M, & Sullwold K. (2008). Reward-related decision-making deficits and elevated impulsivity among MDMA and other drug users. Drug Alcohol Depend. 96(1-2): 99-110.
Harawa NT, Greenland S, Bingham TA, Johnson DF, Cochran SD, & Cunningham WE, et al. (2004). Associations of race/ethnicity with HIV prevalence and HIV-related behaviors among young men who have sex with men in 7 urban centers in the United States. J Acquir Immune Defic Syndr; 35(5):526–536.
Harrop-Griffiths J, Katon W, Walker E, Holm L, Russo J, & Hickok L. (1988). The association between chronic pelvic pain, psychiatric diagnoses, and childhood sexual abuse. Obstetrics and Gynecology; 71(4):589-594.
Hart T, Peterson JL, & Community Intervention Trial for Youth Study Team. (2004). Predictors of Risky Sexual Behavior Among Young African American Men Who Have Sex With Men. Am J Public Health; 94(7): 1122–1124.
Haveman R & Wolfe B. (1995). The Determinants of Children's Attainments: A Review of Methods and Findings. Journal of Economic Literature; 33(4): 1829-1878.
Hays RB, Chauncey S, & Tobey L. (1990). The social support networks of gay men with AIDS. Journal of Community Psychology;18(4):374–385.
Hays RB, Turner H, & Coates TJ. (1992). Social support, AIDS-related symptoms, and depression among gay men. Journal of Consulting and Clinical Psychology;60(3): 463–469.

Heckham T, Kelly JA, Bogart LM, Kalichman SC, & Rompa DJ. (1999). HIV risk differences between African-American and white men who have sex with men. Journal of the National Medical Association; 91(2): 92-100.
Heffernan K, Cloitre M, Tardiff K, Marzuk PM, Portera L, & Leon AC. (2000). Childhood trauma as a correlate of lifetime opiate use in psychiatric patients. Addictive Behaviors;25(5):797–803.
Heflin C, Siefert K, & Williams D. (2005). Food insufficiency and women's mental health: Findings from a 3-year panel of welfare recipients. Social Science & Medicine; 61(9): 1971–1982.
Henry CJK & Ulijaszek S. (Eds.). (1996). Long-term consequences of early environment: growth, development and the lifespan perspective. Oxford, UK: Oxford University Press.
Herbert TB & Cohen S. (1993). Stress and immunity in humans: a meta-analytic review. Psychosom Med; 55(4): 364-379.
Herek GM. (1999). AIDS and stigma. American Behavioral Scientist; 42(7): 1106-1116.
Herek GM & Berrill, KT. (1992). Hate crimes: Confronting violence against lesbians and gay men. Thousand Oaks, CA: Sage.
Herek GM, Capitanio JP, & Widaman KF. (2003). Stigma, social risk, and health policy: Public attitudes toward HIV surveillance policies and the social construction of illness. Health Psychol; 22(5): 533–540.
Herek GM, Capitanio JP & Widaman KF. (2002). HIV-related stigma and knowledge in the United States: Prevalence and trends, 1991-1999. American Journal of Public Health; 92(3):371-377.
Herek GM, Gillis JR, & Cogan JC. (1999). Psychological sequelae of hate-crime victimization among lesbian, gay, and bisexual adults. Journal of Consulting and Clinical Psychology; 67(6):945–951.
Herek GM & Glunt EK. (1995). Identity and community among gay and bisexual men in the AIDS era: Preliminary findings from the Sacramento Men's Health Study. In Herek GM & Greene G. (Eds.), Psychological perspectives on lesbian and gay issues: AIDS, identity, and community: The HIV epidemic and lesbian and gay men (pg. 55–84). Thousand Oaks, CA: Sage Publications.
Herrell R, Goldberg J, True WR, Ramakrishnam V, Lyons M, & Eisen S, et al. (1999). Sexual orientation and suicidality: A co-twin control study in adult men. Archives of General Psychiatry; 56(10): 867–874.
Hershberger SL & D'Augelli AR. (1995). The impact of victimization on the mental health and suicidality of lesbian, gay, and bisexual youth. Developmental Psychology; 31(1):65–74.
Hertzman C, Power C, Matthews S, & Manor O. (2001). Using an interactive framework of society and lifecourse to explain self-rated health in early adulthood. Social Science and Medicine; 53(12):1575-1585.
Hetrick ES & Martin AD. Ego-dystonic homosexuality: A developmental view. In Hetrick ES & Stein TS (Eds.), Innovations in psychotherapy with homosexuals (pg. 2-21). Washington, DC: American Psychiatric Press.
Hibbard RA, Ingersoll GM, & Orr DP. (1990). Behavioral risk, emotional risk, and child abuse among adolescents in a nonclinical setting.

Pediatrics;86(6):896–901.
Hillis SD, Anda RF, Felitti VJ, Nordenberg D, & Marchbanks PA. (2000). Adverse Childhood Experiences and Sexually Transmitted Diseases in Men and Women: A Retrospective Study. Pediatrics.106(1):e11.
Hillis SD, Anda RF, Felitti VJ, & Marchbanks PA. (2001). Adverse childhood experiences and sexual risk behaviors in women: A retrospective cohort study. Family Planning Perspectives; 33(5): 206-211.
Hodes M. (1993). The sexualization of reconstruction politics: White women and Black men in the south after the civil war. Journal of the History of Sexuality; 3(3): 402-417.
Hotez P. (2003). The hookworm vaccine initiative. Washington, D.C.: Sabin Vaccine Institute, Georgetown University
Huebner DM, Davis MC, Nemeroff CJ, & Aiken LS. (2002). The impact of internalized homophobia on HIV preventive interventions. American Journal of Community Psychology; 30(3): 327-348.
Huebner DM & Gerend MA. (2001). The relation between beliefs about drug treatments for HIV and sexual risk behavior in gay and bisexual men. Annals of Behavioral Medicine; 23(4):304–312.
Huebner DM, Rebchook GM, & Kegeles SM. (2004). Experiences of harassment, discrimination, and physical violence among young gay and bisexual men. American Journal of Public Health; 94(7):1200-1203.
Humphreys L. (1975). Tearoom trade: Impersonal sex in public places. Chicago, IL: Aldine Publisher Company.
Hunter AG & Davis JE. (1992). Constructing gender: an exploration of Afro-American men's conceptualization of manhood. Gender & Society; 6(3): 464-479.
Jackson R. (2006). Scripting the Black masculine body: identity, discourse, and racial politics in popular media. Albany, NY: State University of New York Press.
Janz NK & Becker MH. (1984). The Health belief model: A decade later. Health Education Quarterly; 11(1):1-47.
Jessor R & Jessor SL. (1977). Problem behavior and psychosocial development: A longitudinal study of youth. San Diego, CA: Academic Press.
Johnson JG, Cohen P, Brown J, Smailes EM, & Bernstein DP. (1999). Childhood maltreatment increases risk for personality disorders during early adulthood. Archives of General Psychiatry; 56(7): 600–606.
Johnson DF, Sorvillo FJ, Wohl AR, Bunch G, Harawa NT, & Carruth A, et al. (2003). Frequent failed early HIV detection in a high prevalence area: Implications for prevention. AIDS Patient Care and STDS; 17(6):277-282.
Jones EE, Farina A, Hestrof AH, Markus H, & Miller DT, et al. (1984). Social stigma: The psychology of marked relationships. New York, NY: Freeman.
Jones S & Fox S., Pew Internet and American Life Project. (2009). Generations online in 2009. Retrieved 7 May 2012, from http://www.pewinternet.org/Reports/2009/Generations-Online-in-2009/Generational-Differences-in-Online-Activities.aspx
Jones KT, Gray P, Whiteside YO, Wang T, Bost D, & Dunbar E, et al. (2008).

Evaluation of an HIV Prevention Intervention Adapted for Black Men Who Have Sex With Men. American Journal of Public Health; 98(6):1043-1050.
Joseph S. (1999). Social support and mental health following trauma. In W. Yule (Ed.), Post-traumatic stress disorders: Concepts and therapy (pg. 71–91). New York: Wiley.
Kalichman SC, Simbayi LC, Kagee A, Toefy Y, Jooste S, & Cain D, et al. (2006). Associations of poverty, substance use, and HIV transmission risk behaviors in three South African communities. Social Science and Medicine; 62(7): 1641-1649.
Kalichman SC, Carey M, & Johnson BT. (1996). Prevention of sexually transmitted HIV infection: a meta-analytic review of the behavioral outcome literature. Annals of Behavioral Medicine; 18(1): 6-15.
Kalichman SC, Kelly JA, Morgan M, & Rompa D. (1997). Fatalism, current life satisfaction, and risk for HIV infection among gay and bisexual men. J Consult Clin Psychol; 65(4):542-546.
Kalichman SC, Nachimson D, Cherry C, & Williams E. (1998). AIDS treatment advances and behavioral prevention setbacks: Preliminary assessment of reduced perceived threat of HIV-AIDS. Health Psychology;17(6): 546–550.
Kang SY, Deren S, Andia J, Colon H, & Robles R. (2004). Effects of changes in perceived self-efficacy on HIV risk behaviors over time. Addictive Behaviors; 29(3): 567-574.
Kang SY, Deren S, & Goldstein MF. (2002). Relationships between childhood abuse and neglect experience and HIV risk behaviors among methadone treatment drop-outs. Child Abuse and Neglect; 26(12): 1275-1289.
Kegeles SM, Hays RB, & Coates TJ. (1996). The Mpowerment Project: a community-level HIV prevention intervention for young gay men. American Journal of Public Health; 86(8):1129-1136.
Kelaher M, Ross MW, Rohrsheim R, Drury M, & Clarkson A. (1994). Dominant situational determinants of sexual risk behaviour in gay men. AIDS; 8(1): 101-105.
Kelly JA, Kalichman SC, Kauth MR, Kilgore HG, Hood HV, & Campos PE, et al. (1991). Situational factors associated with AIDS risk behavior lapses and coping strategies used by gay men who successfully avoid lapses. American Journal Public Health; 81(10): 1335-1338.
Kelly JA, Murphy DA, Bahr GR, Koob JJ, Morgan MG, & Kalichman SC, et al. (1993). Factors associated with severity of depression and high-risk sexual behavior among persons diagnosed with human immunodeficiency virus (HIV) infection. Health Psychology; 12(3):215–219.
Kelly JA, Murphy DA, Sikkema KJ, McAuliffe TL, Roffman RA, & Solomon LJ.et al. (1997). Randomised, controlled, community-level HIV-prevention intervention for sexual-risk behaviour among homosexual men in US cities. Community HIV Prevention Research Collaborative. Lancet; 350(9090):1500–1505.
Kelly JA, St Lawrence JS, Diaz YE, Stevenson LY, Hauth AC, & Brasfield TL. (1991). HIV risk behavior reduction following intervention with key opinion leaders of population: an experimental analysis. American Journal of Public Health; 81(2):168–171.

Kelly J, St Lawrence JS, Stevenson LY, Hauth AC, Kalichman SC, & Diaz YE, et al. (1992). Community AIDS/HIV risk reduction: The effects of endorsements by popular people in three cities. American Journal of Public Health; 82(11): 1483-1489.

Kendler KS, Bulik CM, Silberg J, Hettema JM, Myers J, & Prescott CA. (2000) Childhood sexual abuse and adult psychiatric and substance abuse disorders in women: an epidemiological and cotwin control analysis. Arch Gen Psychiatry; 57(10):953–959.

Kennamer JD, Honnold J, Bradford J, & Hendricks M. (2000). Differences in disclosure of sexuality among African American and White gay/bisexual men: Implications for HIV/AIDS prevention. AIDS Education and Prevention; 12(6): 519–531.

Kertzner RM. (2001). The adult life course and homosexual identity in midlife gay men. Annual Review of Sex Research; 12:75–92.

Kertzner RM. (1999). Self-appraisal of life experience and psychological adjustment in midlife gay men. Journal of Psychology and Human Sexuality;11(2):43–64.

Kessler RC &Neighbors HW. (1986). A new perspective on the relationship among race, social class, and psychological distress. Journal of Health and Social Behavior; 27(2): 107-115.

Kessler RC, Price RH, & Wortman CB. (1985). Social factors psychopathology: Stress, social support, and coping processes. Annual Review of Psychology; 36: 531-572.

Khan MR, Kaufman JS, Pence BW, Gaynes BN, Adimora AA, & Weir SS, et al. (2009). Depression, Sexually Transmitted Infection, and Sexual Risk Behavior Among Young Adults in the United States. Archives of Pediatrics & Adolescent Medicine; 163(7): 644-652.

Khantzian EJ. (1985). The self-medication hypothesis of addictive disorders: focus on heroin and cocaine dependence. American Journal of Psychiatry; 142(11): 1259-1264.

Kim AA, Kent C, McFarland W, & Klausner JD. (2001). Cruising on the Internet highway. J Acquired Immune Deficiency Syndrome ; 28(1): 89-93.

Kimberly JA & Serovich JM. (1999). The role of family and friend social support in reducing risk behaviors among HIV-positive gay men. AIDS Education and Prevention; 11(6): 465-475.

Kingree JB, Thompson MP, & Kaslow NJ. (1999). Risk factors for suicide attempts among low-income women with a history of alcohol problems. Addictive Behaviors; 24(4): 583–587.

Kippax S, Noble J, Prestage G, Crawford JM, Campbell D, & Baxter D, et al. (1997) Sexual negotiation in the AIDS era: Negotiated safety revisited. AIDS; 11(2): 191-197.

Klein H, Elifson KW, &. Sterk CE. (2007). Childhood neglect and adulthood involvement in HIV-related risk behaviors. Child Abuse & Neglect; 31(1):39–53.

Koblin BA, Bonner S, Powell B, Metralexis P, Egan JE, & Patterson J, et al. (2012). A randomized trial of a behavioral intervention for black MSM: the DiSH study. AIDS; 26(4): 483-488.

Koblin BA, Husnik MJ, Colfax G, Huang Y, Madison M, & Mayer K, et al. (2006). Risk factors for HIV infection among men who have sex with men. AIDS; 20(5): 731–739.

Koening LJ, Doll LS, O'Leary A, & Pequegnat W. (Eds). (2004). From child sexual abuse to sexual risk: trauma, revictimization, and intervention. Washington DC: American Psychological Association Press.

Kraemer HC, Kazdin AE, Offord DR, Kesler, & Jensen PS, et al. (1997). Coming to terms with the terms of risk. Archives of General Psychiatry; 54(4):337-343.

Kraft JM, Beeker C, Stokes JP, & Peterson JL. (2000). Finding the 'community" in community-level HIV/AIDS interventions: Formative research with young African American men who have sex with men. Health Education and Behavior; 27(4): 430-441

Krieger N & Sidney S. (1997). Prevalence and health implication of anti-gay discrimination: A study of Black and White women and men in the CARDIA cohort. International Journal of Health Services; 27(1): 157–176.

Kuh D, Ben-Shlomo Y, Lynch J, Hallqvist J, & Power C. (2003). Life course epidemiology. Journal of Epidemiology and Community Health; 57(10):778–783.

Kuh D & Hardy R (2002). Conclusions: linking the past, present and future. In Kuh D & Hardy R. (Eds.). A life course approach to women's health. Oxford, UK: Oxford University Press.

Kuzel A. (1999). Sampling in qualitative inquiry. In Crabtree B & Miller W. (Eds). Doing Qualitative Research. 2nd ed (pg 33-45). Thousand Oaks, California: Sage Publications.

Landis J. (1956). Experiences of 500 children with adult sexual deviation. Psychiatric Quarterly; 30(Suppl):91–109.

Lantz FM, House JS, Lepkowski JM, Williams DR, Mero RP, & Chen J. (1998). Socioeconomic factors, health behaviors, and mortality: Results from a nationally representative prospective study of US adults. JAMA, 279(21): 1703–1708.

Larkin H. (2009). Adverse childhood experiences linked to health risk behaviors. Policy & Practice; 14-16.

Latkin CA, Curry AD, Hua W, & Davey MA. (2007). Direct and indirect associations of neighborhood disorder with drug use and high-risk sexual partners. American Journal of Preventative Medicine; 32(6 Suppl): S234-41.

Latkin CA, Forman V, Knowlton A, & Sherman S. (2003). Norms, social networks, and HIV-related risk behaviors among urban disadvantaged drug users. Social Science & Medicine; 56(3): 465-476.

Latkin CA, Mandell W, Vlahov D, Oziemkowska M, Celentano DD. (1996). The long-term outcome of a personal network-oriented HIV prevention intervention for injection drug users: the SAFE Study. American Journal of Community Psychology; 24(3): 341-364.

Laumann E & Youm Y. (1999). Racial/ethnic group differences in the prevalence of sexually transmitted diseases in the United States: a network explanation. Sexually Transmitted Diseases; 26(5): 250-261.

Law DC, Serre M, Christakos G, Leone P, & Miller W. (2004). Spatial analysis and mapping of sexually transmitted diseases to optimise intervention and prevention strategies. Sexually Transmitted Infections; 80(4): 294-299.
LCWK2. Deaths, percent of total deaths, and death rates for the 15 leading causes of death in 10-year age groups, by race and sex: United States, 2003. [cited 2009 January 30], from www.cdc.gov/nchs/data/dvs/lcwk2_2003.pdf.
Leap WL. (Ed.). (1999). Public sex: Gay space. New York: Columbia University Press.
Leon DA, Lithell HO, Vagero D, Koupilova I, Mohsen R, & Berglund L, et al. (1998). Reduced fetal growth rate and increased risk of ischaemic heart disease mortality in 15 thousand Swedish men and women born 1915–29. British Medical Journal; 317(7153):241-245.
Lehrer JA, Shrier LA, Gortmaker S, & Buka S. (2006). Depressive symptoms as a longitudinal predictor of sexual risk behaviors among US middle and high school students. Pediatrics; 118(1):189-200.
Lejoyeux M, Arbaretaz M, McLoughlin M, & Ades J. (2002). Impulse control disorders and depression. Journal of Nervous and Mental Disease; 190(5):310-314.
Lemert E. (1967). Human deviance, social problems, and social control. Englewood Cliffs, New Jersey: Prentice-Hall.
Lemp GF, Hirozawa AM, Givertz D, Nieri GN, Anderson L, & Lindegren ML. (1994). Seroprevalence of HIV and risk behaviors among young homosexual and bisexual men: the San Francisco/ Berkeley Young Men's Survey. JAMA; 272(6): 449–454.
Leon DA. (2001). Common threads: underlying components of inequalities in mortality between and within countries. In Leon D & Walt G. (Eds), Poverty, inequality and health: An international perspective (pg. 58-87). Oxford, UK: Oxford University Press.
Lepore SJ. (1997). Social environmental influences on the chronic stress process. In Gottleib B (Ed.). Coping with chronic stressors (pg 133-160). New York, NY: Plenum Press.
Liau A, Millett G, & Marks G. (2006). Meta-analytic examination of online sex-seeking and sexual risk behavior among men who have sex with men. Sexually Transmitted Diseases; 33(9): 576-584.
Liem JH & Boudewyn AC. (1999). Contextualizing the effects of childhood sexual abuse on adult self- and social functioning: An attachment theory perspective. Child Abuse & Neglect; 23(11): 1141–1157.
Link BG & Cullen F. (1990). The labeling theory of mental disorders: A review of the evidence. In Greenley J (Ed), Mental illness in social context (pg 75-105). Greenwich, Conneticut: JAI Press.
Link BG, Cullen FT, Struening E, Shrout P, & Dohrenwent BP. (1989). A modified labeling theory approach in the area of mental disorders: an empirical assessment. American Sociological Reviews; 54:100-123.
Link BG & Phelan JC. (2006). Stigma and its public health implications. Lancet; 367(9509):528-529.
Lipschitz DS, Winegar RK, Nicolau AL, Hartnick E, Wolfson M, & Southwick SM. (1999). Perceived abuse and neglect as risk factors for suicidal behavior in adolescent inpatients. Journal of Nervous and Mental Disease, 187(1): 32–39.

Loseke DR. (2007). The Study of identity as cultural, institutional, organizational, and personal narratives: Theoretical and empirical integrations. The Sociological Quarterly; 48(4):661–688.
Lovell A. (2002). Risking risk: the influence of types of capital and social networks on the injection practices of drug users. Social Science & Medicine; 55(5): 803-821.
Lundberg P, Rukundo G, Ashaba S, Thorson A, & Allebeck P, et al. (2011). Poor mental health and sexual risk behaviours in Uganda:A cross-sectional population-based study. BMC Public Health; 21,11:125.
Luthar SS & Cicchetti D. (2000). The construct of resilience: implications for interventions and social policies. Development and Psychopathology. 12(4):857–885.
MacKellar DA, Valleroy LA, Secura GM, Behel S, Bingham T, & Celentano DD, et al. (2005). Unrecognized HIV infection, risk behaviors, and perceptions of risk among young men who have sex with men. JAIDS; 38(5): 603-661.
Malebranche DJ. (2003). Black men who have sex with men and the HIV epidemic: Next steps for public health. American Journal of Public Health;93(6):862–865.
Malyon AK. (1982). Psychotherapeutic implications of internalized homophobia in gay men. Journal of Homosexuality; 7(2-3): 59-69.
Mansergh G, Marks G, Colfax GN, Guzman R, Rader M, & Buchbinder S. (2002). "Barebacking" in a diverse sample of men who have sex with men. AIDS; 16(4):653–659.
Martin JI & Knox J. (1997). Loneliness and sexual risk behaviors. Psychological Reports; 81(3 Pt 1): 815-825.
Masten AS. (2001). Ordinary magic: Resilience process in development. American Psychologist; 56(3): 227-238.
Masten AS & Coatsworth D. (1998). The development of competence in favorable and unfavorable environments. American Psychologist; 53(2): 205-220.
Masten AS & Garmezy N. (1985). Risk, vulnerability, and protective factors in developmental psychopathology. In Lahey BB & Kazdin AE (Eds.), Advances in clinical child psychology, Vol 1 (pg 1-51). New York: Plenum.
Masten AS & Wright MO. (1998). Cumulative risk and protection models of child maltreatment. Journal of Agression, Maltreatment, & Trauma; 2(1):7-30.
Mayer K & Pizer H. (2009). HIV Prevention: A comprehensive approach. Burlington, MA: Elsevier.
Maton KI, Teti DM, Corns KM, Vieira-Backer CC, Lavine JR, & Gouze KR. (1996). Cultural specificity of support sources, correlates and contexts: Three studies of African American and Caucasian youth. American Journal of Community Psychology; 24(4): 551–587.
Maton KI & & Zimmerman MA. (1992). Psychosocial predictors of substance use among urban black male adolescents. Drugs and Society; 6(1-2): 79–113.
Mayne TJ, Acree M, Chesney MA, & Folkman S. (1998). HIV sexual risk behavior following bereavement in gay men. Health Psychology;17(5):403–411.

Mays VM & Cochran S. (1998). Kinsey and male homosexuality in the African-American population: A question of fit. In Sexualities: Studies in culture and society (pg. 98-100). K. Plummer (Ed.). London: Sage Publications.
Mays VM, Cochran S, & Zamudio A. (2004). HIV prevention research: Are we meeting the need of African American men who have sex with men? Journal of Black Psychology; 30(1):78-103.
Mays VM, Nardi PM, Cochran SD, & Taylor RJ. (2000). The importance of friendship networks in HIV prevention among African American gay men. Proceedings of the Thirteenth International Conference on AIDS, Durban, South Africa.
Mazumder B. (2005). ''Fortunate Sons: New Estimates of Interg∂enerational Mobility In the U.S. Using Social Security Earnings Data.'' Review of Economics and Statistics 87(2):235–255.
McCauley J, Kern DE, Kolodner K, Dill L, Schroeder AF, & DeChant HK, et al. (1997). Clinical characteristics of women with a history of childhood abuse. JAMA; 277(17):1362– 1368.
McKirnan D, Stokes JP, Doll L, & Burzette RG. (1995). Bisexually active men: social characteristics and sexual behaviour. Journal of Sex Research, 1995. 32(1):65-76.
McKirnan D, Vanable PA, Ostrow DG, & Hope B. (2001). Expectancies of sexual "escape" and sexual risk among drug and alcohol-involved gay and bisexual men. Journal of Substance Abuse, 2001. 13(1-2): 137-154.
McKusick L, Hortsman W, & Coates T. (1985). AIDS and the sexual behavior reported by gay men in San Francisco. American Journal of Public Health, 1985. 75(5): 493-496.
Merriam SB. (1998). Qualitative research and case study applications in education. San Francisco: Jossey-Bass.
Meyer IH. (2003). Prejudice, social stress and mental health in lesbian, gay and bisexual populations: conceptual issues and research evidence. Psychological Bulletin; 129(5):674-697
Meyer IH. (1995). Minority stress and mental health in gay men. Journal of Health and Social Behavior; 36(1): 38-56.
Meyer IH & Dean L (1998). Internalized homophobia, intimacy and sexual behavior among gay and bisexual men. In Herek G.(Ed.), Stigma and sexual orientation (pg. 160–186). Thousand Oaks, CA: Sage Publications.
Middlebrooks JS & Audage NC. (2008). The Effects of Childhood Stress on Health Across the Lifespan. US Department of Health and Human Services, and the Centers for Disease Control and Prevention.
Middlestadt SE & Fishbein M. (1990). Factors influencing experienced and inexperienced college women's intentions to tell their partners to use condoms. Paper presented at the VI International Conference on AIDS, San Francisco, California.
Miller RL, Klotz D, & Eckholdt HM. (1998). HIV prevention with male prostitutes and patrons of hustler bars: replication of an HIV prevention intervention. American Journal of Community Psychology; 26(1):97–131.
Miller CT & Major B. (2000). Coping with stigma and prejudice. In Heatherton TF, Kleck RE, Hebl MR & Hull JG. (Eds.), The social psychology of stigma (pg. 243–

272). New York: Guilford Press.
Miller GE, Kemeny M, Taylor S, Cole S, & Vissher B. (1997). Social relationships and immune processes in HIV seropositive gay and bisexual men. Annals of Behavioral Medicine; 19(2):139–151.
Millett GA & Peterson JL. (2007). The known hidden epidemic HIV/AIDS among Black men who have sex with men in the United States. American Journal of Preventative Medicine; 32(4 Suppl):31-33.
Millett GA, Peterson JL, Wolitski RJ, & Stall R. (2006). Greater risk for HIV infection of Black men who have sex with men: A critical literature review. American Journal of Public Health; 96(6): 1007-1019.
Mimiaga MJ, Noonan E, Donnell D, Safren SA, Koenen KC, & Gortmaker S, et al. (2009). Childhood sexual abuse is highly associated with HIV risk-taking behavior and infection among MSM in the EXPLORE Study. JAIDS; 51(3): 349-348.
Mimiaga MJ, Reisner SL, Bland S, Skeer M, & Cranston K, et al. (2009). Health system and personal barriers resulting in decreased utilization of HIV and STD testing services among at-risk Black men who have sex with men in Massachusetts. AIDS Patient Care and STDs; 23(10): 825-835.
Mirowsky J. & Ross CE. (1989). Social causes of psychological distress. Hawthorne, New York: Aldine De Gruyter.
Misovich SJ, Fisher JD, & Fisher WA. (1997). Close relationships and elevated HIV risk behavior: Evidence and possible underlying psychological processes. Review of General Psychology; 1(1): 72-107.
Moak ZB & Agrawal A. (2010). The association between perceived interpersonal social support and physical and mental health: Results from the national epidemiological survey on alcohol and related conditions. Journal of Public Health; 32(2): 191-201.
Moeller TP, Bachman GA, & Moeller JR. (1993). The combined effects of physical, sexual, and emotional abuse during childhood: long-term health consequences for women. Child Abuse and Neglect; 17(5):623-640.
Mohr WK. (1999). Family violence: Toward more precise and comprehensive knowing. Issues in Mental Health Nursing; 20(4): 305-317.
Morin SF, Vernon K, Harcourt J, Steward WT, Volk J, & Riess TH, et al. (2003). Why HIV infections have increased among men who have sex with men and what to do about it: Findings from California Focus Groups. AIDS and Behavior; 7(4): 353-362.
Morrill AC, Kasten L, Urato M, & Larson MJ. (2001). Abuse, addiction and depression as pathways to sexual risk in women and men with a history of substance abuse. Journal of Substance Abuse; 13(1-2): 169-184.
Morris M & Kretzschmar M. (1995). Concurrent partnerships and transmission dynamics in networks. Social Networks; 17(3-4): 299-315.
Morris JF, Waldo CR, & Rothblum ED. (2001). A model of predictors and outcomes of outness among lesbian and bisexual women. Journal of Orthopsychiatry;71:61–71.
Mullen PE, Martin JL, Anderson JC, Romans SE, & Herbison GP. (1993). Childhood sexual abuse and mental health in adult life. British Journal of Psychiatry; 163:721–732.

Mullen PE, Roman-Clarkson SE, Walton VA, & Herbison GP. Impact of sexual and physical abuse on women's mental health. Lancet 1988;1(8590):841-845.
Mulligan CB. (1997). Parental priorities and economic inequality. London: University of Chicago Press.
Mustanski B, Garofalo R, Herrick A, & Donenberg G. (2007). Psychosocial health problems increase risk for HIV among urban young men who have sex with men: Preliminary evidence of a syndemic in need of attention. Annals of Behavioral Medicine; 34(1): 37–45.
Mustanski B, Lyons T, & Garcia SC. (2011). Internet use and sexual health of young men who have sex with men: a mixed-methods study. Archives of Sexual Behavior; 40(2): 289-300.
Myers HF, Javanbakht M, Martinez M, & Obediah S. (2003). Psychosocial predictors of risky sexual behaviors in African American men: implications for prevention. AIDS Education and Prevention; 15(1 Suppl A): 66-79.
Myrick R. (1999). In the life: Cultural–specific HIV communication interventions designed for African American men who have sex with men. Journal of Sex Research; 36(2): 159–171.
Nagy S, Adcock AG, & Nagy MC. (1994). A comparison of risky health behaviors of sexually active, sexually abused, and abstaining adolescents. Pediatrics; 93(4):570-575.
National Institutes of Mental Health. (2001) Social-Cognitive Theory Mediators of Behavior Change in the National Institute of Mental Health Multisite HIV Prevention Trial. Health Psychology; 20(5): 369-376
National Scientific Council on the Developing Child. (2005). Excessive stress disrupts the architecture of the developing brain. Working Paper Cambridge: The Council:No. 3. Accessed 30 November 2011, from: http://www.developingchild.net/pubs/wp/Stress_Disrupts_Architecture_Developing_Brain.pdf.
Nelson KE, Eiumtrakul S, Celetano DD, Beyrer C, & Galai N, et al. (2002). HIV infection in young men in northern Thailand 1991-1998: Increasing role of injection drug use. Journal of Acquired Immune Deficiency Syndromes; 29(1): 62-68.
Nelson DE, Higginson GK, & Grant-Worley JA. (1995). Physical abuse among high school students. Prevalence and correlation with other health behaviors. Archives of Pediatric and Adolescent Medicine;149(11):1254-1258.
Nemoto T, Operario D, Soma T, Bao D, Vajrabukka A, & Crisostomo V. (2003). HIV risk and prevention among Asian/Pacific Islander men who have sex with men: Listen to our stories. AIDS Education and Prevention; 15(1): 7-20.
Newcomb MD, Locke TF, Goodyear RK. (2003). Childhood experiences and psychosocial influences on HIV risk among adolescent Latinas in southern California. Cultural Diversity and Ethnic Minority Psychology; 9(3): 219-235.
Newman P, Rhodes F, & Weiss R. (2004). Correlates of sex trading among drug-using men who have sex with men. American Journal of Public Health; 94(11): 1998-2003.
Nott KH, Vedhara K, & Power MJ. (1995). The role of social support in HIV infection. Psychological Medicine, 25(5): 971-983.

Nungesser LG. (1983). Homosexual acts, actors, and identities. New York: Praeger.
Odonne-Paolucci E, Genuis ML, & Violato C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. Journal of Psychology; 135(1): 17–36.
Offer C, Grinstead O, Goldstein E, Mamary E, Alvarado N, & Euren J, et al. (2007). Responsibility for HIV prevention: Patterns of attribution among HIV-seropositive gay and bisexual men. AIDS Education and Prevention; 19(1): 24-35.
O'Leary D, Purcell R, Remien H, & Gomez C. (2003). Childhood sexual abuse and sexual transmission risk behavior among HIV-positive men who have sex with men. AIDS Care; 15(1):17-26.
Omoto AM & Kurtzman HS. (Eds) (2006). Sexual orientation and mental health: Examining identity and development in lesbian, gay, and bisexual people (pg. 245-267). Washington, DC: American Psychological Association.
Operario D, Smith CD, Arnold E, & Kegeles S. (2010) The Bruthas Project: Evaluation of a Community-based HIV Prevention Intervention for African American Men who Have Sex With Men And Women. AIDS Education and Prevention; 22(1): 37–48.
Operario D, Smith CD, & Kegeles SM. (2008). Social and psychological context for HIV risk in non-gay-identified African American men who have sex with men. AIDS Education and Prevention; 20(4): 347-359.Osofsky JD. (1999). The impact of violence on children. Future Child; 9(3):33–49.
Ostrow DG, Fox K, Chmiel JS, Silvestre A, Visscher BR, & Vanable P, et al. (2002). Attitudes towards highly active antiretroviral therapy are associated with sexual risk taking among HIV-infected and uninfected homosexual men. AIDS; 16(5): 775–780
Ostrow DG, Fox K, Chmiel JS, Silvestre A, Visscher BR, & Vanable P, et al. (2000). Attitudes towards highly active antiretroviral therapy predict sexual risk-taking among HIV-infected and uninfected gay men in the mulicenter AIDS cohort study (MACS). Paper presented at the 13th International AIDS Conference, Durban, South. Africa.
Ostrow DG & McKirnan DJ. (1997). Prevention of substance-related high-risk sexual behavior among gay men: Critical review of the literature and proposed harm reduction approach. Journal of the Gay and Lesbian Medical Association; 1(2):97-110.
Ostrow DG, Whitaker RE, Frasier K, Cohen C, Wan J, & Frank C, et al. (1991). Racial differences in social support and mental health in men with HIV infection: a pilot study. AIDS Care; 3(91):55–63.
Pagani LS. (2007). How does poverty beget poverty? Paediatric and Child Health; 12(8): 693-697.
Palella FJ, Delaney KM, Moorman AC, Loveless MO, & Fuhrer J, et al. (1998). Declining morbidity and mortality among patients with advanced human immunodeficiency virus infection. HIV Outpatient Study Investigators. New England Journal of Medicine; 338(13): 853-860.
Panksep J. (1998). Affective neuroscience. New York: Oxford University Press.
Panter-Brick C & Worthman CM. (Eds.) (1999). Hormones, health and behavior.

Cambridge,UK: Cambridge University Press.
Parillo KM, Freeman RC, Collier K, & Young P (2001). Association between early sexual abuse and adult HIV-risky sexual behaviors among community-recruited women. Child Abuse and Neglect; 25(3): 335-346.
Parker R. (2001). Sexuality, culture, and power in HIV/AIDS research. Annual Review in Anthropology; 30: 163-179.
Parsons JT & Halkitis PN. (2002). Sexual and drug-using practices of HIV-positive men who frequent public and commercial sex environments. AIDS Care; 14(6): 815-826.
Parson JT, Halkitis PN, Wolitski RJ, & Gomez CA, Seropositive Urban Men's Study Team. (2003). Correlates of sexual risk behaviors among HIV-positive men who have sex with men. AIDS Education and Prevention; 15(5): 383-400.
Patton MQ. (2002). Qualitative research and evaluation methods 3rd ed. Thousand Oaks, CA: Sage Publications.
Patton MQ. (1987). How to Use Qualitative Methods in Evaluation. Newbury Park, CA: Sage Publications.
Paul JP, Catania J, Pollack L, & Stall R. (2001). Understanding childhood sexual abuse as a predictor of sexual risk-taking among men who have sex with men: The Urban Men's Health Study. Child Abuse & Neglect; 25(4): 557-584.
Penninx BWJH, van Tilburg T, Boeke A, Deeg D, Kriegsman K, & van Eijk J (1998). Effects of social support and personal coping resources on depressive symptoms: Different for various chronic diseases? Health Psychology; 17(6):551–558.
Pequegnat W & Bray JH. (1997). Families and HIV/AIDS: Introduction to the Special Section Issue. Journal of Family Psychology; 11(1): 3-10.
Perdue T, Hagan H, Thiede H, & Valleroy L. (2003). Depression and HIV risk behavior among Seattle-area injection drug users and young men who have sex with men. AIDS Education and Prevention; 15(1):81–92.
Peretti PO, Early K, & Chmura EK. (1998). Chronic and acute neglected children: Psychological variables. Social Behavior and Personality, 26(2), 175–180.
Perry BD, Pollard RA, Blakely TL, Baker WL, & Vigilante D. (1995). Childhood trauma, the neurobiology of adaptation and use-dependent development of the brain: how states become traits. Infant Mental Health Journal;16(4):271-291.
Peterson JL, Bakeman R, & Stokes J, Community Intervention Trial for Youth Study Team. (2001). Racial/ethnic patterns of HIV sexual risk behaviors among young men who have sex with men. Journal of the Gay and Lesbian Medical Association; 5(4):155–162.
Peterson JL, Coates TJ, Catania J, Hauck WW, Acree M, & Daigle D, et al. (1996). Evaluation of an HIV risk reduction intervention among African-American homosexual and bisexual men. AIDS; 10(3): 319-325.
Peterson JL, Coates TJ, Catania JA, Middleton L, & Hillard B, et al. (1992). High-risk sexual behavior and condom use among gay and bisexual African-American men. American Journal of Public Health; 82(11): 1490-1494.
Peterson JL & Jones KT. (2009). HIV Prevention for Black Men Who Have Sex With Men in the United States. American Journal of Public Health; 99(6):976–980.

Pettigrew TF. (1967). Social evaluation theory: Convergences and applications. In Levine D. (Ed.), Nebraska Symposium on Motivation (pg. 241-304). Lincoln: University of Nebraska Press.
Plummer K. (1995). Telling sexual stories: Power, change and social worlds. New York: Routledge.
Postmes T & Branscombe NR. (2002). Influence of long-term racial environ-mental composition on subjective well-being in African Americans. Journal of Personality and Social Psychology; 83(3): 735–751.
Poundstone KE, Strathdee SA, & Celentano DD. (2004). The social epidemiology of human immunodeficiency virus/acquired immunodeficiency syndrome. Epidemiological Reviews; 26: 22-35.
Prejean J, Song R, Hernandez A, Ziebell R, Green T, & et al. (2011) Estimated HIV incidence in the United States, 2006–2009. PLoS ONE; 6(8): e17502
Preston DB, D'Augelli AR, Kassab CD, Cain RE, Schulze FW & Starks MT. (2004). The influence of stigma on the sexual risk behavior of rural men who have sex with men. AIDS Education and Prevention; 16(4): 291-303.
Purcell DW, Moss S, Remien RH, Woods WJ, & Parsons JT. (2005). Illicit substance use, sexual risk, and HIV-positive gay and bisexual men: differences by serostatus of casual partners. AIDS;19(Suppl 1):37-47.
Quinn SC. (1997). Belief in AIDS as a form of genocide: implications for HIV prevention programs for African Americans. J Health Educ; 28(6):S6-S11
Ramirez-Valles J. (2002). The protective effects of community involvement for HIV risk behavior: a conceptual framework. Health Education Research; 17 (4): 389-403.
Rao U. (2006). Links between depression and substance abuse in adolescents: neurobiological mechanisms. American Journal of Preventative Medicine; 31(6 Suppl 1): 161-174.
Reece M & Dodge B. (2003). Exploring the physical, mental and social well-being of gay and bisexual men who cruise for sex on a college campus. Journal of Homosexuality; 46(1-2): 111-36.
Reilly T & Woo G. (2004). Social Support and Maintenance of Safer Sex Practices among People Living with HIV/AIDS. Health and Social Work; 29(2): 97-105.
Reis HT, Collins WA, & Berscheid E. (2000). Relationships in human behavior and development. Psychological Bulletin; 126(6): 844-872.
Reisen CA, Iracheta MA, Zea MC, Bianchi FT, & Poppen PJ. (2010). Sex in public and private settings among Latino MSM. AIDS Care; 22(6): 697-704.
Remafedi G, French S, Story M, Resnick M.D, & Blum, R. (1998). The relationship between suicide risk and sexual orientation: Results of a population-based study. American Journal of Public Health; 88: 57–60.
Remien RH, Wagner G, Carballo-Dieguez A, & Dolezal C. (1998). Who may be engaging in high-risk sex due to medical treatment advances? AIDS; 12(12): 1560–1561.
Repetti RL, Taylor SE, & Seeman TE. (2002). Risky Families: Family Social Environments and the Mental and Physical Health of Offspring. Psychological Bulletin; 128(2): 330–366.
Rhode Island Department of Health. (2010). 2008 Rhode Island HIV/AIDS

epidemiologic profile with surrogate data. Division of Family Health and Equity. Office of HIV/AIDS and Viral Hepatitis. Government Printing Office.
Rhodes T. (2002). The 'risk environment': a framework for understanding and reducing drug-related harm. International Journal of Drug Policy; 13(2):85-94.
Rhodes SD, Hergenrather KC, Vissman AT, Stowers J, Davis AB, & Hannah A, et al. (2011). Boys must be men, and men must have sex with women: A qualitative CDPR Study to explore sexual risk among African American, Latino, and White gay men and MSM. American Journal of Men's Health; 5(2): 140-151.
Rietmeijer CA, Wolitski RJ, Fishbein M, Corby NH, & Cohn DL. (1998). Sex hustling, injection drug use, and non-gay identification by men who have sex with men: associations with high-risk sexual behaviors and condom use. Sexually Transmitted Diseases, 1998. 25(7): 353-360.

Rigby K, Brown M, Anagnostou P, Ross MW, & Rosser BRS. (1989). Shock tactics to counter AIDS: The Australian experience. Psychology and Health, 3(3): 145–159.
Riley ED, Gandhi M, Hare CB, Cohen J, & Hwang SW. (2007). Poverty, unstable housing, and HIV infection among women living in the United States. Current HIV/AIDS Reports; 4(4): 181-186.
Ritchie J & Lewis J. (2003). Qualitative Research Practice: A Guide for Social Science Students and Researchers. Thousand Oaks, CA: Sage Publications.
Robinson BE, Galbraith JS, Swinburne Romine RE, Zhang Q, & Herbst JH. (2011). Differences between HIV-positive and HIV-negative African American men who have sex with men in two major U.S. Metropolitan areas. Epub ahead of print.
Rodgers CS, Lang AJ, Laffaye C, Satz LE, Dresselhaus TR, & Stein MB. (2004). The impact of individual forms of childhood maltreatment on health behavior. Child Abuse and Neglect; 28(5): 575-586.
Rogoff B. (1990). Apprenticeship in thinking: Cognitive development in social context. New York, NY: Oxford University Press.
Rosenberg S & Gara M. (1985). The multiplicity of personal identity: Self, situations, and social behavior. In Shaver R. (Ed.), Review of Personality and Social Psychology (pg. 87-113). Beverly Hills, California: Sage Publications.
Rosenfield S. (1997). Labeling mental illness: the effects of received services and perceived stigma on life satisfaction. American Sociological Reviews; 62: 660-672
Rosengarten M, Race K, & Kippax S. (2000). "Touch wood, everything will be OK": Gay men's understandings of clinical markers in sexual practice. Sydney: National Centre in HIV Social Research, University of New South Wales.
Rosenstock I, Strecher V, & Becker M. (1994). The Health Belief Model and HIV risk behavior change. In DiClemente RJ & Peterson JL (Eds.), Preventing AIDS: Theories and methods of behavioral interventions (pg. 5-24). New York: Plenum Press.
Rosenthal R. (1966). Experimenter effects in behavioral research. New York:

Appleton-Century-Crofts.
Ross MW. (2005). Typing, doing, and being: Sexuality and the Internet. Journal of Sex Research; 42(4): 342-352.
Ross MW. (1990). The relationship between life events and mental health in homosexual men. Journal of Clinical Psychology; 46(4): 402-411.
Ross MW, Henry D, Freeman A, Caughy M, & Dawson AG Jr. (2004). Environmental influences on safer sex in young gay men: A situational presentation approach to measuring influences on sexual health. Archives of Sexual Behavior; 33(3): 249-257
Ross MW, Timpson SC, Williams ML, & Bowen AM. (2003). Situational correlates of condom use in a sample of African American drug users who are primarily crack cocaine users. AIDS and Behavior; 7(1): 55-60.
Rosser BRS, Bockting WO, Ross MW, Miner MH, & Coleman E. (2008). The relationship between homosexuality, internalized homo-negativity, and mental health in men who have sex with men. Journal of Homosexuality; 55(2): 185-203.
Ruiz J, Facer M, & Sun RK. (1998). Risk factors for human immunodeficiency virus infection and unprotected anal intercourse among young men who have sex with men. Sexually Transmitted Diseases; 25(2):100–107.
Russell GM & Kelly NH. (2002). Research as interacting dialogic processes: Implications for reflexivity. *Forum: Qualitative Social Research*, *3*(3). Retrieved June 5, 2012, from http://www.qualitative-research.net/fqs-texte/3-02/3-02russellkelly-e.htm
Rutter M. (1987). Psychological resilience and protective mechanisms. American Journal of Orthopsychiatry; 57(3): 316-331.
Saleh LD & Operario D. (2009). Moving beyond "the down low": A critical analysis of terminology guiding HIV prevention efforts for African American men who have secretive sex with men. Social Science and Medicine; 68(2): 390-395.
Sanchez T, Finlayson T, Drake A, Behel S, Cribbin M, & Dinenno E. (2006). Human immunodeficiency virus (HIV) risk, prevention, and testing behaviors--United States, National HIV Behavioral Surveillance System: men who have sex with men, November 2003-April 2005. MMWR Surveillance Summary; 55(6): 1-16.
Sanders-Philips K. (2002). Factors influencing HIV/AIDS in women of color. Public Health Reports; 117(Suppl): 151-156.
Sandfort TG, de Graaf R, Bijl RV, & Schnabel P. (2001). Same-sex sexual behavior and psychiatric disorders: Findings from the Netherlands Mental Health Survey and Incidence Study (NEMESIS) Archives of General Psychiatry; 58(1):85–91.
Schreurs KMG & de Ridder DTD. (1997). Integration of coping and social support perspectives: Implications for the study of adaptation to chronic diseases. Clinical Psychology Review; 17(1): 89–112.
Schur E. (1971). Labeling deviant behavior: Its sociological implications. New York: Harper & Row.
Sengupta S, Strauss RP, DeVellis R, Quinn SC, DeVellis B, & Ware WB. (2000). Factors

Affecting African-American Participation in AIDS Research. Journal of Acquired Immune Deficiency Syndromes; 24(3): 275-284.
Shade BJ. (1990). Coping with color: The anatomy of positive mental health. In Ruiz DS. (Ed.), Handbook of mental health and mental disorders among Black Americans (pg. 273–289). New York: Greenwood Press.
Siegel K & Epstein JA. (1996). Ethnic-racial differences in psychological stress related to gay lifestyle among HIV- positive men. Psychological Reports; 79(1):303–312.
Seage GR, Holte S, Gross M, Koblin B, Marmor M, & Mayer KH, et al. (2002). Case-crossover study of partner and situational factors for unprotected sex. JAIDS; 31(4): 432-439.
Seage GR, Mayer KH, Wold C, Lenderking WR, Goldstein R, & Cai B. (1998). The social context of drinking, drug use, and unsafe sex in the Boston Young Men Study. Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology, 1998. 17(4): 368-375.
Shonkoff JP & Phillips D. (Eds.) (2000). From neurons to neighborhoods: The science of early childhood development. Committee on Integrating the Science of Early Childhood Development. Washington, DC: National Academy Press.
Shrier LA, Harris SK, & Beardslee WR. (2002). Temporal associations between depressive symptoms and self-reported sexually transmitted disease among adolescents. Archives of Pediatric and Adolescent Medicine; 156(6):599-606.
Sikkema KJ, Anderson ES, Kelly JA, Winett RA, Gore-Felton C, & Roffman RA. (2005). Epidemiology and Social Outcomes of a randomized, controlled community-level HIV prevention intervention for adolescents in low-income housing developments. AIDS; 19(14): 1509-1516
Silvestre AJ, Hylton JB, Johnson LM, Houston C, Witt M, & Jacobson L, et al. (2006). Recruiting minority men who have sex with men for HIV research: Results from a 4-city campaign. Am J Public Health; 96(6):1020-1027.
Singer M. (1996). Dose of drugs, a touch of violence, a case of AIDS: Conceptualizing the SAVA Syndemic. Free Inquiry in Creative Sociology: 24(2): 99–110.
Singer M. (1994). AIDS and the health crisis of the US urban poor: the perspective of critical medical anthropology. Soc Sci Med; 39:931-948.
Singer M & St. Clair S. (2003) Syndemics and public health: reconceptualizing disease in biosocial context. Medical Anthropology Quarterly; 17(4):423-441.
Smith GD, Gunnell D, & Ben-Shlomo Y. (2000). Life-course approaches to socioeconomic differentials in cause specific adult mortality. In Leon D & Walt G. (Eds.), Poverty, inequality and health: an international perspective (pg. 88-124). Oxford: Oxford University Press.
Smith K & Joshi H. (2002). The millennium cohort study. Pop Trends; Spring(107):30-34.
Solon G. (1992). Intergenerational Income Mobility in the United States. American Economic Review; 82(3):393–408.
Solorio R, Swendeman D, & Rotheram-Borus. (2003). Risk among young gay and bisexual men living with HIV. AIDS Education and Prevention; 15(1): 80-89.
Somerville G, Diaz S, Davis S, Coleman K, & Taveras S. (2006). Adapting the Popular Opinion Leader intervention for Latino young migrant men who have sex with

men. AIDS Education and Prevention;18(4 Suppl A):137–148.
Somlai AM, Kelly JA, Wagstaff DA, & Whitson DP. (1998). Patterns, predictors and situational contexts of HIV risk behaviors among homeless men and women. Social Work; 43(1):7-20.
Sowa CJ & Lustman PJ. (1984). Gender differences in rating stressful events, depression, and depressive cognition. Journal of Clinical Psychology; 40(6): 1334-1337.

Spak L, Spak F, & Allebeck P. (1998). Sexual abuse and alcoholism in a female population. Addiction; 93(9): 1365–1373.
Springs F & Friedrich WN. (1992). Health risk behaviors and medical sequelae of childhood sexual abuse. Mayo Clinic Proceedings; 67(6):527–32.
Stake R. (1995). *The art of case study research.* Thousand Oaks, CA: Sage Publications.
Stall R, Friedman M, & Catania JA. (2008). Interacting epidemics and gay men's health: A theory of syndemic production among urban gay men. In Wolitski RJ, Stall R, & Valdiserri RO. (Eds.), Unequal opportunity: Health disparities affecting gay and bisexual men in the United States (pg 251-274). New York: Oxford University Press.
Stall R, Mills TC, Williamson J, Hart T, Greenwood G, & Paul J, et al. (2003). Association of co-occurring psychosocial health problems and increased vulnerability to HIV/AIDS among urban men who have sex with men. American Journal of Public Health; 93(6):939– 942.
Stall R, Paul P, Greenwood G, Pollack LM, Bein E, & Crosby GM, et al. (2001). Alcohol use, drug use and alcohol-related problems among men who have sex with men: the Urban Men's Health Study. Addiction; 96(11):1589-1601.
Stein MB, Koverola C, Hanna C, Torchia MG, & McClarty B. (1997). Hippocampal volume in women victimized by childhood sexual abuse. Psychological Medicine; 27(4): 951-959.
Stokes JP & Peterson JL. (1998). Homophobia, self-esteem, and risk for HIV among African American men who have sex with men. AIDS Education and Prevention;10(3):278–292.
Stokes JP, Vanable P, & McKirnan D. (1996). Ethnic differences in sexual behaviour, condom use, and psychosocial variables among black and white men who have sex with men. Journal of Sex Research 33(4): 373-381.
Stolte IG & Coutinho RA. (2002). Risk behaviour and sexually transmitted diseases are on the rise in gay men, but what is happening with HIV? Current Opinion in Infectious Disease; 15(1): 37–41.
Strathdee SA, Hogg RS, Martindale SL, Cornelisse PG, Craib KJ, & Montaner JS, et al. (1998). Determinants of sexual risk-taking among young HIV-negative gay and bisexual men. J Acquired Immune Deficiency Syndromes and Human Retrovirology; 19(1):61–66.
Strauss A & Corbin J. (1998). Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory. Thousand Oaks, CA: Sage Publications.
Straus MA & Gelles RJ. (1986). Societal change and change in family violence from 1975 to 1985 as revealed by two national surveys. Journal of Marriage and

Family; 48(3):465–479.
Stryker S & Statham A. (1985). Symbolic interaction and role theory. In Lindzey G. & Aronson E. (Eds.), Handbook of social psychology (pg. 311-378). New York: Random House.
Sumartojo E. (2000). Structural factors in HIV prevention: concepts, examples, and implications for research. AIDS; 14(Suppl 1): 3-10.
Sullivan PS, Salazar L, Buchbinder S, & Sanchez TH. (2009). Estimating the proportion of HIV transmissions from main sex partners among men who have sex with men in five US cities. AIDS; 23(9): 1153-1162
Susser E, Terry MB, & Matte T (2000). The birth cohorts grow up: new opportunities for epidemiology. Paediatric and Perinatal Epidemiology; 14(2):98–100.
Tajfel H & Turner JC. (1986). The social identity theory of intergroup behaviors. In Worchel S & Austin WG. (Eds.). Psychology of intergroup relations (pg. 7-24). Chicago, IL: Nelson-Hall.
Tak YR & McCubbin M. (2002). Family stress, perceived social support and coping following the diagnosis of a child's congenital heart disease. Journal of Advanced Nursing; 39(2): 190-198.
Taylor SE, Repetti RL, & Seeman T. (1997). Health psychology: what is an unhealthy environment and how does it get under the skin? Annual Reviews of Psychology; 48:411-47.
Teicher MH, Ito Y, Glod CA, Andersen SL, Dumont N, & Ackerman E. (1997). Preliminary evidence for abnormal cortical development in physically and sexually abused children using EEG coherence and MRI. Annals of the New York Academy of Sciences; 821:160-175.
Teunis N. (2007). Sexual objectification and the construction of whiteness in the gay male community. Culture, Health, and Sexuality; 9(3): 263-275.
Tewksbury R. (2003). Bareback sex and the quest for HIV: Assessing the relationship in internet personal advertisements of men who have sex with men. Deviant Behavior; 24(5):467-483.
Thoits PA. (1995). Stress, coping, and social support processes: Where are we? What next? Journal of Health and Social Behavior; 35(Special Issue): 53-79.
Thomas SB & Quinn SC. (1991). The Tuskegee Syphilis Study, 1932 to 1972: Implications for HIV education and AIDS risk education programs in the Black community. American Journal of Public Health; 81(11):1498-1505.
Thompson RA. (2000).The legacy of early attachments. Child Development; 71(1):145-152.
Thompson RA. (1999). Early attachment and later development. In Cassidy J & Shaver PR. (Eds.). Handbook of attachment: Theory, research, and clinical applications (pg. 265-286). New York: Guilford Press.
Thompson RA. (1998). Early sociopersonality development. In Damon W (Ed.) & Eisenberg N (Vol. Ed.). Handbook of child psychology (Vol. 3): Social, emotional, and personality development 5th ed. (pg. 25-104). New York, NY: John Wiley & Sons.
Thompson JC & Sampson LA. (2005). High rates of incarceration as a social force associated with community rates of sexually transmitted infection. Journal of Infectious Diseases; 191(Suppl 1): 55-60.

Torian L, Chen M, Rhodes P & Hall HI. (2011). HIV Surveillance - United States, 1981—2008. Morbidity and Mortality Weekly Report; 60(21): 686- 728

Treadwell H & Ro M. (2003). Poverty, race, and the invisible men. American Journal of Public Health; 93(5): 705-707.

Turner JC. (1999). Some current issues in research on social identity and self-categorization theories. In Ellemers N, Spears R, & Doosje B. (Eds.). Social identity: Context, commitment, content (pg. 6-34). Oxford, England: Blackwell.

Turner HA, Hays R, & Coates T. (1993). Determinants of social support among gay men: The context of AIDS. Journal of Health and Social Behavior; 34(1):37–53.

Turner RJ & Lloyd DA. (1995). Lifetime traumas and mental health: the significance Of cumulative adversity. Journal of Health and Social Behavior; 36(4):360-376.

Twenge JM, Catanese KR, & Baumeister RF. (2002). Social exclusion causes self-defeating behavior. Journal of Personality and Social Psychology; 83(3): 606-615.

Uchino BN, Cacioppo JT, & Kiecolt-Glaser JK. (1996). The relationship between social support and physiological processes: A review with emphasis on underlying mechanisms and implications for health. Psychological Bulletin; 119(3): 488-531.

Uhlenberg P. (1996). Mutual attraction: demography and life-course analysis. Gerontologist; 36(2):226-229.

Ungar M. (2003). Qualitative contributions to resilience research. Qualitative Social Work; 2(1): 85-102.

United States Census Bureau (2010). Housing and Household Economic Statistics Division, Fertility & Family Statistics Branch. www.census.gov/population/www/socdemo/hh-fam/cps2010.html.

United States Department of Justice. (2000). Extent, nature and consequences of intimate partner violence: Findings from the National Violence Against Women Survey, Washington, DC.

Upchurch DM, Levy-Storms L, Sucoff CA, & Aneshensel CS. (1998). Gender and ethnic differences in the timing of first sexual intercourse. Family Planning Perspectives; 30(3): 121-127.

Valdiserri RO. (2004). Mapping the roots of HIV/AIDS complacency: implications for Program and Policy Development. AIDS Education and Prevention; 16(5): 426-439.

Valdiserri RO. (2002). HIV/AIDS stigma: An impediment to public health. American Journal of Public Health; 92(3):341–342.

Valdiserri R, Lyter D, Leviton LC, Callahan M, & Kingsley LA. (1988). Variables influencing condom use in a cohort of gay and bisexual men. American Journal of Public Health; 78(7): 801-805.

Valleroy L. (2002). High HIV prevalence and incidence among young African American men who have sex with men in 6 US cities: what factors are contributing? in XIV International AIDS Conference. Barcelona, Spain.

Van de Ven P, Kippax S, Knox S, Prestage G, Crawford J. (1999). HIV treatments

optimism and sexual behaviour among gay men in Sydney and Melbourne. AIDS, 13(16): 2289–2294.
Van de Ven P, Prestage G, Knox S, & Kippax S. (2000b). Gay men in Australia who do not have HIV test results. International Journal of STD and AIDS; 11(7): 456–460.
VanLandingham MJ, Suprasert S, Grandjean N, & Sittitrai W. (1995). Two views of risky sexual practices among Northern Thai males: The health belief model and the theory of reasoned action. Journal of Health and Social Behavior; 36(2): 195-212.
Van der Kolk BA, Perry JC, & Herman JL. (1991). Childhood origins of self destructive behavior. American Journal of Psychiatry; 148(12):1665–1671.
Van der Kolk BA & Fisler RE. (1994). Childhood abuse and neglect and loss of self-regulation. Bulletin of the Menninger Clinic; 58(2): 145-168.
Waldo C & Coates T. (2000). Multiple levels of analysis and intervention in HIV prevention science: exemplars and directions for new research. AIDS; 14(Suppl 2):18-26.
Waldo CR, Kegels Sm, & Hays RB. (1998). Self-acceptance of gay identity predicts decreased sexual risk behavior and increased psychological health in U.S. young gay men. Paper presented at the 12th International AIDS Conference, Geneva, Switzerland.
Waller MW, Hallfors DD, Halpern CT, Iritani BJ, Ford CA, & Guo G. (2006). Gender differences in associations between depressive symptoms and patterns of substance use and risky sexual behavior among a nationally representative sample of U.S. adolescents. Archives of Women's Mental Health; 9(3):139-150.
Waters E, Kondo-Ikemura K, Posada G, & Richters JE. (1991). Learning to love: Mechanisms and milestones. In Gunnar M & Sroufe L. (Eds.). Self processes and development (pg. 217-255). Hillsdale NJ: Erlbaum.
Weinberg MS & Williams CJ. (1974). Male homosexuals: Their problems and adaptations. New York: Penguin Books.
Weinhardt LS, Forsyth AD, Carey MP, Jaworski BC, & Durant LE. (1998). Reliability and validity of self-report measures of HIV-related sexual behavior: Progress since 1990 and recommendations for research and practice. Archives of Sexual Behavior; 27(2): 155-180
Weiss MJS & Wagner SH. (1998). What explains the negative consequences of adverse childhood experiences on adult health? American Journal of Preventative Medicine; 14(4):356-360.
Whitehead T. (1997). Urban low-income African American men, HIV/AIDS, and gender identity. Medical Anthropology Quarterly; 11(4): 411-447.
Widom CS. (1999). Childhood victimization and the development of personality disorders. Unanswered questions remain. Archives of General Psychiatry; 56(7): 607-608.
Williams JK, Wyatt GE, Resell J, Peterson J, & Asuan-O'Brien A. (2004). Psychosocial issues among gay- and non-gay-identifying HIV-seropositive African American and Latino MSM. Cultural Diversity and Ethnic Minority Psychology; 10(3): 268-286.

Williams DR & Collins C. (2001) Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health. Public Health Reports; 116(5): 404-416
Wills TA. (1986). Stress and coping in early adolescence: Relationship to substance abuse in urban school samples. Health Psychology; 5(6): 503-529.
Wilson P, Wright K, & Isbell M. (2008). Left behind: Black America: A neglected priority in the global AIDS epidemic. Los Angeles, CA: Black AIDS Institute.
Wilsnack SC & Vogeltanz ND, Klassen AD, & Harris TR. (1997). Childhood sexual abuse and women's substance abuse: National survey findings. Journal of Studies on Alcohol; 58(3): 264–271.
Wilson HW & Widom CS. (2011). Pathways from childhood abuse and neglect to HIV-risk behavior in middle adulthood. Journal of Consulting and Clinical Psychology; 79(2): 236-246.
Wilson HW & Widom CS. (2009). A prospective examination of the path from child abuse and neglect to illicit drug use in middle adulthood: the potential mediating role of four risk factors. Journal of Youth and Adolescence; 38(3): 340-354.
Wilson P & Yoshikawa H. (2004). Experiences of and Responses to Social Discrimination among Asian and Pacific Islander Gay Men: Their Relationship to HIV Risk. AIDS Education and Prevention; 16(1): 68-83.
Wilton L, Herbst JH, Coury-Doniger P, Painter TM, English G, & Alvarez ME, et al. (2009). Efficacy of an HIV/STI Prevention Intervention for Black Men Who Have Sex with Men: Findings from the Many Men, Many Voices (3MV) Project. AIDS and Behavior; 13(3):532–544
Windle M. (1992). A longitudinal study of stress buffering for adolescent problem behaviors. Developmental Psychology; 28(3): 522–530.
Winfield EB & Whaley AL. (2002). A Comprehensive test of the Health Belief Model in the prediction of condom use among African American college students. Journal of Black Psychology; 28(4): 330-346.
Wright ER, Gronfein WP, & Owens TJ. (2000). Deinstitutionalization, social rejection, and the self-esteem of former mental patients. Journal of Health and Social Behavior; 41(1): 68-90
Wohl AR, Galvan FH, Myers HF, Farland W, George S, Witt M, Cadden J, Operskalski E, Jordan W, & Carpio F. (2010). Social support, stress and social network characteristics among HIV-positive Latino and African American women and men who have sex with men. AIDS and Behavior; 14(5): 1149-1158.
Wohl AR, Galvan FH, Myers HF, Farland W, George S, Witt M, Cadden J, Operskalski E, Jordan W, Carpio F, Lee ML. (2010). Do social support, stress, disclosure and stigma influence retention in HIV care for Latino and African American men who have sex with men and women? AIDS and Behavior; 15(6):1098-1110.
Woodyard J, Peterson J, & Stokes J. (2000). "Let us go into the house of the Lord": Participation in African American churches among young African American men who have sex with men. Journal of Pastoral Care; 54(4): 451-460.
Wulfert E, Safren SA, Brown I, & Wan CK. (1999). Cognitive, behavioral, and personality correlates of HIV-positive persons' unsafe sexual behavior. Journal of Applied Social Psychology; 29(2): 223–244.
Wulfert E & Wan C. (1993). Condom use: A self-efficacy model. Health Psychology;

12(5): 346–353.
Wulfert E, Wan CK & Backus CA. (1996). Gay men's safer sex behavior: An integration of three models. Journal of Behavioral Medicine, 19(4): 345-366.
Wyatt GE, Williams JK, & Myers HF. (2008). African-American sexuality and HIV/AIDS: recommendations for future research. Journal of National Medical Association; 100(1): 44-8, 50-1.
Wyatt GE & Peters SD. (1986). Methodological considerations in research on the prevalence of child sexual abuse. Child Abuse & Neglect; 10(2):241–251.
Xia Q, Tholandi M, Osmond DH, Pollack LM, Zhou W, Ruiz JD, & Catania JA. (2006). The effect of venue sampling on estimates of HIV prevalence and sexual risk behaviors in men who have sex with men. Sexually Transmitted Diseases; 33(9): 545-550.
Yates TM, Egeland B, & Sroufe LA. (2003). Rethinking resilience: a developmental process perspective. In Luthar SS (Ed.). Resilience and vulnerability: Adaptation in the context of childhood adversities (pg. 243-266). New York: Cambridge University Press.
Zaric G. (2002). Random vs. nonrandom mixing in network epidemic models. Health Care Management Science; 5(2):147-155.
Zenilman JM, Ellish N, Fresia A, & Glass G. (1999). The geography of sexual partnerships in Baltimore: applications of core theory dynamics using a geographic information system. Sexually Transmitted Diseases; 26(2): 75-81.
Zierler S, Feingold L, Laufer D, Velentgas P, Kantrowitz-Gordon I, & Mayer K. (1991). Adult Survivors of Childhood Sexual Abuse and Subsequent Risk of HIV Infection. American Journal of Public Health; 81(5): 572-575.
Zlotnick C, Mattia J, & Zimmerman M. (2001). Clinical features of survivors of sexual abuse with major depression. Child Abuse & Neglect; 25(3): 357-367.
Zimmerman BJ. (2000). Attaining self-regulation: A Social cognitive perspective. In Boekaerts M, Pintrich PR, & Zeidner M. (Eds). Handbook of self-regulation (pg. 13-41). San Diego, CA: Academic Press.

APPENDICES

Appendix 1: Participant consent form

University of Oxford
Department of Social Policy and Social Work

BARNETT HOUSE
32 WELLINGTON SQUARE
OXFORD OX1 2ER
ENGLAND
TEL 01865 270325
FAX 01865 270324
http://www.spsw.ox.ac.uk

SITUATION AND SEX PARTNER FACTORS OF HIV RISK BEHAVIORS IN AFRICAN AMERICAN MEN
Participant Information and Consent Form

Purpose and Value of Study
Lena Saleh, MSc, is a doctoral student at the University of Oxford under the supervision of her advisor, Dr. Don Operario. She is conducting a study to better understand the factors that lead to increased HIV transmission among African American men who have sex with men and do not identify as gay. Sharing your experience as an African American male who has sex with men is very important because we know little about the factors leading to the high rate of HIV/AIDS among African American men. The information you share will help future researchers, policy makers, and those providing services better understand your needs. This study has been reviewed by, and received ethics clearance through, the University of Oxford Central University Research Ethics Committee.

Potential Participants and Procedures
You are being asked to participate in this study because are an African American man who has sex with men. If you agree to be in the study, I will schedule a time and place to meet that is most convenient for you. When I return for this meeting, I will collect this form and ask you some interview questions. This interview will take about two hours. I will take notes on what we talk about and also tape-record your answers to help us remember what you tell us. All of these notes and tapes will be stored in a locked file cabinet and only Ms. Saleh and her supervisor, Dr. Operario, can look at this information.

Discomforts and Risks
This interview does cover sensitive topics that may cause some discomfort. If you decide not to answer some or all of the questions, just tell Ms. Saleh or any member of her research team at any time and I will stop the survey. You can decide not to answer some or all of the questions with no penalty. Participation in research may mean that you share private information with us, but information about you will be handled as confidentially as possible. This means that only Ms. Saleh will have access to information about you. Your personal information (for example, your name, address, phone number, etc.) will be protected and comply with all applicable laws. All research records will be destroyed by Ms. Saleh at the conclusion of this study.

Benefits
You will receive no direct benefit for participating in this research. However, the information you provide may improve the types of programs and services provided to the African American community.

Questions
Please ask Ms. Saleh and/or her research team if you have any questions, comments, or concerns about this study. If you have more questions, comments, or concerns, please contact Ms. Saleh at:

St. Cross College
St. Giles'
Oxford OX1 1NF, United Kingdom
Telephone: +44(0)7726336993
Email: lena.saleh@stx.ox.ac.uk

When known, local address and telephone number will also be provided

If you do not wish to speak to Ms. Saleh or her research team, contact Dr. Don Operario, Ms. Saleh's academic supervisor at:

Department of Social Policy and Social Work Barnett House
32 Wellington Square
Oxford OX1 2ER, United Kingdom
Telephone: +44(0)1865 270325
Email: don.operario@socres.ox.ac.uk

CONSENT

You will be given a copy of this information sheet/consent form to keep.

Participation in this study is voluntary. You can refuse to be a part of this study or you can decide to withdraw from this study at any point without penalty or loss of benefits. If you wish to withdraw, tell Ms. Saleh or her research team.

Have you read or been read this information and understand the information given to you here? (yes or no)_____

Have you had your questions answered by Ms. Saleh or her research team, received answers, and been able to ask for additional information? (yes or no)_____

Do you understand that this study has been reviewed by the University of Oxford Central University Research Ethics Committee? (yes or no)_____

Do you understand that you can withdraw from the study without penalty at any time be telling Ms. Saleh or her research team? (yes or no)_____

Do you understand who will have access to your data, how this data is stored, and what happens to the data at the end of the study? (yes or no)_____

Do you understand how to raise a concern and make a complaint if necessary? (yes or no)_____

Sign your name if you understand what is expected to take part in the study and agree to participate:

_____	_____	_____
Signature of Person Obtaining Consent	Printed Name	Date
_____	_____	_____
Signature of Person Witnessing Consent (only if participant is illiterate)	Printed Name	Date
_____	_____	_____
Signature of Researcher Gaining Consent	Printed Name	Date

Appendix 2: Ethics approval letters

SOCIAL SCIENCES & HUMANITIES
INTER-DIVISIONAL RESEARCH ETHICS COMMITTEE

Hayes House, 75 George Street, Oxford. OX1 2BQ
Tel: +44(0)1865 614871 Fax: +44(0)1865 614855
chris.ballinger@socsci.ox.ac.uk www.socsci.ox.ac.uk

Co-ordinator of the IDREC
Social Sciences Divisional Office

Ref. SSD/2/3/IDREC

27 January, 2009

Lena Saleh
St Cross College

Dear Lena Saleh,

Application for research ethics approval

Ref No.: SSD/CUREC2/08 – 54

Title: Multi-level factors implicated in HIV risk among African American men who have sex with men: a systematic review and qualitative examination of situational and partner related factors.

The above application has been considered on behalf of the Social Sciences and Humanities Inter-divisional Research Ethics Committee (IDREC) in accordance with the procedures laid down by the University for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and accordingly approval has been granted.

Should there be any subsequent changes to the project, which raise ethical issues not covered in the original application, you should submit details to the IDREC for consideration.

Yours sincerely,

Dr Chris. Ballinger

cc: Elaine Evers, SPSW, Barnett House, 32 Wellington Square
Dr Lucie Cluver, SPSW, Barnett House, 32 Wellington Square

CAJB/CAJB

BROWN

Research Protections Office
Box 1986
Providence, RI 02912
Tel: (401) 863-3050
Fax: (401) 863-7292

Memorandum

To: Don Operario, Box G-S121-5
From: Research Protections Office
Date: August 24, 2009
RE: Protocol Entitled: Situational Context of HIV Risk Among African American Men Who Have Sex with Men (#0907000012).

The above referenced protocol was reviewed by the IRB, under Exempt Category 2 on August 21, 2009, and determined to be exempt from the regulations at 45CFR46 regading the inclusion of human participants in research.

No further IRB oversight is necessary, and no continuing progress report will be requested.

If your project should change in any way which would no longer allow for a classification of 'exempt,' please contact the Research Protections Office, to determine the appropriate procedure for obtaining IRB review and approval. If you are unsure as to whether a modifcation to your study would require IRB review, please call RPO to discuss the situation. Also, any change in the status of participants to any of the vulnerable populations (as identified in 45CFR46) including, pregnant women, prisoners, or those with diminished capacity, requires IRB review and approval prior to their continuing in the study.

The IRB anticipates that investigators will employ recruitment procedures that allow for the equitable recruitment of women and minorities into research studies.

Note: All research staff must successfully complete the Brown University Education Program in the Protection of Human Research Participants (CITI at http://www.citiprogram.org) prior to beginning work on the project.

*** For Your Information ***

The next deadline for submission of new protocols, modifications to protocols, and annual progress reports, requiring full board review, is August 30, 2009.

All pertinent Federal and University policies and guidelines related to the involvement of participants in research can be obtained through the Research Protections Office (RPO) at http://research.brown.edu/rschadmin/hrpo.php. This includes the *Belmont Report*, 45 CFR 46, and the Brown University Federal Wide Assurance #00004460.

Appendix 3: Interview guide

Briefly explain the objectives of the study:

The purpose of this interview is to understand HIV risk in the lives of African American men who have sex with men. As a member of this community, we are interested in learning more about your life, your partners, and your past sexual episodes. We'll discuss one past episode where you slept with someone with a condom and another time without a condom. Our goal from these interviews is to increase our knowledge of this community so that we can implement an HIV prevention intervention specific to the needs of men like you.

I will be recording our conversation so that my colleagues and I can review and study this discussion. As you read in the informed consent form, we will not use your name or other identifiers for any report based on the interview. Any information you provide will be anonymous.

Take your time in answering the questions and share only what you feel comfortable.

Please imagine that you are telling me a story of your experiences of living as a Black man who has sex with other men. If you can, please talk about the daily challenges that you face in your life. So, your story can go something like this: it can start with the current circumstances of your life (i.e. education, employment, housing, etc.) and end with the events leading up to a specific time you slept with someone without using a condom and later with a condom. I have a set of questions to help you to tell your story and I may ask questions during the interview to try to get more information.

Note to interviewer: Encourage men to describe their experiences in a narrative format. Ask questions indicated by italics and arrows. Let the respondent tell his story. The following probes (indicated by PQ1, PQ2, etc.) are likely to come up during his telling, so probe when needed and clarify details after he tells his story. If he goes with the story idea, keep to a conversation style. If he finds telling a story about himself difficult, use the interview guide to focus him. Anticipate that participants' responses will likely span several questions.

Opening/Ice-breaker questions:

→
- *Are you from here?*
- *I'm not from here, what do you like about this area? What are some things that I should check out?*

- *Do you have any questions at all?*
- *Before we start talking about hiv risk, let's talk about what's going on in your life generally. What are the three main things that are important to you right now/what's going on (this may include looking for work, stress about paying rent, etc.)*

Q1: How do participants' self-identify?

→ *People identify themselves in many ways, sometimes based on their race or gender, other times based on their relationship or dating partners, sometimes based on where they live. Can you tell me how you identify yourself?*

PQ1. How would you describe your identity to others?

a. Gender
b. Culture
c. Sexuality
    a. Sleep only with men? With both men and women? Primarily men or women?
    b. What about *who* you want to have sex with?
    c. Does it matter if you want to have sex with men but don't?

PQ2. Why do you identify yourself in these ways?

In general, where do you hang out? Where do you go to meet other friends? Other Black friends that also sleep with guys?

Q2: What is the participants' socio-economic status?

Do you know your HIV status?

When was the last time you were tested?

Within the last year, when was the last time you have unprotected sex?

Within the last year, when was the last time you had protected sex with a different person than you had unprotected sex with?

Are you usually a top or bottom?

→ *I would now like to get some background information from you. Can you tell me about yourself? I'm looking for stuff like your age, education, etc.?*

PQ1. How old are you?
PQ2. How far did you get in school?
PQ3. Are you currently working?
If not working:
When was the last time you worked?
Last time you had steady work?
If working:
Do you make more than 14k/yr? 21k/yr?, 28k/yr?, 35k/yr?, 50k/yr+?
PQ4. Do you have a permanent address?
PQ5. How many people do you regularly live with?
PQ6. Do you receive any social assistance?
PQ7. Have you ever been to jail or prison?
PQ8. Have you ever had sex in exchange for money, a place to stay, food, etc?

Q3: How do daily stressors impact the decision to engage in high-risk behaviors?

→ *Thinking back to the last time you had unprotected sex, can you tell me about some of the daily challenges that you were facing at the time?*

If not described by participant, probe for details about the following possible stressors:

PQ1. Housing (unstable housing, always looking for housing, poor housing, etc.)

PQ2. Transportation (access to car? public transportation? Does this affect employment?)

PQ3. Unemployment (looking for work? Stable work?)

PQ4. Discrimination

PQ5. Poor education

PQ6. Violence (in the neighborhood? In the home?)

PQ7. Crime/Fear

PQ8. Expectations:

a. Personal- current and future. Do you focus more on today and tomorrow or long term goals? Why or why not?
b. Family
c. Cultural

PQ9. Family support network PQ9. Support Network

a. Family
b. Friends

Attitudes about safe sex and condom use.

- How do you feel about using condoms?
- Do you think
- When do you usually use condoms? When do you not?
- If you sleep with men and women, do you use condoms with one but not the other?

Q4: What were the circumstances surrounding the participants' last episode of unprotected anal intercourse?

→ *Now, I'd like to talk in more detail about the last time you had sex with a man without using a condom. Can you describe the environment and atmosphere of where you met your partner and where you had sex?*

PQ1. Where did you meet your partner?
PQ2. How long did you know him before (first) having sex with him?

PQ3. Where did you have sex with that partner?
PQ4. Was alcohol or other drugs available at this location?
a. Did you drink or use any drugs? Were you 'high'?
b. Was your partner 'high' on alcohol or drugs?
c. Do you normally drink or take drugs prior to having sex?
i. If participant has used alcohol or drugs:
1. Did this make it easier for you to have sex with him?
ii. If participant also sleeps with women: Do you drink or use drugs before sleeping with a woman?

PQ5. Were condoms available at this location?
PQ6. Was there a specific reason you decided to have sex at this location? (i.e., convenience, privacy, etc.)
PQ7. Do you feel that the environment is generally accepting of same sex behaviors?
PQ8. Did you go there with the specific intention of finding someone to sleep with?

Q5: What emotional/affective states are associated with engaging in high-risk behaviours?

→ *Can you tell me about how you were feeling in the weeks/days/minutes leading up to that episode? How about how you felt with your partner/how he made you feel?*

PQ1. What made you want to have sex with him? (spontaneous, sexual gratification, seeking intimacy/affection?)

PQ2. What was your mood like prior to having sex with him? How were you feeling?

PQ3. Were you feeling particularly stressed in the days or hours prior to having sex

PQ4. Did you feel comfortable around him? (what made or did not make you feel this way?)

PQ5. How close did you feel to him?

PQ6. Were you in a steady relationship?

a. If yes: With a man or a woman?
b. If yes: were you generally happy in that relationship. Why or Why not?

Q6: How did participants communicate about condom use with their partners?

→ *Can you tell me how you and your partner discussed using a condom?*

Can you tell me how you and your partner discussed your sexual pasts?

PQ1. Did condom use come up?

a. If not, why not? If yes, who brought it up?
b. How was it brought up? (get clarity about verbal and non-verbal cues)
c. When was it brought up? prior to/during/after having sex with him?

PQ2. How did you know you would not use a condom (verbal or non verbal cues)?
PQ3. Did you want to use a condom? If no, why not?
PQ4. Did you want to ask him to use a condom?
PQ5. Did you feel like you could ask your partner to use a condom? (get him to elaborate).
PQ6. Did you want to ask him about his sexual history?

a. How many people he had slept with
b. How many he had slept with without a condom?
c. If he knew his HIV/AIDS status?
d. Did you know your own HIV/AIDS status?

PQ7. Did you feel comfortable with him? (based on answer from previous question)

a. if yes, did that make it easier to discuss condom use?
b. If no, did that make it more difficult to discuss condom use?

PQ8. Did/Do you trust him?

a. If yes, Did that make you still want to discuss using a condom?

PQ9. Do you think how little/well you knew him affected your decision to use/not use a condom?

PQ10. Were you comfortable with the way in which the subject of condoms was handled?

Q7: How did participants communicate about HIV/AIDS with their partners?

→ *Can you tell me if and how you and him talked about HIV/AIDS?*

PQ1. Did you talk about HIV before, during, and/or after having sex?
PQ2. Did you know your partner's HIV status?
a. If yes, how did you know?
b. If no, did you need to know or was not knowing okay?

PQ3. If he assumed (make sure you know that he did assume instead of knew), did assumption feel like a good one? Did that change afterwards?

PQ4. Do you think the sex had any risk of HIV transmission to it (STDs, etc.)?
a. did you know this before having sex with him?

.

- Do you see sex as a way to relax? Or to take a time-out from life?
- Does sex allow you to escape from the pressures of your life?

→ *Now, I'd like to talk about the last time you had protected sex.*

(Go through questions 3-7 again).

Okay, that is the end of interview. Do you have any questions for me? How do you feel about doing this interview? How does it feel to discuss these issues?

Again, thank you very much for your time and if you think of any questions or concerns in the future, please just give us a call or drop by.