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Living and Loving: A Qualitative Exploration of the Dating and Sexual Relationships of HIV-Positive Young Black Gay, Bisexual, and Other Men Who Have Sex with Men

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Living and Loving:
A Qualitative Exploration of the Dating and Sexual Relationships of HIV-Positive
Young Black Gay, Bisexual, and Other Men Who Have Sex with Men

A Dissertation
Presented in Partial Fulfillment of the
Requirements for the Degree of
Doctor of Philosophy

By

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August 10, 2016

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I would like to extend my sincerest thanks to the young men who participated in my study. I consider their willingness to share their personal experiences of dating and sex with me a great sacrifice, one that I hope will be able to inform work that can eventually improve the lives of men like them. Further, I would like to extend thanks to the members of my CAB and peer debriefing team. Their investment in my work and their willingness to give their time to my dissertation study was invaluable.

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Lastly, I dedicate this work to the memory of my forefathers lost to the consequences of racism, heterosexism, and HIV stigma. This work is done in tribute to the lives of men like Essex Hemphill, Marlon Riggs, Willi Ninja, and the countless other Black men who lay the groundwork for a world wherein my work can be pursued and my life can be affirmed.

Biography

The author was born in Gary, Indiana, February 5, 1984. He graduated from Emerson School for the Visual and Performing Arts in 2002 with a major in Drama. He received his Bachelor of Arts degree in Psychology with a Certificate in African American Studies from Princeton University in 2006 and a Master of Arts degree in Clinical Community Psychology from DePaul University in 2013.

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Abstract

Infection with HIV is a global pandemic that continues to have particular impacts on Black men who have sex with men. Accordingly, researchers have examined risk behaviors in order to inform interventions that seek to decrease transmission. However, there has been relatively little research that has examined the dating and sexual experiences of Black GBMSM living with HIV absent a particular focus on sexual risk and potential transmission. The present study seeks to better understand the dating and sexual experiences of a sample of young Black GBMSM living with HIV. Twenty young Black GBMSM living with HIV were interviewed using a semi-structured interview guide meant to explore their dating and sexual experiences since diagnosis. Using thematic analysis, the author identified salient aspects of the broad identity-related experiences, dating experiences, and sexual experiences for young Black GBMSM living with HIV. Salient themes related to identity were: (1) broad experiences as young Black GBMSM living with HIV, (2) experiences related to Black identity, (3) experiences related to sexual orientation, and (4) experiences related to HIV. Salient themes related to dating were: (1) broad dating experiences as related to Blackness, (2) impacts of HIV on new relationships, (3) impacts of HIV on existing relationships, and (4) qualities of healthy dating relationships. Salient themes related to sexual relationships were: (1) sexual experiences as related to Blackness, (2) relationship between HIV and sexual desire, (3) impacts of HIV on sexual intercourse, (4) fear of hurt if partner becomes HIV-positive, (5) sexual risk negotiation, and (6) qualities of healthy sexual relationships. Salient themes

that related to both dating and sex were: (1) selecting partners and (2) navigating disclosure in relationships. Findings suggest that HIV is the most salient factor HIV-positive young Black GBMSM consider when exploring their experiences in intimate relationships. Given the primacy of HIV and the negative trend of participants' experiences related to others' perception of HIV, suggestions for improving sexual health education and public health campaigns are offered.

Introduction

The Human Immunodeficiency Virus (HIV) is a virus that suppresses the immune response of infected persons and may lead to a diagnosis of Acquired Immunodeficiency Syndrome (AIDS). Progressive failure of the immune system due to HIV/AIDS may result in the development of life-threatening opportunistic infections and cancers, including toxoplasmosis of the brain, pneumonia, and Kaposi's sarcoma, a disease which causes cutaneous lesions on the bodies of those affected (Panel on Opportunistic Infections, 2013). As such, it has long been understood as a life-altering and ultimately life-threatening disease.

Infection with HIV is a global pandemic that began to emerge in the United States approximately 30 years ago. At present, it is estimated that 1.1 million people in the US are living with HIV. In 2010, approximately 48,000 Americans received diagnoses of HIV (CDC, 2012). Of these 48,000 individuals, approximately 12,000 were between ages 13 and 24, and 14,000 were between ages 25 and 34 (CDC, 2012). Among individuals 13 to 24, young Black gay, bisexual, and other men who have sex with men (GBMSM) accounted for 39% of new infections. Among individuals 25 to 34, Black GBMSM accounted for 21% of new infections. Given that Black people (inclusive of all sexual orientations and genders) constituted approximately 14% of the US population in 2010 (Rastogi, Johnson, Hoeffel, & Drewery, 2011), these statistics demonstrate a disproportionate impact of HIV on this group.

Accordingly, there is a budding mass of research examining HIV risk for Black GBMSM and developing interventions intended to prevent the transmission

of HIV to HIV seronegative Black GBMSM. However, there has been less attention focused on how normative aspects of life function after HIV diagnosis in this population (Halkitis, Wolitski, & Gomez, 2005). Given that most Black GBMSM contract HIV through male-male sexual intercourse (CDC, 2012), it is particularly noteworthy that there has been little examination of their dating and sexual relationships, apart from the specific focus on transmission risk. Further, given advancements in antiretroviral treatments, persons living with HIV are living longer, healthier lives (Panel on Opportunistic Infections, 2013). With the shift in emphasis from a terminal disease to a chronic, manageable illness, the need for work that examines more broadly the lives of persons with living with HIV is even clearer. The present study seeks to examine dating and sex for young Black GBMSM living with HIV in detail. It considers the intersectional roles of gender, sexual orientation, youth, and race/ethnicity in addition to HIV serostatus. In order to foreground the multiple aspects to be considered, the following literature review will examine these identities and experiences concentrically: first examining dating and sex in a GBMSM context, then additionally considering the increasingly complicating roles of youth, race/ethnicity, and HIV status. In the absence of a robust literature examining the lived experience of young Black GBMSM living with HIV, this approach to reviewing the literature is an attempt to recognize the intersectional nature of these men's experiences. This approach attempts to offer the complex context in which young Black GBMSM living with HIV cultivate and engage in intimate relationships by considering these identities

concentrically with an eye toward how they intersect and thereby are complicated by one another.

Dating & Sex for GBMSM

Men who have sex with men are a diverse group and, accordingly, have diverse dating and sexual experiences. Even the label GBMSM speaks to the complexity of the group, as it includes men who identify as gay, bisexual, or queer, but also includes men who identify as heterosexual. In examining how dating and sex function among these men, it is key to explore the range of possibilities for dating and sexual relationships as well as how these relationships may be sought, given that GBMSM are members of a sexual minority.

Potential Dating Relationships for GBMSM. Research that has examined dating and sex among GBMSM has found a variety of approaches. In particular, complexity has emerged related to conceptualization and prioritization of monogamy and fidelity. Adam (2006) argued that part of this complexity is the absence of analogues to heterosexual relationship progression markers, such as engagement and marriage. The longstanding absence of a relationship state considered by most to be of lifelong intent (i.e., marriage) allowed for the proliferation of other options. Adam's (2006) research has demonstrated that living together has been the primary analogue of relationship progression and permanence for gay men. As such, fidelity and monogamy have been demonstrated to be of greater import in relationships where male partners live together versus relationships where they live separately. Given the recent legalization of marriage for same-sex partners across the US, it warrants

consideration how the diversity of same-sex dating relationships will change, if at all.

One of the dating options which has been more commonplace for gay couples has been the open relationship (Blumstein & Schwartz, 1983; Parsons, Starks, DuBois, Grov, & Golub, 2011). In these relationships, there is the agreed upon option of engaging with other partners either romantically or sexually. The particular parameters of this engagement are often specific to the relationship and the partners therein. Accordingly, some open relationships between men might allow for dates with other partners while others may allow for sex. In addition, particular sexual or romantic acts may be explicitly prohibited (e.g., kissing, oral sex, or being anally penetrated) and “saved” for interactions between the two dating partners. In situations where one or both partners are bisexual (whether behaviorally or in terms of identity), there may also be particular rules about the sex/gender with which each partner may engage outside the relationship. It must be noted that, even in open relationships, partners may or may not actually act upon the option of engaging with other partners (Blasband & Peplau, 1985). However, the option of engagement with other partners is still a key part of these relationships and impacts their health and course. Adam (2006) has argued though that one of the most important factors in the success of these relationships is a clear distinction between primary and secondary partners. Given that fidelity in these relationships is specifically defined by what forms of engagement with secondary partners have been agreed upon, circumstances where a secondary partner begins to take priority over the individual’s primary partner may lead to

feelings of distrust and/or dissatisfaction which may damage the health of the dating relationship.

Another option exercised by some gay men is what has been termed “monogamish” relationships. In monogamish relationships, a temporary third party is brought in to meet sexual needs (Parsons et al., 2011; Parsons, Starks, Garamel, & Grov, 2012). These needs may arise from sexual incompatibility between the dating partners (e.g., both prefer to be either insertive or receptive partners in anal intercourse, one partner is unable to engage in intercourse due to physiological limitations, differences in libido) or a more general preference for multi-partner sexual engagement. Given that fidelity in these relationships is related to an emotional commitment between the two partners and monogamy is related to only engaging in sex with third parties while both dating partners are present, Adam (2006) has posited that the success of these relationships relies on maintaining the distinction between sexual and romantic bonds. In circumstances where third parties brought in for sex begin to elicit romantic feelings from one of the partners, the primary relationship may suffer due to infidelity or jealousy associated with a fear of a partner’s infidelity.

It is possible that there are also gay men who engage in relationships that are both open and invite third parties in for sexual engagement. However, there has been inadequate research examining their experience to explore it here. It is important though to acknowledge that they likely do exist and may exist among this study’s population, young Black GBMSM living with HIV.

Potential Sexual Relationships for GBMSM. In terms of sexual engagement among GBMSM, it is important to understand that the meaning attached to sex is related to the social, cultural, and interpersonal contexts of GBMSM's lives (Heyl, 1989). As such, there are a variety of needs met by sex among GBMSM and also a variety of approaches to reaching that goal.

Given the stressors related to having same-sex desire in a context where such desire is stigmatized, many GBMSM describe sex as a means of escape from negative feelings (Bird & Voisin, 2013; Halkitis & Wilton, 2005). While there may be guilt or shame associated with their same-sex desire, the men can distract themselves from it through sexual engagement. Further, GBMSM whose self-esteem has been negatively impacted by societal stressors or more proximal negative interactions with others may utilize sex as a way to bolster their self-esteem (Halkitis, 1999; Halikitis, 2001). Both of these approaches to sexual interaction are often related to anonymous sex in particular. The need for escape and/or validation may be immediate and may only require a partner willing to engage in the physical act of sex, rather than someone with whom the GBMSM would be emotionally intimate. These anonymous encounters may also be useful for those who utilize sex to reach an emotional high or to relieve feelings of stress and frustration.

There are also GBMSM who utilize sex as a means of feeling connected to others. Halkitis and Wilton (2005) found that some men describe sex as a way to achieve or reinforce feelings of intimacy with a partner. These men tended to describe their sexual interactions in the context of a longer-term relationship with

a primary partner. However, there are also men who desire this intimacy, but do not have access to such a relationship. Accordingly, they may engage in sex with a more casual or even an anonymous partner in order to have a semblance of the intimacy and connectedness they desire. Halkitis and Wilton described this as exchanging sex for intimacy.

Some GBMSM have described the act of sex as primarily a response to a biological drive, akin to eating or drinking water (Poppen & Reisen, 1997). They describe it as simply something the body needs, and, as such, they must indulge in it. This does not necessarily connote heightened or lessened enjoyment of the activity, but more so describes why it must occur.

Similarly, some GBMSM describe the utility of sex as related to the forms of physical pleasure which may be achieved through it, including the general pleasure of erotic touch and ejaculation (Halkitis & Wilton, 2005; Wilton, Halkitis, English, & Roberson, 2005). These GBMSM may seek ephemeral sexual liaisons, such as meeting anonymous partners for sex or engaging in “no strings attached” encounters with casual partners. These relationships may take the form of “friends with benefits,” non-monogamous but prolonged sexual relationships with friends, or hook-ups with sexual partners for 1 or 2 sessions.

Sex may also have utility for GBMSM, as some crave a physical connectedness with other men that is distinct from a more emotional intimacy (Halkitis & Wilton, 2005; Wilton, Halkitis, English, & Roberson, 2005). It does not require a partner to be caring or sensual, but is more related to the presence of the man’s body and pleasure derived from being in such intimate contact. For

some of these men, there is particular utility in the way that the physical act of sex also allows them to exert physical power and control over partners, or have such power and control exerted over them. This exertion of power offers the man the opportunity to demonstrate his sexual prowess and/or sexual endurance in a way that is self-affirming and thereby pleasurable. Given the absence of emotional intimacy here, this sort of sexual liaison may occur in the context of a monogamous relationship with a primary partner, but may also occur through casual or anonymous sexual interaction.

Given the variety of needs which may be met by sexual interaction, GBMSM engage in any number of forms of sexual relationship over the life course. Sexual relationships may occur for some GBMSM primarily in the context of dating relationships. Other GBMSM may meet their sexual needs through friends with benefits, casual sex partners, or anonymous sex partners (Bauermeister, 2015; Epstein, Alco, Smiler, & Ward, 2009; Owen & Fincham, 2011). Accordingly, it must be understood that many dating relationships are also sexual relationships and many sexual relationships are also dating relationships. However, it is also the case that there are multiple forms of sexual relationships that GBMSM endorse that are not romantic in nature and therefore may not be classified by individuals as dating relationships.

Meeting Partners. GBMSM have historically had limited venues in which to meet dating and sexual partners due to the criminalization of

homosexual behavior¹ and social stigma attached to homosexuality more generally. GBMSM who live in “gayborhoods” or “gay ghettos,” neighborhoods primarily occupied by members of the LGBT community, have had increased access to potential partners, as they can safely assume persons they interact with may be interested in same-sex romantic and sexual interactions (Mills et al., 2001). However, these men fit a particular profile. They tend to be White, educated, higher income, and identify as “gay,” “homosexual,” or “queer.” It must be noted that many GBMSM of color face experiences of racism in these spaces and are made to feel as if they do not belong (Giwa & Greensmith, 2012; Martinez & Sullivan, 1998). As such, the existence of these spaces does not necessarily portend opportunities for young Black GBMSM to find potential partners for intimate relationships.

For GBMSM outside of gayborhoods, the primary venues to meet dating and sexual partners, beyond chance encounters with others they were able to somehow identify as interested in same-sex interactions, have generally been bars that catered to gay clientele and places like bath houses, adult bookstores, and public parks, often referred to as cruising areas (Hospers, Harternink, van den Hoek, & Veenstra, 2002). While bars and clubs geared toward gay clientele have been conducive to meeting a variety of potential dating and sexual partners, other cruising venues, by their nature, have been more conducive to meeting casual and anonymous sexual partners (Binson et al., 2001).

¹ In 2003, the United States Supreme Court struck down sodomy laws in Texas and, by extension, deemed all laws criminalizing same-sex sexual activity unconstitutional in the *Lawrence v. Texas* decision (Tribe, 2004).

Personal ads, listings in the newspaper classified area indicating interest in a dating or sexual partner, were another avenue GBMSM could use to meet one another discreetly (Bailey, Kim, Hills, & Linsenmeier, 1997). Later, “party lines” became another venue for GBMSM to initiate contact (Martinez & Hosek, 2005). These party lines were automated telephone answering and broadcasting services, through which individuals could record personal ads and also respond to the ads of others. These party lines were and continue to be of particular use for GBMSM who prefer to keep their same-sex sexual interactions discreet.

While contact through newspaper personal ads and party lines was generally asynchronous, the advent of the internet created a new venue for GBMSM to meet one another wherein they could engage in real-time communication. This often took the form of interaction in chat rooms, areas on the internet where individuals with a shared interest were able to communicate en masse in real time (Groves, Brewslow, Newcomb, Rosenberg, & Bauermeister, 2014; Hospers, Harterink, van den Hoek, & Veenstra, 2002). It has been demonstrated that the internet has increasingly become a primary mode of meeting partners for many GBMSM. Research which has examined GBMSM who utilized chat rooms to meet partners have found that as many as 50% engage in sex with these partners and, of those that do, about 30% reported inconsistent use of condoms in anal intercourse (Hospers, Harterink, van den Hoek, & Veenstra, 2002; Hospers, Kok, Harterink, & de Zwart, 2005).

As internet communication and social networking evolved, dating/sex websites dedicated to GBMSM, like Adam4Adam and ManHunt, began to

proliferate (Chiasson, Hirshfield, & Rietmeijer, 2010). On these sites, GBMSM could post personal ads with descriptions of themselves and even photos in order to solicit romantic and/or sexual interaction with other men. In addition to sites like Adam4Adam and Manhunt which targeted GBMSM generally, there have also been websites dedicated more specifically to Black GBMSM and men interested specifically in Black GBMSM (e.g., BGCLive, formerly Black Gay Chat; Robinson, 2008b).

Most recently, smartphone applications which allow GBMSM to find potential dating and sexual partners based on proximity have begun to proliferate. These applications use global positioning systems (GPS) in the men's smartphones, tablets, and portable media devices to track the locations of users, allowing them to see and communicate with other GBMSM who are near them, ostensibly to heighten potential for and hasten off-line contact. One of the first such applications, Grindr, reports more than 253,000 users in Chicago (Grindr, 2013). They report having 3 million active users across the globe, with as many as 300,000 users logged in at any given time. While Grindr's user base tends to be younger, more educated, and White (Burrell et al., 2012), a cursory search for "gay dating" on the App Store for Apple's iPhone or the Google Play Market for Android devices will result in multiple other GPS apps like Adam4Adam's RADAR and Jack'd.

Given that the internet has increasingly become a primary space where GBMSM can meet partners (Blackwell, 2008; Lever, Grov, Royce, & Gillespie, 2008), it is important to understand what it may mean for their dating and sexual

experiences. GBMSM who meet sex partners online have been found to report more sexual partners in general (Horvath, Rosser, & Remafedi, 2008; Rosser et al., 2009a; Rosser et al., 2009b; Taylor et al., 2004), more sex with casual partners (Horvath, Rosser, & Remafedi, 2008; Rosser et al., 2009; Rosser et al., 2009b; Taylor et al., 2004), and more condomless anal intercourse (Hooper et al., 2008). This behavior has not been demonstrated, however, to be incongruent with these men's behavior with men they meet off-line (Chiasson et al., 2007; Mustanski, 2007; Bolding, Davis, Hart, Sherr, & Elford, 2005; Rhodes, DiClemente, Cecil, & Hergenrather, 2002). A subset of GBMSM who meet sexual partners on the internet report active seeking of partners willing to participate in condomless anal intercourse (Blackwell, 2008); however, it is unclear how common this behavior is. Nonetheless, relative to peers who meet partners off-line, GBMSM using the internet to meet dating and sexual needs may be at greater risk for the acquisition and transmission of HIV and other STIs, given the prototypical risk profiles of other GBMSM utilizing these avenues to meet partners.

Dating & Sex for Young GBMSM

In general, young adults engage in a variety of dating and sexual partnering relationships, ranging from chaste dating relationships intended to culminate in marriage to anonymous sexual encounters with persons they have met for the primary or sole purpose of sexual intercourse (Banker, Kaestle, & Allen, 2010; Pedersen & Blekesaune, 2003). The nature of these relationships is impacted by many factors, including psychosocial and physical needs and desires, access to models of healthy dating and sexual relationships, and societal, familial,

and peer values, norms, and expectations. However, for young GBMSM, all of these factors are complicated by the availability of useful social scripts.

Developing GBMSM Dating Scripts. There is a societal expectation that young adults will seek to engage in romantic and sexual relationships with persons they find sexually attractive (DeLamater & Friedrich, 2002; Romig & Bakken, 1992), much due to the growing physical and emotional maturity developed during adolescence (Buhrmester & Furman, 1987; DeLamater & Friedrich, 2002; Romig & Bakken, 1992). Accordingly, many young GBMSM have desires consistent with this expectation. However, the societal expectation of partnering is more specifically communicated that young adults should seek partnership with persons of the opposite sex whom they find attractive (Kubicek, Beyer, Weiss, Iverson, & Kipke, 2010). As such, heterosexual young adults are intentionally provided social scripts to guide their romantic and sexual relationships, but young GBMSM are not. These romantic and sexual scripts for heterosexual young adults may be communicated through familial socialization, peer feedback, mass media, or through formal sex education (Hussen, Bowleg, Sangamoorthy, & Malebranche, 2012). These scripts offer prototypical sequences of events to occur in romantic and sexual interactions (Metts & Spitzberg, 1996), affording young heterosexual adults a shared knowledge of what can be expected or would be deemed appropriate in romantic and sexual relationships. For example, these scripts may delineate the role of romantic pursuer to the male partner and may also mark the male partner as the sexual aggressor as well. The roles assigned will be related to the values and traditions of the socializing agent.

Accordingly, there may be a multiplicity of available scripts, given the diversity of values which may be communicated to heterosexual young adults. However, there are relatively few sources available to young people which offer dating scripts of same-sex attraction. In the absence of dating scripts which speak directly to their experience, many young GBMSM attempt to adapt heteronormative dating scripts. This adaptation is fraught with potential issues though, including reduced opportunities to explore dating as an adolescent and inadequate fit of heterosexual dating scripts.

Heterosexual persons generally begin to explore their sexual identities through their first dating and sexual relationships in adolescence (Carver, Joyner, & Udry, 2003), but the stigma attached to same-sex attraction and difficulty identifying other GBMSM keep young GBMSM from experiencing as many dating relationships as heterosexual peers (Bogle, 2008; Bruce, Harper, & ATN, 2011; Diamond, 2003; Diamond et al., 1999; Remafedi, 1990; Savin-Williams, 1996). Further, the systems in which young GBMSM exist (which may include family, peer, school, and work environments) may even enact verbal and/or physical violence against young GBMSM if their same-sex attractions are made too salient (D'Augelli & Hershberger, 1993; Bruce, Harper, & ATN, 2011; Pilkington & D'Augelli, 1995; Ryan, Huebner, Diaz, & Sanchez, 2009). Accordingly, these young men may begin their exploration of dating at a later age than heterosexual peers (Bruce, Harper, Fernandez, Jamil, & the ATN, 2012).

In addition, heteronormative dating scripts presume that there is a male partner and a female partner, each with the associated gender socializing that

accompanies the gender binary. As a dating relationship between two GBMSM necessarily lacks a female partner, young GBMSM may face a negotiation of sexual identity which requires them to take on either the traditionally male or female role in the heteronormative dating script. While this role structure may be an easier prospect for GBMSM who desire a masculine-feminine dyad in a relationship, it may pose a greater challenge to GBMSM who are more comfortable with concordant masculinity or femininity in dating partners. As such, roles adapted from heterosexual dating scripts may not represent the fullness of romantic possibilities for young GBMSM. They may, however, serve as an initial role with which young GBMSM may experiment and use to better understand their preferences.

One avenue that young GBMSM have identified as a useful space for learning about same-sex relationships has been the internet (Harper, Serrano, Bruce, & Bauermeister, 2016; Muessig et al., 2013). In addition to meeting partners on the internet, young GBMSM also reported utilizing the internet to become more aware of their own sexual orientation identity and learn about same-sex relationships. Sometimes this occurred through interaction with other GBMSM while other times it was through reading articles and other material targeted toward the population. This engagement with other GBMSM through the internet serves as an opportunity for these young men to learn about dating scripts more prevalent among GBMSM, including monogamish and open relationships. Further, they may also learn about possibilities for intimacy that eschew dating, including friends with benefits and fuck buddies.

Developing GBMSM Sexual Scripts. Akin to the absence of dating scripts which speak directly to the experiences of young GBMSM, there is a relative absence of sexual scripts for these young men as well. It is generally understood that, for most people (irrespective of sexual orientation), sex may be a source of physical pleasure (Reiss, 1989). It is also understood that most adults will desire and engage in sexual relationships (DeLamater & Friedrich, 2002; Romig & Bakken, 1992). However, what a sexual relationship is supposed to entail can be unclear without useful sexual scripts. For heterosexual youth, there is a clear sexual script which defines how normative pleasure may be sought in a sexual act: the partners may engage in mutual masturbation or other forms of non-penetrative sexual activities (e.g., sensual massage, nipple stimulation, and frottage), or the male partner may penetrate the female partner's mouth, vagina, or anus (Hussen, Bowleg, Sangamoorthy, & Malebranche, 2012). The sexual script is less clear for young GBMSM as the media and sex education courses to which they have access may not speak as directly to them about negotiating a sexual identity in same-sex intercourse (Kubicek et al., 2010). For example, young GBMSM must make decisions regarding how they will negotiate the act of penetration, if at all. More specifically, young GBMSM must determine whether they will be an insertive partner, receptive partner, engage in both insertive and receptive anal sex, or refrain from anal sex altogether. Accordingly, it is the case that many young GBMSM report their first same-sex sexual experiences as being oral sex with insertive and receptive anal sex often coming years after these initial sexual experiences, if ever (Bruce et al., 2012). This allows young GBMSM to

explore their sexuality with partners and develop their own sexual scripts as they determine their preferred sexual acts. This is particularly important for young GBMSM, as, while the act of sex may be a smaller part of the sexual identity of young heterosexual persons, it may be of particular importance to the sexual identity of a young GBMSM (Halkitis & Wilton, 2005).

Hook-up Culture. Research has continually examined what has been described as “hook-up culture,” among the general emerging adult population (Garcia, Reiber, Massey, & Merriweather, 2012; Kaestle & Halpern, 2007). Hook-up culture refers to the widespread practice of engaging in intimate behavior with persons who may be friends or less acquainted persons. These casual encounters (hook-ups) may include any number of intimate interactions, ranging from cuddling to sexual intercourse (Banker, Castle, & Allen, 2010; Garcia et al., 2012)². Garcia and colleagues (2012) have argued that this type of sexual relationship is becoming increasingly normative, and that is perhaps underlined by a finding that 64% of heterosexual-identified and 74% of gay-identified males in a study of college students endorsed having hooked up (Barrios & Lindquist, 2012). It has been argued that young adults may engage in more intimate sexual behaviors (including penetration and experimentation with kink) with partners to whom they feel greater closeness (Kaestle & Halpern, 2007); however, it is unclear if this finding extends to young GBMSM. Further, it

² In general, hook-ups are distinguished from dating relationships by their comparatively short lengths (often one or two encounters) and ephemeral ties to the partner. The short time length, though, is not always that case as there are longer term casual relationships, often referred to as “friends with benefits” or “fuck buddies” (Banker et al., 2010). These relationships allow individuals to engage in the physical intimacy they seek with a partner they know and trust while maintaining a level of emotional intimacy less serious than a dating relationship.

has been argued that the propagation of hook-up culture has led many young adults to identify sex as narrowly being defined by insertive vaginal or anal intercourse, while other behaviors inhabit a more amorphous space (Gute, Eshabugh, & Weirsma, 2008). Accordingly, any exploration of sex among young GBMSM must be sure to explore how these men define sex. In addition, while the literature which examines hook-up culture seems to locate it as particularly prevalent among young adults (often college students in particular), research has not demonstrated if this holds true for GBMSM, given the potential difference in dating and sexual initiation as well as the relative absence of the social pressures to engage in monogamous and potentially lifelong relationships.

Dating & Sex for Young Black GBMSM

Just as the experience of being GBMSM generally or a young GBMSM more specifically have particular implications for dating and sex, being Black may shape these young men's experiences of dating and sex in specific ways. The necessity of considering the role of race is particularly salient as it relates to how racism and other oppression impact sexual behaviors, how Black male sexuality has been constructed. Further, a consideration of race is necessary to explore how masculinity functions for Black GBMSM, how race and racism proscribe young Black GBMSM's sexual networks, and how intra-racial colorism may inform dating and sexual partner preferences and possibilities.

Impacts of Racism, Heterosexism, and Homophobia. Examinations of Black health and experience often cite race as a risk factor for health disparities, including mental health concerns, physical health problems, and STIs (cf.

Mokdad et al., 2003; Sumartojo, 2000). However, it is not the African heritage itself which is the risk factor, but complex sets of historical, environmental, and cultural factors which impact the behaviors of Black people, including racism, poverty, denial, and stigmas (CDC, 2007). Existing in spaces where options are limited due to overt and covert forms of discrimination and oppression causes consistent stress. These circumstances and experiences of prejudice also force Black people to consider and reconsider their value, given narratives of Black worthlessness and pathology (Flores, Tschann, Dimas, Pasch, & de Groat, 2010). For Black GBMSM, the experience of racism is coupled with the discrimination they face due to their sexual orientation and/or sexual behaviors. This sort of stress and the resultant dilemma of self-value have been consistently addressed in studies of Black sexual risk (cf. Bowleg et al., 2013; Halfors, Iritani, Miller, & Bauer, 2007). While the present study is not an examination of risk specifically, risk behavior does help to characterize sexual behavior more broadly.

In a study of Black GBMSM, Jeffries and colleagues (2012) found that experiences of homophobia in the past 12 months were associated with more frequent condomless anal intercourse among HIV-negative and HIV-positive Black GBMSM. These experiences included experiencing both physical and verbal abuse, feeling as though their same-gender attraction was visible and drawing negative attention, and feeling it necessary to appear more masculine in order to evade suspicion. The researchers examined whether social factors would inhibit this impact. However, the impact of these experiences was not buffered by social support, closeness with family members and friends, attachment to the

black gay community, being out in their religious spaces, or being connected to a large social network of other GBMSM. The findings of this study highlight the ways that Black GBMSM may exercise less caution in their sexual behaviors after experiencing the stress associated with existing in homophobic and heterosexist spaces. These findings may be related to research demonstrating GBMSM often use sex as a means to escape negative feelings (Halkitis, 1999; Halkitis, 2001; Klitzman, 1997; McKirman, Ostrow, & Hope, 1996). Such findings also suggest that these men not only engage in sex to escape negative feelings but may engage in riskier sex to escape these feelings.

In a study of Latino gay men, Diaz, Ayala, and Bein (2004) found something similar. They found that there was significant psychological stress associated with experiences of homophobia and heterosexism. Moreover, men who had experienced these stressors were more likely to engage in sex in higher risk situations. These included sex in public places, sex in conjunction with illicit substance use, sex with partners who resist condom use, sex with partners who hold unequal interpersonal power, and sex with the explicit goal of escaping negative emotions. While it is the case that these kinds of sexual interactions can occur between people who are not particularly impacted by systems of oppression, it must be understood that the stress associated with oppression (particularly multiple oppressions) may heighten the frequency of these behaviors or result in less safe engagement in these behaviors (Mizuno et al., 2012).

In addition to findings with other ethnic minority GBMSM, there are also findings in studies of heterosexual Black men that support the idea that

experiences of oppression increase particular kinds of sexual behavior that place them at increased risk. Reed and colleagues (2013) found that heterosexual Black men who had experienced higher levels of racial discrimination were more likely to report engaging in condomless intercourse, involvement in transactional sex (both buying and selling), and having more than 4 sexual partners in the past year. Bowleg and colleagues (2013) found that heterosexual Black men were less likely to consistently use condoms as the amount of racial discrimination they had experienced increased. Interestingly, social support was found to be a buffer for the relationship between discrimination experiences and consistent condom use in heterosexual Black men. Social support was also found to be a buffer between experiencing discrimination and sexual risk behaviors (condomless anal intercourse) among Asian and Pacific Islander gay men (Yoshikawa, Wilson, Chae, & Cheng, 2004). Given that social support has been demonstrated to not buffer this relationship among Black GBMSM (Jeffries et al., 2012), this suggests that there is something about the combination of homophobia and anti-Black racism which lessens the utility of social support for Black GBMSM. This question, however, has not been addressed explicitly in the literature.

Construction of Black Men's Sexuality. While acts of discrimination may impact individual Black GBMSM's sexual behavior, their behavior is also impacted by how society has constructed its notions of Black men's sexuality more broadly. These notions are communicated to young Black GBMSM and may inform their self-concept, their concept of one another, and their concept of

their romantic and sexual possibilities. Accordingly, it is important to understand how Black men's sexuality has been constructed.

Like many other phenomena, normative sexuality and the associated normative masculinity are social constructs (Brod, 1987; Connell, 1987; Kimmel & Messner, 1992; Segal, 1990). As such, they are not the product of predetermined truths, but instead the product of society's beliefs and values. Much due to the ways that racism, patriarchy, and heterosexism have impacted and shaped the construction of normative Black male sexuality, it has long been a phenomenon mired in complexity. This is possibly clearest in the way that Black men's sexuality has been construed generally, as well as the particular forms of pathology which have been ascribed to it.

Much due to White supremacist constructions of Black humanity, there is a persistent conceptualization of Black people as primitive and, as a result, hypersexual (Collins, 2005; Farley, 1997; hooks, 2001; hooks, 2004). This construction asserts that Black people have higher sexual drives than do (presumably White) others and that Black bodies are equipped accordingly for this primal drive toward sex over more intellectual pursuits (hooks, 2004; Farley, 1997). As such, there is a common assumption that Black men have large penises, and much of how Black men's sexuality is constructed is predicated on this idea. It is key to foreground the racist and reductionist nature of this assumption when considering it though, because it can be (and often has been) viewed as complimentary rather than oppressive and demeaning (hooks, 2001).

In a system where Blackness is tied to multiple forms of oppression, oppressed Black men can assert their manhood and value by embracing the reductionist notion that they are sexually superhuman (hooks, 2001; hooks, 2004). Although this reductionist view places their value centrally in the utility of their body and ignores their intellectual capabilities, sex nonetheless becomes a space where Black manhood can eclipse that of whom or what he sees as oppressing him (hooks, 2001). The Black penis becomes the central beam on which Black masculinity can be constructed. Consequently the archetypes of Black maleness that emerge foreground physicality and the associated assertion of manhood and value which may occur there. Among these archetypes are the “player” and “pimp” (Collins, 2005). The value of the “player” is centrally located in his ability to romantically and sexually engage with partners absent close connection. For him, sex is an act of fun, and the impact on the player’s partner is not taken into account because it does not matter to him. The “pimp” is similar in his ability to secure romantic/sexual partners and his lack of concern for his partners, but is distinguished from the player in that there may be elements of domination or coercion in his romantic/sexual pursuit³. Neither of these archetypes portends healthy dating or sexual relationships with partners. Rather, they both demonstrate clear routes to demonstrating one’s value and power through procuring partners and having sexual access to them, presumably due to Black male sexual prowess.

³ The pimp archetype must be disambiguated from the profession. While men engaged in the literal work of serving as a pimp to one or more sex workers may embody the qualities of the archetype, it is not the case that men who embody the archetype are necessarily involved in sex work to any degree (Collins, 2005).

Both the player and pimp archetypes demonstrate a sort of pathological construction of Black sexuality that limits these men's interactions with partners to cold, utilitarian pursuits of sexual access in exchange for feelings of hegemonic masculinity. Further, they are both predicated on notions of compulsory Black heterosexuality. Accordingly, while these archetypes of Black sexuality may be mapped onto Black GBMSM, they necessarily fail to fit given that the partners pursued are male and further because they presuppose a desire to assert a facsimile of hegemonic masculinity. However, none of this precludes young Black GBMSM from being socialized into a belief that these are normative or even laudable expressions of Black male sexuality.

In addition to the player and pimp archetypes trafficking in a construction of Black sexuality that relies on the sexual superhuman assumption, these archetypes also utilize another problematic assumption about Black male sexuality, that it is predatory (Collins, 2005; hooks, 2001; hooks, 2004). The fear of the predatory Black male has long underlay the racist assumption that Black men are eager to rape White women (Collins, 2005; Farley, 1997), but it also underlies a particularly modern pathological reading of Black male sexuality: the threat posed by Black men living on the "down low."

The "down low" or DL refers to a subset of Black men who have sex with men and women (GBMSMW). These men have been characterized as living "double lives," wherein they live as heterosexuals for the majority of the time but engage in sex with men in secret (King, 2004). One of the first pieces to explore the DL was Denizet-Lewis's 2003 New York Times article where he

characterized these men as masculine, “thuggish,” often having girlfriends, and preferring condomless anal intercourse. The notion of the DL was further moved into the zeitgeist by J.L. King’s 2004 book, wherein he described his experiences as a man on the DL and further popularized the notion that these men were apt to engage in condomless sexual intercourse with both their female and male sexual partners. Further, King asserted that these men’s engagement with men was purely sexual and these men did not engage in dating relationships with other men, as they considered themselves heterosexual. Popular press and researchers continued to propagate the notion that there was a subset of Black GBMSMW (or Black GBMSM masquerading as heterosexual men) who were engaging in condomless sex with both their female and male partners. Further, these men were hypothesized to be potentially responsible for the rising rates of HIV infection among Black heterosexual women (cf. Agyemang, 2007; King, 2004; Mitchell, 2006; Valera, 2007). These arguments were generally made absent data to support the claims and studies of DL men often focused on their purported deceptive practices rather than their sexual risk behaviors (Malebranche, 2008), arguably because the narrative of predatory Black GBMSMW fit popular conceptions of Black male sexual pathology (Ford et al., 2007; Flores et al., 2010)⁴.

Later research has consistently demonstrated that Black GBMSMW, even those who identify as DL, engage in routine HIV testing, limit their number of partners, and tend to more consistently use condoms, especially with their male

⁴ The inherent racism is made more clear by the existence of an analogous group of White men called “dudes” (Robinson & Vidal-Ortiz, 2013; Ward, 2007; Ward, 2008), who identify as heterosexual while engaging in sex with men but have not been deemed vectors of HIV infection.

partners (Bond et al., 2009; Dodge, Jeffries, & Sandfort, 2008; Millett, Malebranche, Mason, & Spikes, 2005). While many Black GBMSMW report being less likely to disclose their same-sex attractions to female partners, this subset of men was also more likely to engage in fewer HIV risk behaviors than men more apt to disclose (Millett et al., 2005). Accordingly, the construction of the DL Black man as the conduit through which Black women contracted HIV was proven more myth than fact. Further, the findings of the research imply that Black GBMSMW have particular strengths in relation to sexual decision making that have been overlooked or assumed absent by others given persistent narratives of Black pathology.

The pathological DL construct, much like notions of the player and pimp, has penetrated the zeitgeist in a meaningful way. Accordingly, Black GBMSMW and Black GBMSM navigate potentially having internalized these ideas of sexual pathology with regard to other Black GBMSM and also having these ideas mapped onto them by potential dating and sexual partners.

Compulsory Black Masculinity. Among GBMSM generally, masculinity has been regularly identified as a desired trait in dating and sexual partners (Gomez, Mason, & Alvarado, 2005; Kendall, 1993; Lanzieri & Hildebrandt, 2011). This preference has been described as partially related to a desire to remain unidentified as gay (given associated potential for oppression and/or violence; Clarkson, 2006), but may also relate to a level of internalized homonegativity (Sanchez, Westfield, Liu, & Vilain, 2010). This has been demonstrated in personal ads (both newspaper ads and more modern digital personals) via requests

for “straight-acting” or “discreet” men (Clarkson, 2006). More recently, the adage “no fems” has become a mainstay of profiles that seek to demonstrate a preference for masculine dating and sexual partners.

In Black spaces, the utility or necessity of a masculine or “straight-acting” partner has been heightened by hegemonic ideas of Black maleness and masculinity as well as what has been described as an intra-racial mandate of masculinity (Collins, 2005). This compulsory masculinity for all Black men has been conceptualized as a by-product of feelings of emasculation due to larger systems of racial oppression (hooks, 2001; hooks, 2004; Wade, 1996). As such, masculinity acts as a humanizing agent and appearances to the contrary threaten notions of Black humanity and value. Given that same-sex attraction is viewed by some as contrary to Black masculinity and therefore a threat to perceptions of Black decency and humanity more generally, a preoccupation with one’s own masculinity and the masculinity of one’s partners among Black GBMSM may serve as a protective strategy. It may function as both work to protect perceptions of Black people in general, but also to evade any consequences that come with appearing a threat to respectable perceptions of Black people (e.g., rejection, isolation, and violence). Considering this, it is potentially unsurprising that the “no fems” mandate is a very present factor in the environments where Black GBMSM seek dating and sexual partners, including party lines, dating websites, dating apps, and Black gay social spaces.

The particular value placed on masculinity among Black GBMSM situates effeminate Black GBMSM in an uncomfortable position. They may be seen as a

risk to a prospective partner's own masculinity and, in the cases of partners with an undisclosed sexual orientation, a risk to their ability to pass as heterosexual. This may limit their pool of potential partners, but it also may make them the objects of ridicule, rejection, and potential violence, particularly given how central a rejection of femininity may be to maintenance of a masculine persona or identity (Malebranche, Fields, Bryant, & Harper, 2009).

The romantic prospects of these effeminate Black GBMSM are further impacted by sexual role expectations attached to masculinity and femininity. While the construction of the White masculine GBMSM is generally a "jock" or "frat boy" archetype, the archetype for Black masculine GBMSM is usually the "thug" (Robinson & Vidal-Ortiz, 2013; Ward, 2007; Ward, 2008). This thug archetype is not only representative of a particular working class or blue collar class presentation, but he is also characterized as an ideal top (i.e., insertive sexual partner), given his presumed large penis and aggressiveness. This necessarily relegates effeminate Black GBMSM to being assumed bottoms (i.e., receptive sexual partners) and to be seen as unfit to serve as tops (Fields et al., 2012). This assumption may or may not align with the actual preferences of these men though, and, as such, constrains their dating and sexual possibilities in a meaningful way. Further, it has been demonstrated that there is also a preference among many for masculine bottoms as well. A study examining the preferences of self-identified DL men found that masculinity was a primary focus in their partner selection (Robinson & Vidal-Ortiz, 2013). These men sought masculine men both for insertive and receptive partners, in contrast to previous work that described DL

men as primarily insertive partners themselves (Malebranche et al., 2009). If masculine GBMSM are sought primarily for both insertive and receptive sexual partners, effeminate GBMSM are moved even further to the margins and their dating and sexual possibilities become even more circumscribed.

While masculinity and femininity may be ascribed to people who identify or do not identify themselves as such, these factors are often understood in relation to gendered performances of sort (e.g., clothing, mannerisms, speech, etc.). However, the impact of an anti-fem or pro-masculine attractiveness preference also has potential to impact some individuals based on their body type, given how an athletic body functions as part of masculine GBMSM archetypes (Lanzieri & Hildebrandt, 2011). In the burgeoning fat studies literature, it has been argued that the distaste for overweight GBMSM as dating and sexual partners is related to an aversion to the feminizing aspects of larger bodies, such as enlarged breasts, hips, and thighs (Bell & McNaughton, 2007; Durgadas, 2008). These men stand in stark contrast to the athletic builds represented in pornography and other gay/queer media that help to construct popular notions of masculine GBMSM. As such, it is unsurprising that “no fats” tends to be paired with “no fems” in profiles on dating/hook-up websites and apps geared toward GBMSM and that overweight GBMSM may be subject to the same limitations that fem-identifying or fem-performing GBMSM encounter.

Racial Homophily in Partnering. Given the rising rates of HIV infection among Black GBMSM, researchers struggled for years to determine what underlay the racial disparity in HIV infection. Studies examined whether Black

GBMSM were participating in risk behaviors at a rate higher than White and Latino/Hispanic peers, but found, on average, their risk behaviors were not unlike White peers (Feldman, 2010; Malebranche 2003; Millett, Flores, Peterson, & Bakeman, 2007). Some researchers even found significantly less condomless anal intercourse among Black GBMSM relative to White GBMSM (Millett, Flores, Peterson, & Bakeman, 2007; Newcomb & Mustanski, 2013). However, Black GBMSM were subject to increased risk due to racial homophily in sexual partnering (Feldman, 2010; Newcomb & Mustanski, 2013). Black GBMSM were primarily engaging in sex with other Black GBMSM, a situation which necessarily leads to a smaller pool of potential partners and thusly greater risk of encountering a partner with HIV. While this finding was discovered in the context of Black GBMSM's risks for contracting HIV, it reveals an important aspect of dating and sex for Black GBMSM. Their partners are more likely to be other Black GBMSM, whether due to proximity, an explicit preference for intra-racial dating and sex, or sexual racism which limits their access to non-Black partners (Oster et al., 2013).

While it is the case that most Black GBMSM in the aforementioned studies of risk report primarily engaging with other Black men, that does not mean that Black GBMSM do not engage with non-Black GBMSM. However, there are substantial barriers to healthy romantic and sexual engagement outside of their racial communities, including sexual racism and racism experienced more generally.

In GBMSM spaces (much like in heterosexual spaces), interracial dating has long been stigmatized (Gomez, Mason, & Alvarado, 2005; Han, 2007). This is particularly salient in the slang term used to describe White GBMSM interested in Black men: dinge queens (Morton, 2007). While there are other reductionist terms to describe ethnic interests in the gay community (e.g., snow queen, rice queen, bean queen, etc.; Morton, 2007), dinge queen is particularly problematic, in that it aligns Black men with dirt/grime and stigmatizes a desire for romantic or sexual involvement with Black men.

While this stigma exists and may limit Black GBMSM's engagement with White GBMSM, there is nonetheless a subset of the gay community which fetishizes sexual engagement with Black men due to notions of the aforementioned myth of exceptional Black sexual prowess and a desire to be dominated by him accordingly (Han, 2007). While this may afford some Black GBMSM sexual or romantic access to these men, these relationships may not be healthy, as they are predicated on a reduction of the Black GBMSM to his sexual organs and the racist notion that he is somehow more sexually feral. Further, it has been demonstrated that, likely due to this fetishization of the Black penis, Black receptive sexual partners receive less interest than do Black insertive sexual partners (Robinson, 2008a). In fact, when compared to dating profiles for White and Latino/Hispanic receptive partners, Black GBMSM were the least likely to receive communication from interested parties (Robinson, 2008b). The value of Black GBMSM being tied to the potential existence of a large penis and primal sexual approach limits the potential health of these relationships and limits the

partner pool more generally. In addition, Black GBMSM who do not meet the expectations created by the myth of the necessarily large Black penis or feral sexuality may be met with negative responses from the non-Black men whose interest in him is based on assumptions related to these myths (Han, 2007).

If a Black GBMSM is able to begin a healthy relationship with a non-Black GBMSM, other persons' distaste for the interracial pairing may negatively impact them. In fact, it has been demonstrated that racism experienced during and due to an interracial relationship causes decreased relationship satisfaction (Grewal, 2005). This may place the relationship in jeopardy and potentially lead to its end.

Skin Color & Colorism. Racism and oppression circumscribe the dating and sexual experiences of young Black GBMSM in many ways, some more explicit than others. Colorism, preference given to people due to the color of their skin, is an intra-racial phenomenon which impacts self-perception and perception of potential partners. As such, it may have particular impacts on dating and sex of young Black GBMSM.

Much due to the impacts of White supremacy, there has historically been a trend toward conferring aesthetic and other social currency to lighter skinned Black people (Russell, Wilson, & Hall, 1992). This may be demonstrated by beliefs that lighter skinned Black people are more attractive and more valuable (Hochschild & Weaver, 2007; Hughes & Hertel, 1990), or that lighter skinned Black people are of greater virtue, merit, intelligence, and prestige (Hill, 2002; Hill, 2002a; Hughes & Hertel, 1990). In contrast, colorism may imply that darker

skinned Black people are more criminal or otherwise disadvantaged (Dasgupta et al., 1999; Maddox & Gray, 2002). These assertions, if internalized by young Black GBMSM, may limit or broaden the pools of partners the young men think available to them and may impact the standards which they use to evaluate interested parties.

In examining heterosexual partnering, researchers have consistently found that African American men report finding lighter skin more attractive than darker skin when selecting African American women for dating and marital relationships (Robinson & Ward, 1995; Ross, 1997). This pattern was not replicated among African American women in their selection of African American men for these relationships (Collins, 2005; Hill, 2002). This raises particular questions about how skin color may function for Black GBMSM. It may be that these patterns will be replicated, in that insertive partners may demonstrate preferences similar to heterosexual Black men and receptive partners may not demonstrate a preference. This possibility is supported by assertions that lighter skin may be conceptualized as a feminine characteristic (Hill, 2002), akin to being a receptive sexual partner. Given this, skin color preferences may further circumscribe the dating and sexual options of young Black GBMSM, perhaps as a function of their sexual role. It also may be the case that Black GBMSM function differently than their heterosexual counterparts and colorist preference for light skin may predominate, may be rejected, or may exist in some combination across sexual roles. However, colorism has not been examined among Black GBMSM, and therefore it is unclear how it may function for this population.

Dating & Sex for Young Black GBMSM Living with HIV

Given that sexual intercourse is a primary route of HIV transmission, living with HIV can complicate the dating and sexual experiences of young Black GBMSM in many ways. The Seropositive Urban Men's Study (SUMS), a qualitative study of 250 gay and bisexual men living with HIV, sought to move toward better understanding this impact by asking HIV-positive men about the impact of HIV on their experiences with dating and sex (Halkitis, Wolitski, & Gomez, 2005). In particular, this study explored the impact of HIV on their self-concept, how they negotiate risk in sexual relationships, the impacts of stigma and disclosure, and the impact of HIV treatment on their relationships.

SUMS exists as one of the only large-scale studies of HIV-positive gay and bisexual men's sexual lives absent a particular focus on risk and transmission. However, the data for the study was collected in 1997, one year after treatment for HIV changed radically with the advent of HAART (highly active antiretroviral therapy). HAART refers to aggressive regimens of multiple medications to treat HIV (Crepaz, Hart, & Marks, 2004). These combination therapies attack HIV at multiple sites and limit the development of resistances to the drugs. HAART has drastically improved the life expectancy of people living with HIV and, for most in the United States, transformed the disease from terminal to chronic (Crepaz, Hart, & Marks, 2004; Ramien & Borkowski, 2005; van Kesteren, Hospers, & Kok, 2007). In many ways, SUMS stands as the primary forerunner to the present work and therefore the findings of SUMS must be considered. However, the SUMS respondents represent a wider range of ages and ethnicities than studied in the

present work. Therefore, less attention was paid to the particularities of how HIV functions in tandem with age, race, and culture in shaping the dating and sexual experiences of young Black GBMSM living with HIV. Accordingly, the findings of other studies of HIV-positive GBMSM, even if less focused on dating and sex specifically, will be explored as well.

Self-Concept and Sexual Practices. Many young Black GBMSM living with HIV are able to cope with their diagnosis and continue to engage in dating and sexual relationships akin to those they had prior to diagnosis. However, HIV has the potential to have many meaningful impacts on their self-concepts due to the fact that it is incurable, potentially fatal, and communicable through sex. These impacts to self-concept can shape the way these men engage in both dating and sex, but research has consistently demonstrated impacts on sexual behavior in particular.

For many GBMSM, the act of sex and the meanings attached to it may be an important part of how they construct their sexual and social identities (Heyl, 1989; Sadownick, 1996). Their desire to engage romantically and sexually with other men may become central to their identity. In addition, other aspects of this contact (e.g., sexual role) may also become important to their construction of self. As such, a man may think of himself as a bisexual versatile bottom or same-gender-loving top, and this notion of self will be useful in communicating his sexual self to others as well as acknowledging a level of comfort with his desires and behaviors. The sexual communicability of HIV may force these men's HIV status to also become an integral part of their sexual identity and, accordingly,

their self-concept more generally (Halkitis & Wilton, 2005). Because their sexual desires and behaviors carry the specter of transmitting HIV to someone else, it may become difficult to think of oneself sexually without having to consider or consciously ignore the presence of HIV. While there are other STIs which one could contract and potentially communicate to others, the incurable nature of HIV makes it an enduring consideration.

Some HIV-positive men refrain from sexual contact after diagnosis in order to avoid communicating the disease to someone else (Bailey & Hart, 2005). However, this may not be a viable long-term solution, as many men continue to have normative desires for the pleasure and intimacy that sexual interaction can offer. In order to have this intimacy or meet this physical desire for sex, some men may re-enter the dating market to meet partners by returning to live and virtual spaces where they can meet potential partners. Some SUMS respondents described public sex environments (e.g., parks, alleys, and other outdoor areas) and commercial sex environments (e.g., bathhouses and sex clubs) as useful venues to meet casual and anonymous sexual partners, if they were not ready to re-engage in more serious or intimate relationships (Parsons & Vicisio, 2005). These venues allowed the men to meet their immediate needs without having to think as much about HIV. Public venues were preferable in part because partners met in these venues were assumed HIV-positive and there was little conversation about HIV status in these environments. As such, respondents could engage in various forms of sex (with or without condoms) without having to be reminded of their HIV status.

In addition to the sexual communicability of HIV, the physical manifestations of the disease may also have meaningful impacts for a man's self-concept. Some SUMS respondents described manifestations of HIV such as Kaposi's sarcoma, a disease which causes cutaneous lesions on the bodies of those affected, as marking them both as HIV-positive and as physically unattractive (Halkitis & Wilton, 2005). For these men, others' willingness to engage in sex with them was an affirmation of their continued attractiveness and sexual value. The attractiveness of these partners was important for some respondents, being able to engage with a more attractive partner as more affirming of one's own attractiveness. For other respondents, the attractiveness of the partner was less important, and any sexual engagement was sufficient affirmation of their sexual value and attractiveness.

Physical manifestations of HIV may also remind some men of the potential for early death due to HIV complications or opportunistic infections. Given this association, sexual interaction can act as an opportunity to affirm or re-affirm a man's vitality (Halkitis & Wilton, 2005). The ability to engage in sex serves as a declaration of life and thusly combats the notion of imminent death, as related to HIV. Given that HAART has reduced many of the physical symptoms of HIV and limited the potential for early mortality due to HIV complications, it is unclear if this factor will continue to impact the sexual behaviors of GBMSM living with HIV. While it has been demonstrated by research that there are a range of relationship typologies present among GBMSM (Bauermeister, 2015), a thorough search of the literature does not reveal studies which have examined

whether these typologies are necessarily present to the same degree in young Black GBMSM living with HIV. Accordingly, it may be the case that these men engage in the same range of relationships (e.g., monogamous dating and/or primarily sexual relationships, monogamish dating and/or primarily sexual relationships, open dating and/or primarily sexual relationships, friends with benefits, fuck buddies, etc.; Bauermeister, 2015). However, they may have a different set of prototypical relationships given the intersections of their cultural backgrounds/norms, beliefs about same-sex attraction, age, and stigma/beliefs related to their HIV-positive status.

Negotiating Risk. The decision to engage in sex requires anyone, but people living with HIV in particular, to negotiate risk. Arguably, even those who decide to not consider risk in their sexual behaviors have made their own negotiation of risk. Some ways that GBMSM living with HIV have described negotiating risk include serosorting, strategic positioning, and condom use.

Serosorting is the pairing of persons with concordant HIV serostatuses (McDaid & Hart, 2010). As such, HIV-negative persons would only have sex with other HIV-negative persons, and HIV-positive persons would only have sex with other HIV-positive persons. Ideally, this practice allows participants to minimize risk of HIV transmission to an HIV-negative person while also allowing participants to engage in a wider variety of sexual behaviors, some of which have particular risk for HIV transmission (e.g., condomless anal intercourse; Frost, Stirratt, & Oullette, 2008). In addition to the risk reduction and sexual freedom associated with serosorting, SUMS respondents also reported greater comfort with

HIV-positive partners. Rates of serosorting have ranged from 14 to 44% among HIV-positive GBMSM (Crepaz et al., 2009; Jin et al., 2009; Golden, Stekler, Hughes, & Wood, 2008; Snowden, Raymond, & McFarland, 2004; Zablotska et al., 2009). The internet has particular utility for HIV-positive GBMSM seeking HIV-positive partners, as there are many sites dedicated to HIV-positive persons finding seroconcordant partners (Bolding et al., 2005; Davis, Hart, Bolding, Sherr, & Elford, 2006a). Further, a number of gay dating and sex websites allow participants to list their HIV status as part of their profile. More recently, some websites and applications geared toward meeting dating and sexual partners for GBMSM have added the option to indicate whether one had an undetectable viral load as well.

Many HIV-positive GBMSM describe partnering with other HIV-positive men as preferable, because they have had previous negative experiences with serodiscordant partners (Frost, Stirratt, & Oullette, 2008). These experiences may include having been demeaned due to their HIV status or potentially having their status disclosed to others without their permission. Additionally, many men have described feelings that serodiscordant sex was risky, even when condoms were used. As such, they continued to feel that they would be placing an HIV-negative partner at risk for HIV infection (Frost, Stirratt, & Oullette, 2008).

While serosorting has a particular utility and potential to decrease communicability of HIV to HIV-negative persons, there is a clear limitation to the utility of serosorting. Two GBMSM living with HIV could have different genotypes of HIV. Accordingly, they could have differing resistances to HIV drug

treatment regimens, and infection with a different HIV genotype could render one or both of their treatment regimens ineffective.

Strategic positioning refers to HIV-positive GBMSM primarily taking a receptive role in condomless anal intercourse, given that HIV is more easily communicated from an insertive partner to a receptive partner (McDaid & Hart, 2010). Rates of strategic positioning range from 14 to 35% among HIV-positive GBMSM and 6 to 15% among HIV-negative GBMSM (Crepaz et al., 2009; Jin et al., 2009; Snowden, Raymond, & McFarland, 2004). In a survey of 200 predominantly Black young GBMSM living with HIV, Bruce and colleagues (2013) found that men who believed in the effectiveness of serosorting were more apt to participate in condomless anal intercourse with HIV-positive male partners. While these men do expose partners to reduced risk of communicability as compared to if these men were the insertive partners, it must be reiterated that HIV is still communicable in this circumstance. Nonetheless, it does represent a way these men attempt to moderate the risk of transmission to their sexual partners.

While there are GBMSM who seek to utilize serosorting or strategic positioning to minimize HIV transmission risk, there are also many GBMSM who rely upon consistent condom use in order to avoid HIV transmission. A key factor which has been identified as facilitating consistent condom use is communication about sex and HIV exposure (Catania, Coates, Golden, & Dolcini, 1994). This open communication about sex helps both partners be attuned to the potential for HIV transmission and foregrounds the necessity of a condom. Further, it has been

demonstrated that condomless sex is more likely when a desire for safer sex is not communicated (Gold & Skinner, 1992). Given that a GBMSM living with HIV may have a partner who is not interested in using condoms, he must also be able to and willing to engage in negotiation about condom use. This process may include refusing condomless sex, eroticizing safer sex, reassuring a partner of love and trust when using barrier methods, or discussing the consequences of condomless sex (Gold & Skinner, 1992; Hoff & Manchikanti, 2005). These are strategies which can help GBMSM living with HIV avoid condomless sex if that is their desire.

Research has demonstrated that GBMSM living with HIV have negotiated multiple routes to safer sexual interactions. Given the level of stigma attached to any sexual interaction for someone living with HIV, this negotiation of safety arguably represents a particular strength of the population. However, the desire to consistently utilize condoms or otherwise practice safer sex can be compromised by substance use. Substance use can hamper the judgment of these men, and, accordingly, substance use prior to a sexual encounter has been demonstrated to predict higher frequencies of condomless anal intercourse⁵ (Hays et al., 1997; Wilkerson, Smolenski, Morgan, & Rosser, 2012). This substance use may have particular relevance for young Black GBMSM living with HIV, as Bruce, Harper, and Fernandez (2013) found that a quarter of their sample of young Black GBMSM living with HIV used marijuana daily to manage stress, relax, or manage

⁵ This finding was not unique to GBMSM living with HIV, as it was also demonstrated that HIV-negative GBMSM were more likely to engage in condomless anal intercourse while under the influence of substances (Hays et al., 1997; Wilkerson, Smolenski, Morgan, & Rosser, 2012).

the side effects of HIV medications. This rate of use is particularly high when compared to rates among the greater population of emerging and young adults (18 to 30 years old), wherein 4 to 6% report daily use of marijuana (Johnston, O'Malley, Bachman, & Schulenberg, 2010). As such, the role of marijuana and other substances in young GBMSM's risk negotiation must be consistently considered.

Finally, while most GBMSM living with HIV attempt in some form to practice safer sex, there is a subset of the population which consciously intend to engage in condomless anal intercourse without particular consideration of HIV communicability. Further, it has been argued that condomless sex is not just a behavior for these men, but may represent an identity (Carballo-Diéguez et al., 2009; Parsons & Bimbi, 2007). These men have been referred to as "barebackers," "barebacking" being a term describing intentional condomless anal intercourse. While the term was initially born in spaces where HIV-positive GBMSM had condomless anal intercourse with one another, it has come to mean intentional condomless anal intercourse more generally. It is not clear though whether the population of HIV-positive barebackers purposefully seek other HIV-positive partners at present (Parsons & Bimbi, 2007). HIV-positive barebackers have been found to use illicit drugs (e.g., crystal methamphetamine, cocaine, marijuana, alkyl nitrates, etc.) at a higher frequency than non-barebacker GBMSM living with HIV and exist within peer networks where there are norms endorsing condomless anal intercourse (Hirshfield, Remien, Humberstone, Walavalkar, & Chiasson, 2004; Kelly, Bimbi, Izienicki, & Parsons, 2009).

Further, these men tend to have a higher number of sexual partners as well. The combination of substance use and the intent to engage in condomless anal intercourse with multiple partners has been termed “party and play” (Kelly, Bimbi, Izienicki, & Parsons, 2009). It has been theorized that these GBMSM who engage in party and play are attempting to cope with gay-related stress and HIV stigma through the numbing impacts of substance use and high volume, risky sexual intercourse.

Stigma and Disclosure. Goffman (1963) describes stigma as a discrediting attribute that marks an individual as both different and less desirable than those without the attribute. As it relates to the impact of stigma on dating and sex for young Black GBMSM living with HIV, it is the “less desirable” aspect of stigma which is most salient. As previously stated, being Black is stigmatized in particular ways that impact dating and sex for young Black GBMSM, marking them as undesirable or desirable only as sexual objects (Han, 2007; Morton, 2007; Robinson, 2008b). Young Black GBMSM living with HIV must also manage the additional stigma attached to their serostatus (Bird & Voisin, 2013; Hosek, Harper, & Domanico, 2000). Given this additional stigma attached to their HIV status, these young men also must negotiate how and when they will disclose their status to others, if at all, weighing the potential benefits and consequences of such disclosure.

It must be stated that same-sex attraction itself is a heavily stigmatized status (Bird & Voisin, 2013), and stigmas attached to living with HIV are often also connected to stigmas attached to being a GBMSM more generally.

Accordingly, many young Black GBMSM have experienced HIV stigma even before becoming HIV-positive. They are subject to an assumption that HIV is “a gay disease” and therefore an inevitability for all GBMSM (Herek & Capitano, 1999; Crandall, 1991; Pryor, Reeder, & Landau, 1999; Rood, Bruce, Harper, & ATN, 2012). Further, GBMSM must endure societal beliefs which describe them as promiscuous and therefore susceptible to HIV, abnormal and therefore deserving of HIV, and/or the population primarily associated with HIV (Herek & Capitano, 1999). Some young GBMSM have reported internalizing these beliefs early on, so much so that some assumed that all gay men were HIV-positive. Some young GBMSM have even reported being exposed to and potentially internalizing an association between HIV and Black GBMSM specifically, which led them to believe that all Black GBMSM were HIV-positive (Rood, Bruce, Harper, & ATN, 2012). This underlines the potential HIV stigma associated with young Black GBMSM, both before an HIV-positive status and after.

The assumption that someone may contract or have already contracted HIV in and of itself may be insufficient to constitute stigma, as it only marks them as different though not necessarily less desirable. It is the beliefs about what it means to be HIV-positive that move these assumptions toward stigma, as they presume a diminished value for those living with HIV and those presumed to be fated to living with HIV at some point in the future.

The stigmas attached to being HIV-positive are many and may include ideas about the person’s sexual behavior, morality, communicability, and health status (Bird & Voisin, 2013; Herek, 1999a; Herek, 1999b; Herek & Capitano,

1999). For example, there are assumptions that people living with HIV (potentially given their assumed same-sex behavior or simply because HIV is potentially transmitted sexually) have been and may continue to be sexually promiscuous. This idea is often intimately linked to notions of morality and deserved HIV status. More specifically, some believe that people who contract HIV have done something to “deserve” the disease, and therefore HIV may be understood as a consequence of immoral behavior (Herek, Capitanio, & Widaman, 2002). Some even believe that HIV is a punishment from God for people who are sexually immoral, a group which often necessarily includes GBMSM (Herek & Capitanio, 1999). Further, there may be assumptions that people living with HIV are contagious to anyone with whom they have contact or that they intend to transmit HIV to unknowing others in an act of spite (Herek, Capitanio, & Widaman, 2002). Potentially due to a generally poor understanding of HIV and HIV treatment among the larger public, there may also be assumptions that people living with HIV will have physical markers of their diseased status and that they will likely die soon (Bird & Voisin, 2013).

Given the pervasiveness of these beliefs, these messages of HIV stigma may be received from strangers, media, and other distal entities. However, they may also be received from friends, family, churches, and others in the gay community (Herek, 1999a; Herek, 1999b). In addition, many GBMSM report having held negative ideas about HIV-positive people prior to their own diagnoses (Bird & Voisin, 2013). As such, they may have to reconcile beliefs they have about themselves with a combination of their own stigma-laden beliefs about

HIV as well as HIV stigma communicated from others. This tension between prior beliefs and current status may result in anxiety, depression, or even suicidal ideation. Further, this tension may lead to isolation and resultant loneliness, as some HIV-positive GBMSM have described an aversion to interacting with HIV-negative people in order to avoid experiences of stigma and associated rejection (Courtenay-Quirk, Wolitski, Parsons, Comez, & SUMS Team, 2006).

The rejection HIV-positive GBMSM may experience may include poor treatment by HIV-negative friends and family and rejection by current and potential lovers (Carr, 1989; Herek, Capitanio, & Widaman, 2002; Mansson, 1992). The impact to these relationships proves particularly problematic, given the utility of close relationships in mitigating the impacts of stigma (Cohen & Willis, 1985; Harvey & Wenzel, 2002) and given how many HIV-positive GBMSM continue to desire dating relationships (Bailey & Hart, 2005; Bruce, Harper, & ATN, 2012). For example, though 78% of the men in the SUMS study reported being single, 67% reported a desire to be in a relationship (Bailey & Hart, 2005). A study by Hatala, Baack, and Parmenter (1998) found that HIV-positive men may find a reduced pool of potential partners online, as most dating ads by HIV-negative men described a preference for an HIV-negative partner. This was echoed by findings in other studies, wherein HIV-negative GBMSM endorsed a disinterest in HIV-positive partners (Herek, 1999; Hoff, McKusick, Hillard, & Coates, 1992). As such, it is unsurprising that many HIV-positive GBMSM report experiencing rejection by HIV-negative men while others report an expectation of being rejected by them (Bailey & Hart, 2005). Some SUMS

respondents reported a decision to abandon the pursuit of a dating relationship given the potential impact of stigma if they disclosed their HIV status. These men chose instead to engage in anonymous sex, given the low likelihood that HIV status would be discussed. Many of these respondents reported a renewed interest in dating after the advent of HAART, but research has not clearly demonstrated if HAART has reduced stigma and increased HIV-positive GBMSM's access to partners. For these participants in the SUMS study, dating relationships appeared to be distinct from primarily sexual relationships. In addition, dating relationships seemed to hold an esteemed status for these men. In the absence of access to such relationships though, they met a degree of their needs through relationships that were sexual in nature but did not have opportunities for dating.

Prior to the advent of HAART, it was likely that GBMSM living with HIV could become symptomatic and therefore have a visible HIV status (Sullivan, 2005). While some GBMSM living with HIV in the post-HAART era may have their status exposed to others without their permission, it is often the case that a willful disclosure is the catalyst for others knowing his HIV status. Such a disclosure potentially exposes him to stigma, rejection, and unsanctioned disclosure of his status by others. Therefore, many GBMSM living with HIV describe disclosure as a very difficult process, both as it relates to intimate partners and other significant persons in their lives (Bruce, Harper, & ATN, 2012; Stirratt, 2003). Not only is disclosure a significant challenge for these men. It is also a recurrent one, as each disclosure carries the same risks of rejection, loss, and vulnerability. Further, disclosure of HIV status to a current or potential sexual

partner may also place these men at risk for violence, as their partner may attempt to harm them due to feelings of being misled or endangered (Stirratt, 2003; Stirratt, 2005). Some HIV-positive men also report particular reservations about disclosure given the ways they responded to HIV-positive men before their own HIV diagnoses, fearing that they would receive similar rejections (Stirratt, 2005).

In a review of the nursing literature, Sullivan (2005) found that rates of disclosure to primary sex partners ranged from 67% to 88% among HIV-positive men, suggesting that up to a potential third of main sex partners were not disclosed to. As a man's number of partners increased, the likelihood of disclosure to all partners decreased as well, ranging from 25% to 58%. This range of disclosure frequencies is reflective of the complex process that people living with HIV must negotiate for every disclosure, as each person will have a different combination of relevant factors to consider in each disclosure attempt. Myriad factors have been identified as facilitating or inhibiting disclosure to partners. These factors have fallen primarily into four domains: intrapersonal, interpersonal, sociocultural, and situational.

Intrapersonal factors which may impact disclosure are aspects of the person which may heighten or dampen the necessity of disclosing their HIV status to a partner. Factors like emotional distress and perceived responsibility have been highlighted in the disclosure literature. For example, initial HIV diagnosis is a traumatic event for many, and, as such, many GBMSM living with HIV must take time to accept their status and the associated changes in self-concept that accompany this status. Accordingly, many GBMSM find it hard to disclose their

status to partners in the time immediately following diagnosis (Klitzman, 1999). In fact, Marks and Crepaz (2001) found that GBMSM were more likely to disclose their status to partners if they had been HIV-positive for longer than 3 years.

An important part of integrating HIV-positive status into many young GBMSM's self-concept is acknowledging the potential transmission of HIV to sexual partners, and many GBMSM living with HIV cite this as an impetus for disclosure (Wolitski & Bailey, 2005). This responsibility for preventing transmission to partners may manifest as disclosure early in the relationship or personal mandates of disclosure before any sexual contact (Stirratt, 2003). However, internalizing the responsibility for preventing transmission is not universal across GBMSM living with HIV. As such, some report feelings that it is their partner's responsibility to ensure their own safety and that partners who would be willing to engage in condomless anal intercourse are likely already HIV-positive, whether they know it or not (Stirratt, 2003; Wolitski & Bailey, 2005). Accordingly, these men will be less likely to disclose.

In addition to the intrapersonal factors which may impact disclosure of HIV status, there are also factors related to the interpersonal relationship between a GBMSM living with HIV and his sexual partner. In multiple studies, GBMSM living with HIV have reported that disclosure was not part of the sexual script with casual and anonymous partners, as these were non-serious relationships and lacked the trust necessary for disclosure (Paiva, Maria, & Filipe, 2011; Stirratt, 2005). In relationships with primary partners, respondents endorsed comfort with

disclosure when there was trust, but particularly when they believed the relationship would endure post-disclosure (Stirratt, 2005). It was important for these men that they believed the partner would not reject them due to their HIV status.

In addition to the elements of the relationship which shaped disclosure practices, some GBMSM living with HIV described characteristics of their particular partners which would determine whether they disclosed their HIV status. For example, Paiva and colleagues (2011) found that GBMSMW were more likely to disclose to female partners than to male partners. In addition, a subset of SUMS respondents described feeling that a partner's perceived promiscuity (or lack thereof) was an important factor in determining whether they would disclose, even with primary partners (Wolitski & Bailey, 2005). Partners assumed to be less promiscuous would be more deserving of disclosure whereas they would be less likely to disclose to partners perceived to have had a higher number of sexual partners, potentially given assumptions that they may already be HIV-positive or unconcerned about risk of becoming HIV-positive. GBMSM may be assumed to be promiscuous and therefore likely to be HIV-positive or unconcerned about risk. Accordingly, GBMSMW living with HIV may disclose to other GBMSM less often (Paiva et al., 2011) due to this assumption.

Research examining sociocultural factors underlying disclosure practices has focused on perceived HIV stigma, perceived sexual orientation stigma, perceived social support, and the role of counseling related to disclosure. For example, young GBMSM of color living with HIV can experience triple stigma,

which may limit their access to social support and therefore increase the challenge of disclosing serostatus to partners (Kanuha, 1999; Stein, 1998; Zea et al., 2004). Research has demonstrated that this triple stigma may be particularly salient for young Black GBMSM living with HIV (when compared to White and Latino GBMSM living with HIV), as the experience of anti-Black racism and associated stigmas may make them unwilling to endure the shame associated with same-sex attraction and HIV status (Stein et al., 1998). As such, these men may refuse to disclose their status to partners, as the perceived risks of disclosure may outweigh the perceived benefits.

Lastly, there are a number of situational factors which have been found to impact disclosure of HIV status. Visible signs of HIV (e.g., Kaposi's sarcoma or the presence of HIV medications in the man's place of residence) lead some GBMSM to disclose to their partners (Stirratt, 2003; Sullivan, 2005). This effect is perhaps due to the notion that a partner would be able to determine the person's status. Therefore, disclosure may be a preemptive measure in this case.

Some GBMSM have described consistent condom use in a relationship as a factor which may allow them greater comfort with non-disclosure of their HIV status (Stirratt, 2005). Consistent condom use alleviates the men of feelings of guilt related to potentially exposing an HIV-negative partner to HIV, but does not force them to face the potential rejection associated with disclosure of HIV status.

Another factor some GBMSM have described is the HIV status or perceived HIV status of their partners. Across multiple studies, GBMSM have demonstrated a willingness to disclose HIV status to partners who they know are

HIV-positive (Hatala, Baack, & Parmenter, 1998; Paiva, Maria, & Filipe, 2011; Stirratt, 2003). Presumably, the stigma of their status is alleviated in this situation, as both parties are living with HIV. However, this comfort with disclosure seems lessened in situations where HIV status is assumed rather than stated. As stated earlier, some GBMSM have described a partner's willingness to engage in condomless anal intercourse as indicative of a partner who is HIV-positive or unconcerned about potentially contracting the virus (O'Leary, 2005; Schwartz & Bailey, 2005; Stirratt, 2003). In addition, some GBMSM have described using physical appearance to determine a partner's HIV status. This might include looking for symptoms like wasting or lesions (O'Leary, 2005). GBMSM living with HIV reported no feelings of responsibility related to disclosing to partners who appeared HIV-positive nor did they describe increased comfort with disclosing their status to these partners.

Online dating presents an interesting space where GBMSM living with HIV negotiate disclosure. Some GBMSM living with HIV report disclosing their serostatus as part of their profile in order to minimize the need to disclose later to a partner who may or may not respond positively (Davis, Hart, Bolding, Sherr, & Elford, 2006b). Some of these men disclose overtly by stating they are HIV-positive while others imply HIV-positive serostatus by utilizing usernames that imply positive status (i.e., including "poz" or "plus" in a username) or stating an absolute disinterest in protected anal intercourse. This allows these men to avoid social rejection connected with the stigma of HIV-positive status. GBMSM living with HIV who do not disclose in these ways report negotiating disclosure in a

fashion similar to dealing with non-virtual relationships if they are asked about their HIV status online.

While disclosure may be useful in increasing the psychological well-being of young Black GBMSM living with HIV and improving the quality of their romantic relationships (Paiva, Maria, & Filipe, 2011), disclosure is not consistently associated with safer sex practices (Crepaz & Marks, 2003; Prestage et al., 2001; Sullivan, 2005). For example, 53% of GBMSM in the Sydney Men and Sexual Health cohort study indicated that they disclosed their HIV-positive serostatus to casual sex partners and 36% of those men subsequently engaged in condomless anal intercourse with these partners; only 10% of those who did not disclose their status engaged in condomless anal intercourse (Prestage et al., 2001). The absence of an explicit impact of disclosure on safer sex practices may be related to beliefs about partners' responsibility for maintaining their own safety. Some GBMSM have described the act of disclosure as alleviating them of responsibility for their partner's safety, as their partner is now choosing to engage in condomless anal intercourse with what can be presumed to be a full understanding of the present risks (Wolitski & Bailey, 2005). Prestage and colleagues found that it was not disclosure, but greater familiarity with partners and communication about the desire to use condoms which predicted less condomless anal intercourse. Crepaz and Marks (2003) also found that discussion of safer sex was key to increasing protected anal intercourse. They found that GBMSM who disclosed their HIV-positive status and discussed safer sex with

partners evidenced a higher prevalence of protected intercourse as compared to men who disclosed only.

Impacts of Highly Active Antiretroviral Therapy. Prior to the availability of HAART, many SUMS respondents reported a loss of interest in sex after their HIV diagnoses due to a combination of factors. These included the psychological burden of knowing they had a terminal, sexually communicable disease; the effects of associated illnesses; the potential mandatory disclosure of status that could accompany a decline in health; and the side effects of the antiretroviral therapies available at the time (Ramien & Borkowski, 2005). However, HAART has dramatically changed the lived experience of people living with HIV. Because the drugs used in HAART act on multiple parts of HIV's viral replication process, daily use of HAART under the care of a physician can lead to reductions in a person's viral load and strengthening of their immune system. Patients may even reach an undetectable viral load in their blood (<40-75 copies of HIV per mm³; US Department of Health and Human Services, 2009). In ideal circumstances, HAART can reduce a person's viral load by 90% in 6 months. This level of effect has, for most people, changed HIV from a terminal condition to a chronic one and eliminated some consequences of HIV that were once considered expected. For example, the likelihood of KS and wasting syndrome (a condition wherein the patient would lose considerable amounts of weight which could not be reversed by increased caloric intake) has become relatively low.

Given this change in prognosis, many of the SUMS respondents described a rejuvenated sex drive after beginning HAART (Halkitis, Wolitski, & Gomez,

2005). They described increased hope for the future, increased interest in being around other people, and increased feelings of attractiveness. However, the men in the study did not report a desire to be more risky after beginning HAART. In fact, some men stated that treatment optimism increased their desire to practice safe sex, to further lengthen their lives.

It must be noted though that researchers have observed a rise in barebacking (both the behavior and adoption of the identity) since the advent of HAART (Halkitis & Parsons, 2003; Halkitis, Parsons, & Wilton, 2003; Mansergh et al., 2002). In attempting to understand this phenomenon, it is important to consider the multiple factors which could underlie it. For example, using HAART alone did not predict higher levels of condomless sex among HIV-positive GBMSM (van Kesteren, Hospers, & Kok, 2007). The factor found to underlie condomless anal intercourse was the belief that HAART reduced the risk of HIV transmission (Crepaz, Hart, & Marks, 2004; Ostrow et al., 2002; van Kesteren, Hospers, & Kok, 2007). This idea and the associated engagement in condomless anal intercourse were not isolated to HIV-positive GBMSM though, as they were found to also predict the behavior of HIV-negative GBMSM. While the evidence necessary to support the idea of treatment as prevention (TasP) had not yet been established at the time much of this research was conducted, more recent evidence supports these men's assertion. In a two-year study of nearly 800 couples with HIV-discordant statuses, Rodger (2014) found that no couples experienced transmission of HIV if the HIV-positive partner's viral load was undetectable. She concluded that there was an approximately 1% chance per year of HIV

transmission via condomless anal sex if the HIV-positive partner's viral load was suppressed to such a level⁶. Given these data, adherence to HAART can be understood as prophylactic in addition to therapeutic for the individual. As such, HIV-positive GBMSM are now in a dating and sexual market wherein HIV-negative partners may not be as averse to condomless intercourse if they understand the relationship between treatment adherence, undetectable viral load, and reduced transmission risk.

Impacts of Antiretroviral Prophylaxis. While the advent of HAART has extended the lives of individuals living with HIV, improved their quality of life, and provided a new form of prophylaxis for them, it has also provided new forms of prophylaxis for HIV-negative individuals.

Given that it takes time for HIV cells to replicate in an individual's system, there is a window of opportunity for post-exposure prophylaxis (PEP) after being exposed to HIV. Individuals who believe they have been exposed to HIV can be prescribed a 28 day regimen of HAART (usually tenofovir, emtricitabine, and raltegravir or dolutegravir; NY Dept of Health AIDS Institute, 2014), and this will reduce risk of seroconversion. As such, if an HIV-positive individual is using condoms with a sexual partner and there is somehow a breach of that barrier method, PEP could be an option to manage risk.

⁶ Although individuals taking HAART move toward undetectable viral load with adherence to their medication, it is not the case that every HIV-positive person taking HAART has an undetectable viral load. For some, this is a consequence of inconsistent adherence and, for others, it is more related to a combination of strain virulence and treatment effectiveness. No matter the reason, this possibility necessitates a distinction between persons who are virally suppressed due to taking HAART and persons who are not yet virally suppressed despite taking HAART.

Truvada (a combination of tenofovir and emtricitabine) has been proven effective for reducing transmission of HIV when taken daily by HIV-negative individuals (Baeten et al., 2012; Buchbinder & Liu, 2011; Grant et al., 2010). This approach to HIV prevention has been termed pre-exposure prophylaxis (PrEP), given that it occurs before the potential risk event. Though the availability of PrEP could allow a much wider range of persons to consider sex with HIV-positive individuals less risky, the uptake of PrEP has faced a particular challenge as it relates to perception. Although the FDA approved PrEP in 2012 (FDA, 2012) and multiple studies have demonstrated its effectiveness, individuals who have been open about taking PrEP have been characterized as promiscuous and prone to engage in risky sexual behavior (Calebrese & Underhill, 2015). Often termed “Truvada whores,” these HIV-negative men have been denigrated by other HIV-negative men for what is seen as too great a willingness to engage in risky sexual activities. Although data has not consistently supported the idea that GBMSM who utilize PrEP engage in more risky sexual behaviors (Carlo Hojilla et al., 2015; Golub, Operario, & Gorbach, 2010), this perception may have a chilling effect on PrEP uptake and thereby minimize the potential positive impact of PrEP for the sex lives of GBMSM living with HIV.

Theory: Intersectionality

The dating and sexual lives of young Black GBMSM living with HIV may be circumscribed in particular ways given how they experience each of these identities and behaviors as well as the ways that these identities and behaviors are understood by the world around them. There is a growing mass of research which

considers the ways that particular aspects of identity and behavior may impact experiences. However, it is important to understand not only the potential individual impacts of these factors but their synergistic roles in impacting these young men's lives.

In representing their own experiences, Black gay-, bisexual-, and queer-identified men have long attempted to articulate the ways that the particular combination of their identities produce specific life conditions (cf. Delany, 1967; Hardy, 1994; Harris, 1991; Nugent, 1925; Riggs, 1989). Through multiple modes of creative expression (e.g., poetry, prose, drama, film, etc.), these men have attempted to demonstrate the nuances of living as someone at the vertex of Blackness, maleness, and same-sex attraction. More recently, scholars and activists have begun to explore explicitly how the vertex of identities produce the particular spaces that multiply marginalized people, like these men, inhabit.

Much of the foundation of this work was laid by the Combahee River Collective, an organization of Black lesbian feminists. In their Combahee River Collective Statement (1977), they proposed the notion that various forms of oppression are interlocking and experienced simultaneously. They argued that it was in the synthesis of these oppressions that the context for one's life was created. More specifically, they argued that the contexts of Black lesbian women's experiences were particular, given the intersection of racism, sexism, and heterosexism.

In her 1989 piece "Demarginalizing the Intersection of Race and Sex," Black feminist legal scholar Kimberle Crenshaw further articulated this idea,

positing that Black women's experiences of oppression were necessarily poorly understood due to a tacit assumption that Blackness referred to Black maleness and womanhood referred to White womanhood. Utilizing a Black feminist lens, she identified the ways that this sort of single-axis analysis disallowed a consideration of the unique experiences of Black women, given their simultaneous Blackness and womanhood. This analysis, which Crenshaw termed "intersectionality," asserts that multiple social identities intersect at the individual level of experience to reflect multiple interlocking social structural inequalities (Collins, 1991; Crenshaw, 1989, 1991; Davis, 2008). Intersectionality contests the notion that social identities are additive, independent, and one-dimensional. Rather, it asserts that identities are multiple, interdependent, and mutually constitutive (Collins, 1991; Crenshaw, 1991).

Since Crenshaw named and articulated the fundamental bases of intersectionality, other scholars have made important clarifications and expansions to the theory. For example, Patricia Hill Collins (1991) expanded the lens of intersectionality by exploring what she termed an intersectional "matrix of domination." This matrix which acted to oppress and marginalize particular people included the intersectional racism and sexism described by Crenshaw, but also included oppression due to age, sexual orientation, religion, and other factors. Further, Collins incorporated a consideration of the privilege associated with particular identities and experiences in order to more fully understand the vertex at which people exist. This addition allowed an exploration of the ways that privileges and oppressions work in tandem to create one's context.

In her work exploring how Black queer people navigate their multiple oppressions, Cathy Cohen (2005) explored how privilege and the exercise of it in particular spaces may foreground or shroud particular aspects of Black queer people's intersectional experience. For example, young Black GBMSM living with HIV may be able to avoid feelings of isolation in predominately White gay spaces if they have particular privilege to leverage (e.g., cultural assimilation, lighter skin, aesthetic beauty, educational privilege, etc.). This exercise of privilege may limit the felt experience of anti-Black racism in the space. However, Cohen is purposeful in highlighting that it does not negate the existence of the Black GBMSM's multiple oppressions. Accordingly, it is important to understand that even in spaces where particular aspects of one's identity or experience are highlighted or downplayed, an intersectional analysis remains useful as one's multiple oppressions and privileges continue to have impact.

Scholars in the area of Black queer theory, like Cohen, have consistently explored how the experiences of Black queer people are complicated by the intersections of their identities. This exploration of Black queer experiential complexity is perhaps clearest in Black queer theory's deconstruction of homonormativity (i.e., the hegemonic notion of same-sex-attracted experience). For example, White queer theorists and White gay men more generally have long centered the coming out process as a key part of gay identity development (Cass, 1979; Coleman, 1982; Troiden, 1989). In fact, it has often been described as a central or essential step in the evolution of queer modernity (Ferguson, 2005; Ross, 2005). The value placed on coming out seems to assume that it is necessary

for all people with same-sex attraction. The prizing of coming out fails to acknowledge the diversity of circumstances and contexts in which same-sex-attracted people live. Black queer theorists have argued that there may exist a spectrum of sexual identity and behavior disclosure, within which no particular position is optimal for the general population of GBMSM (Ferguson, 2005; Ross, 2005). While White queer theorists have described coming out as an important part of crystallizing one's identity, Black queer theorists have described circumstances where an individual chooses not to disclose his sexual orientation or behaviors, because it has already been assumed or because he does not deem it anyone's business (Ross, 2005). Ferguson (2005) argues that the centrality of coming out is one of many aspects of mainstream gay identity and experience which may be particularly bourgeois and therefore do not reflect the lived experience of many Black queer people. Other aspects that he highlights are the fights for gay marriage and military inclusion. While he does not argue that these are not worthwhile endeavors, he notes that Black queer people often have more proximal concerns, such as protection from hate crimes or equal access to housing and services.

The work of these Black theorists demonstrate the necessity of an intersectional lens in exploring the experiences of Black GBMSM. However, there has been very little work in psychology which has explicitly utilized a lens of intersectionality and particularly few studies that consider intersectionality as it relates to the experiences of Black GBMSM. In a book chapter examining the role of race in understanding lesbian, gay, and bisexual (LGB) communities, Wilson

and Harper (2013) highlighted that an absence of an intersectional lens facilitates research that fails to consider the complexity within marginalized groups. More specifically, they identified how an intersectional lens facilitates research that reveals new information about how racial factors influence the lives of LGB people of color. In a study of Black gay and bisexual men's experiences of intersectionality, Lisa Bowleg (2012) found that these men often found liberation in the intersection of their identities. Because roles had been narrowly defined for the groups they belonged to, without consideration of someone like them, they felt free to create their own roles. For example, they could define masculinity for themselves given that Black masculinity was devised for Black heterosexual men. In this way, Bowleg was able to identify something which had not been previously articulated as part of intersectionality—strengths and resilience born of the intersections. In addition to the empowerment Bowleg's participants describe, researchers have identified other strengths and evidence of resilience in young Black BGMSM. In a study examining psychosocial outcomes for young Black gay and bisexual men, Wilson and colleagues (2016) found that these men evidence self-efficacy and adaptive coping despite being impacted by syndemic conditions and minority stress. In fact, they found that the majority of the men in their sample possessed some form of resilience and argued that, accordingly, resilience was not an exceptional quality in this population. They posited rather that it could be a characteristic that the majority of young Black gay and bisexual men possess. Further, they argued that this resilience may be necessarily related to their identities as both Black and gay or bisexual, given previous research

suggesting that Black gay and bisexual men draw strength from those identities in response to stigma (Meyer, Ouellette, Haile, & McFarlane, 2011). It is important, however, to avoid fetishizing this resilience. There is a long history in the United States of Black people's ability to endure stress being marshalled against them and their desires for improved conditions (Harris-Lacewell, 2001). More specifically, Black people's ability to thrive despite oppression has been used to justify inaction on the part of those who benefit from their oppression or to minimize their lived experiences of challenge. Accordingly, recognition of the strength and resilience of young Black GBMSM living with HIV must be balanced with strident critique of the circumstances in which they exist which necessitate such strength and resilience.

Given what is known about intersectionality, the present work begins with an understanding that the circumstances of young Black GBMSM living with HIV are not simply the additive result of youth, maleness, same-sex attraction, Blackness, and HIV-positive serostatus. Rather these men's circumstances are born of a synergy created by living as all of these things at once. These identities and experiences come with both privileges and oppressions. Some have found that the intersectional space they inhabit allows space for defining the self as one sees fit. As such, the present study will utilize a lens of intersectionality which attends to the oppressions and privileges which intersect for young Black GBMSM living with HIV. Further, it will attend to the strengths and resilience which result from these intersections. This intersectional lens will afford an opportunity to understand the space in which young HIV-positive Black GBMSM date and have

sex. In addition, this lens will afford an opportunity to critique programs intended for GBMSM, youth, Black people, and people living with HIV more generally, considering whether they consider the unique needs of these men who may be ignored given how their other identities obscure the assumed homogeneity of any one of these identities.

Rationale

Infection with HIV is a global health concern that has had and continues to have disproportionate impacts on young Black GBMSM (CDC, 2012; Rastogi, Johnson, Hoeffel, & Drewery, 2011). As such, there has been extensive research examining their risk behaviors and ways to decrease potential transmission to others. However, there has been a lack of research which has examined more generally their romantic and sexual experience (Halkitis, Wolitski, & Gomez, 2005). With data collected from qualitative interviews with 250 GBMSM living with HIV, the Seropositive Urban Men's Study (SUMS; 2003) stands as one of the most thorough examinations heretofore which has explored the impact of HIV-positive serostatus on the romantic and sexual lives of GBMSM. The study is limited, however, in many ways as it relates to the current dating and sexual experiences of young Black GBMSM living with HIV.

First, data collection for SUMS occurred just as there were significant changes in the treatment of HIV. For those with access to appropriate medications, the advent of HAART transformed HIV from a terminal illness to a more chronic condition (Panel on Opportunistic Infections, 2013). This change in treatment and its effects may have particular implications for how GBMSM living

with HIV conceptualize themselves, but also how they are conceptualized by potential partners. For example, before the advent of HAART, physical symptoms of HIV were much more likely. These physical symptoms caused many GBMSM living with HIV to consider themselves unfit for dating and sexual relationships (Bird & Voisin, 2013). This management of symptoms has also made disclosure more optional than it previously had been (Sullivan, 2005). GBMSM living with HIV must now negotiate if, how, and when they will disclose their status to partners, while also considering the potential consequences of disclosure and non-disclosure (Stirratt, 2003; Stirratt, 2005).

Secondly, when SUMS data were collected, it was not legal for GBMSM to marry one another and consensual same-sex activity was still illegal in many states. As such, young Black GBMSM living in the current era may understand the possibilities for their dating and sexual lives very differently from those who were young GBMSM in the 1990s. Prior to civil unions and marriage, there was no permanent, state-sanctioned romantic state for GBMSM to work toward. As such, many GBMSM developed a variety of potential dating and sexual pairings to meet their particular needs (Adam, 2006; Blasband & Peplau, 1985; Blumstein & Schwartz, 1983; Harry, 1984). Some of these pairings included monogamy while others did not, and the meaning of monogamy had to be negotiated in many of these relationships. Further, the potential inclusion of a third partner was also an option, as was a preference for more ephemeral sexual bonds. Given marriage is now an option, the men interviewed for the present study will have a different world of possibilities to consider than did their forebears.

Thirdly, when the SUMS data were collected, the internet was still in its infancy and GBMSM seeking one another had to meet in a gay space (e.g., cruising area, gay club or bar, gay neighborhoods, etc.), via personal ads in print, or via party lines (Bailey, Kim, Hills, & Linsenmeier, 1997; Binson et al., 2001; Hospers et al., 2002; Martinez & Hosek, 2005). In the time since then, internet dating sites and GPS dating applications have become a primary venue for many GBMSM looking to meet dating and sexual partners (Blackwell, 2008; Chiasson, Hirshfield, & Rietmeijer, 2010; Lever, Grov, Royce, & Gillespie, 2008; Robinson, 2008b). These venues have allowed young Black GBMSM who would not be comfortable in “gay spaces” to engage potential partners and meet for dating and/or sex. Further, these meeting spaces may facilitate easier disclosure of HIV serostatus given that many sites/apps allow one to report this as standard practice or facilitate meeting other HIV-positive GBMSM (Bolding et al., 2005; Davis et al., 2006a; Davis et al., 2006b). Further, these sites and applications may assist these men in identifying other GBMSM in their local communities more generally.

Lastly, young Black GBMSM are disproportionately impacted by the HIV epidemic and, while Black GBMSM were included in SUMS, there are particularities of their lives which may shape their dating and sexual experiences. For example, Black GBMSM are subject to discrimination based on both their race and sexual orientation or desires. This kind of discrimination circumscribes their lives in particular ways that differentiate them from the general mass of GBMSM. Black GBMSM living with HIV must navigate dating and sex in a

context where they are often devalued due to their race (Collins, 2005; hooks, 2001). Moreover, they may be valued primarily due to racist assumptions about their penis size (Farley, 1997; hooks, 2004) and/or may be assumed to be a threat to the health and safety of Black heterosexual women (Agyemang, 2007; King, 2004; Mitchell, 2006; Valera, 2007). All of these factors have potential implications for how these men see themselves, but also how they are seen by potential partners and society at large.

Considering the myriad, intersecting factors which may shape the dating and sexual experiences of young Black GBMSM living with HIV in the current era, there was a clear need for an updated study which attends to the nuances of these men's lives. However, there is a tendency for researchers to primarily characterize historically oppressed populations by their relationship to this oppression. As such, the researcher for the present study sought to engage this population with a more complex lens, as to capture the breadth of experiences had by these men. The present study utilized thematic analysis to explore the potential intersecting roles of gender, sexual orientation, youth, race, and HIV status in the dating and sexual experiences of young Black GBMSM living with HIV. The study attended to the role of intersectionality, considering how multiple identities and statuses may work in tandem to shape these men's experiences.

Statement of Research Questions

Research Question I. What is the lived experience of being a young Black GBMSM living with HIV?

Research Question II. What is the experience of dating relationships for young Black GBMSM living with HIV?

Research Question III. How do young Black GBMSM living with HIV describe healthy dating relationships?

Research Question IV. What is the experience of sexual relationships for young Black GBMSM living with HIV?

Research Question V. How do young Black GBMSM living with HIV describe healthy sexual relationships?

Method

Research Participants

Participants for the present study were 20 young Black men living with HIV. Inclusion criteria were selected in order to ensure the specificity of the present analysis. Given that research has yet to meaningfully explore the experiences of trans GBMSM, a cursory exploration in the context of the present study was deemed insufficient by the researcher. As such, the study was restricted to (a) individuals who were assigned male at birth and identified as male at the time of study participation. Further, the present study sought to examine the experiences of young GBMSM. While some studies characterize adolescence as ending at age 24, the present study utilized the Study of Emerging Adult (SSEA) definition of emerging adulthood. Accordingly, the study was open to (b) individuals between the ages of 18 and 29, inclusive. In order to have a definition of Blackness sufficiently broad to encompass the diversity of young Black GBMSM impacted by HIV, the study was open to (c) individuals who identified as being of African descent, regardless of whether they identified as “African American.” Given that GBMSM are a diverse group and many do not identify as “gay,” “homosexual,” or “queer,” participants in this study were included if they were (d) individuals who desired to engage with men romantically or sexually. Participants were not required to endorse exclusive interest in men, so GBMSMW were also eligible for participation. Screening questions are attached as Appendix A.

Demographic data for participants are displayed in Table 1. The demographic questionnaire is attached as Appendix B.

Table 1

<i>Demographics</i>				
Variable	Mean	Range	N	Percentage
Age	26.85	22 - 29	-	-
Sexual Orientation				
Gay	-	-	12	60
Bisexual	-	-	7	35
Queer	-	-	1	5
Years since Diagnosis	5.55	1 - 13	-	-
CD4 Count	565.00	300 - 750	-	-
Did Not Know	-	-	10	50
Viral Load				
Undetectable	-	-	15	75
Detectable	70.00	70 - 70	1	5
Did Not Know	-	-	4	20
Under MD's Care				
Yes	-	-	19	95
No	-	-	1	5
On Medication to Treat HIV				
Yes	-	-	18	90
No	-	-	2	10
Annual Income (\$K/year)	26.17	0 - 65	-	-
Education				
HS Diploma/GED	-	-	9	45
Vocational School	-	-	1	5
Some College	-	-	5	25
4-Year College Degree	-	-	4	20
Graduate Degree	-	-	1	5
Parents' Annual Income (\$K/year)	41.94	12 - 100	-	-
Maternal Education				
HS Diploma/GED	-	-	13	65
4-Year College Degree	-	-	5	25
Did Not Know	-	-	2	10
Paternal Education				
HS Diploma/GED	-	-	6	30
4-Year College Degree	-	-	6	30
Did Not Know	-	-	8	40
Dating Partners in Last 12 Months	2.00	0 - 3	-	-

Current Number of Dating Partners	0.20	0 - 1	-	-
Sexual Partners in Last 12 Months	5.60	1 - 15	-	-
Current Number of Sexual Partners	1.40	0 - 4	-	-

The Community Advisory Board

A community advisory board (CAB) of six Black GBMSM living with HIV was assembled for this study in order to utilize the perspectives of community members in the study’s development and execution. Community advisor boards serve to ensure that work with marginalized communities is not exploitative and proceeds with the care necessary to engage with the community respectfully (Brieland, 1971; Cox et al., 1998).

Each of the men selected for this study’s CAB self-identify as Black or African American, cisgender, and male. They ranged from ages 27 to 39 at the onset of the study. Four of the six members had previously worked in social services related to HIV. Further, all of the members of the CAB were familiar with the concept of intersectionality and considered it a necessary component of exploring the experiences of young Black GBMSM.

The CAB met three times to review the interview guide and give feedback on its appropriateness for the study. CAB members also gave feedback on whether the questions were sufficient to explore dating and sex among young Black GBMSM living with HIV. They were asked to assess whether the questions were ones they would feel comfortable answering, whether the language was respectful, and whether the language was accessible. Their suggestions for changes to the interview guide were incorporated. In the data collection and analysis phase of the dissertation, the CAB was convened to review samples of

the researcher's coding as a form of member checking. No members of the CAB took part in the study as participants.

Interview Guide

A semi-structured interview guide was developed by the researcher for this study. The guide included questions about the respondent's experience of engaging in dating and sexual relationships, exploring their perceptions of any role played by aspects of their identity and life experience. Attention to the role of identity and life experiences was purposeful, in order to facilitate conversation wherein participants could think of how the intersection of their identities and experiences framed or shaped their experiences in relationships.

This interview guide was revised through meetings with the study's CAB. In these meetings, CAB members gave feedback on topics like the scope of the conversation to be had with participants, the invasiveness of the guide's questions, and the wording of questions. In addition, the researcher consulted with researchers and clinicians with experience serving the population⁷. The researcher pilot tested the interview guide with 2 young Black GBMSM living with HIV in order to determine the quality of the data it elicited. No edits were made to the guide after these pilot interviews. However, the pilot interviewees suggested that the researcher make the interview more conversational. This feedback was incorporated into how subsequent interviews were conducted.

⁷ These consultants included a physician and nurse practitioner who have worked with HIV positive populations since the 1980s, two clinical psychologists who work with HIV positive populations, and two academic psychologists who study HIV in various populations of GBMSM (e.g., adolescents, ethnic minority, etc.).

The final interview guide was approved by the institutional review board for the researcher's university. The full interview guide is attached as Appendix C.

Procedure

Recruitment. Participants were recruited from social service agencies in Chicago serving Black GBMSM living with HIV (e.g., HIV Care Program, Core Center, Task Force Prevention & Community Services). In order to recruit from these agencies, the researcher met with program administrators to explain the purpose of the study and gain their permission to post flyers. No additional IRBs required consultation. Flyers were posted in these agencies with tear-away contact information for the researcher. Participants contacted the researcher by phone⁸ and were administered a screener to establish that they met inclusion criteria for the study. After establishing that the potential participant met criteria for inclusion, he was scheduled for an interview. If the participant preferred not to meet at DePaul for his interview, he was interviewed at the researcher's office at Northwestern University.

Interview Process. When participants arrived for the individual interview, they were given a consent form to read and asked for verbal consent for participation in the study. The DePaul IRB issued the researcher a waiver of documentation of consent in order to better afford participants confidentiality.

After consenting, participants completed the demographic questionnaire. After this questionnaire was complete, participants were interviewed by the

⁸ The researcher set up a Google Voice number for participant contact.

researcher in a private office. Participants received \$30 as compensation for their time. The average interview was approximately 60 minutes in length. Interviews were digitally recorded and transcribed verbatim by the researcher.

Seven participants were re-contacted by the researcher after the initial interview for member checking. These participants were selected at random before the interviews began⁹. During these meetings, participants were presented with the codes and themes drawn from passages of their interview and asked to assess if the codes and themes accurately reflected their meaning. Analysis was refined based on this feedback. These participants received an additional \$15 for their time.

Analytical Approach: Thematic Analysis

The present study utilized thematic analysis to explore respondents' experiences of dating and sex, making use of multiple steps of inductive coding (i.e., allowing codes to be identified within the data rather than pre-establishing *a priori* codes; Miles & Huberman, 1994). Thematic analysis was selected for its flexibility and utility for providing a rich and detailed interpretation of complex data. The present analysis utilized this flexibility in order to allow a social constructionist interpretation of the data. More specifically, the researcher analyzed the data with the explicit assumption that the phenomena described by the participants were born of an interaction between the individual and the society in which he exists (Boghossian, 2001; Hacking, 1999). Accordingly, young Black

⁹ There are not established guidelines as to how many participants should be consulted for member checking. Seven participants were chosen for the present study as they constituted approximately a third of the sample. Using a random number generator, participants 1, 3, 5, 6, 16, and 17 were selected for member checking.

GBMSM's experiences in dating and sexual relationships are not interpreted as simply internal phenomena or external phenomena, but co-constituted by their context and internal experience.

There were five steps in this study's analysis: familiarization with the data, generation of initial codes, identifying themes, theme refinement, and finalizing themes (Miles & Huberman, 1994). In order to familiarize himself with the data, the researcher read the transcripts in full in order to identify larger patterns. Transcripts were read while data collection was still in progress in order to allow earlier interviews to inform dialogue in later interviews.

In the second step of analysis, the researcher began to code the individual transcripts, identifying the bits of meaning existent in the interviews that were relevant to the research questions. As such, for each chunk of text relevant to the research questions, a distilled interpretation of this text was identified as a code (Patton, 2015). This text was considered in the context of the larger narrative offered by the participant in order to ensure it was well understood by the researcher. Vaismoradi, Turunen, and Bondas (2013) argue that this consideration of context is necessary for appropriate analysis and interpretation of data in thematic analyses. Terminology used by the participants was employed to name these codes and organize them in an initial version of the study's codebook. As transcripts were read, identified codes were added to the manual as appropriate. In order to ensure that codes were exhaustive (i.e., inclusive of all material relevant to the study's research questions), transcripts were reviewed multiple times throughout this step. Many researchers describe this level of analysis as when

codes “emerge” from the data. However, Ely, Vinz, Downing, and Anzul (1997) caution that it is important avoid such passive description of the analytic process, given that the researcher is the instrument for analysis. As such, it must be understood that the researcher has identified these codes and that this identification is subject to his analytic lens. Braun and Clarke (2006) assert that more instances of a given code is an insufficient criterion to assume that the code is more crucial than any other. Accordingly, there was no minimum number of times a topic needed to be mentioned in order to merit coding. After all interviews were coded and reviewed sufficiently, the codebook contained an exhaustive list of mutually exclusive codes.

The exhaustive list of codes was used for the process of thematic identification. During this, the third step in the analysis, the researcher reviewed the codes in order to identify how they fit into broader patterns (Taylor & Bogdan, 1984). These broader patterns, termed “themes,” would constitute the primary units of analysis for the study, as they would be used to determine the larger narrative in the data. After the researcher was able to identify an initial set of these themes, the researcher worked to delineate precise descriptions of these themes based on analysis of what clusters of codes meant when considered in tandem.

In the fourth step of the analysis, the researcher reviewed initial themes to determine how they related to one another as well as how they related to the research questions more generally. This review allowed the researcher to refine themes in order to ensure they best represented the data. In cases where themes

were deemed insufficiently differentiable by the researcher, multiple themes were collapsed into one theme; in cases where themes were deemed sufficiently different but still clustered together, themes retained their independence while being organized under a larger meta-theme (Braun & Clarke, 2006). This organization, review, and reorganization of the themes was the key aspect of this fourth step of analysis. In order to maintain a level of analytic clarity, themes and meta-themes were organized into a thematic map representing the hierarchical relationship between themes and the experience described by the data more generally. This map was revised continually until the data represented a coherent narrative about the participants' experiences that could be articulated in the Results chapter of the dissertation. In this finalized document, the highest level themes were termed meta-themes, the next level of themes were simply termed themes, and the third level of themes were termed "sub-themes."

The fifth step of the analysis was finalizing the themes. In this step, the researcher finalized the names of the themes, described them clearly, and articulated how they were relevant to the research questions. Given that thematic analysis allows the identification of myriad themes and many may be esoteric to the identified research questions, drawing a relationship between themes and the research questions was an important aspect of this last analytic step (Braun & Clark, 2006). This ensured that any themes represented in the Results chapter of this study were pertinent to the study, as proposed. In order to have clear examples of the texture of participants' experiences, excerpts were selected which could best illustrate each theme. Along with the participants' quotes, these

excerpts included relevant demographic data and a pseudonym to be used when presented in the Results chapter. This finalized hierarchical set of themes is also included as Appendix D.

Trustworthiness

In order to ensure the trustworthiness of the present data analysis, the following steps were taken: considering the researcher's positionality (Cousin, 2003), prolonged engagement, member checking, peer debriefing, and negative case analysis (Lincoln & Guba, 1985). This trustworthiness served as an analog to the internal validity often sought in quantitative analyses. Given that the researcher was the sole coder of the data, no measures of coding consistency are included.

Positionality. Given that the researcher is a key instrument in the present analysis, he was purposeful in considering his position in relation to the experiences of young Black GBMSM living with HIV. This attention to the researcher's positionality was a continual process wherein he considered how his perspective informed the collection of the data and the researcher's understanding of the gathered data (Cousin, 2003). As part of this process, the researcher reflected on his sociocultural background, his relation to the population of interest, the development of his views on normative romantic and sexual function, his ideas about the impacts of gender, sexual orientation, youth, race, and HIV status on dating and sex, and his motivations for pursuing this line of inquiry.

The researcher is a 32 year old Black MSM. At various times in his life, he has identified as "bisexual" or "gay," but necessarily rejects other labels like

“queer” or “same-gender loving” as they do not fit his identity. Prior to the proliferation of popular press regarding the DL phenomenon, the researcher identified as “DL.” For him, this descriptor meant that he had not widely disclosed his attraction to men, but did not imply any “double life” or other deceptive engagement with female dating and sexual partners. To be clear, the researcher’s adoption of various identity labels over the course of his lifespan was not an assumption of affiliation with a larger gay or bisexual community. Further, his use of these labels was not intended to communicate alignment with what he considered the bourgeois politics of the gay political establishment. Rather, the use of “gay” and “bisexual” were chosen in order to more easily communicate his disjunction with heterosexuality to others who lacked a broader lexicon of terminology for same-sex attraction. At the start of the study, the researcher existed in various stages of disclosure related to his sexual orientation. By the end of the study, the researcher had disclosed his sexual orientation more universally, given his entrance into a long term romantic relationship.

The researcher became acquainted with the concept of intersectionality in the summer of 2008 while in conversation with other young Black sexual and gender minority academics. In these dialogues, the researcher was challenged to complicate his notion of self, taking into account the multiple oppressions and privileges which served to frame the context of his position in the world. Further, these dialogues challenged the researcher to consider how hegemonic narratives about his identities served to insidiously move him toward alignment with oppressive forces (e.g., White supremacy, patriarchy, homonormativity). Lastly,

these dialogues challenged the researcher to think critically about the impact of any work he produced, given his actual and assumed identities¹⁰. Thinking of himself through an intersectional lens was a challenging process for the researcher. As such, the researcher recognizes the kind of challenge posed by pursuing a research study with the explicit goal of garnering explicit intersectional analysis from his participants.

Over the course of his life, the researcher has inhabited multiple socioeconomic strata. He was raised in a working class context, but pursued his undergraduate education in an elite private school. As such, he amassed particular kinds of cultural capital, even as his financial status remained working class. He has since been employed as a researcher and pursued graduate education. Accordingly, he has continued to amass cultural capital and has been able to move toward a middle class financial status. As such, the researcher has a level of familiarity with many of the participants' experiences of stress and challenge as a consequence of living in a lower socioeconomic stratum. However, he also has a degree of distance, given his current status.

The researcher is HIV-negative, but has many close relationships with Black GBMSM who are living with HIV. Most of these close relationships began before the men became HIV-positive or became aware of their HIV status. As such, the researcher has witnessed these men react to receiving their HIV

¹⁰ It is necessary to recognize that intersectionality does not require identification with an identity in order for it to be impactful. The assumptions of third parties about an individual's identities is sufficient to impact his/her/their experience, particularly if the individual is already oppressed due to other identities. For example, MSM who eschew traditional labels for same-sex attraction may still be subject to homophobic antagonism

diagnoses, and the researcher has witnessed many of these men navigate dating and sexual partnering both before and after HIV diagnosis. In addition, the researcher has dated men living with HIV, and these men have been in various stages of disclosure related to their HIV status. Some disclosed in the beginning of the relationship while others have disclosed later in the relationship or after the termination of the relationship. Given these experiences, the researcher is acquainted in many ways with the phenomenon of young Black GBMSM's experiences of dating and sex. However, the researcher understands that these experiences are a mere fraction of the potential experiences of young Black GBMSM living with HIV. As such, these experiences were utilized as a lens through which to generate questions and hypotheses about the data rather than to achieve concrete conclusions.

The researcher's views on normative dating and sexual function have been influenced by his lived experiences as a Black MSM as well as his research in the areas of dating and sex. Throughout his personal and professional growth, the researcher has considered and reconsidered the utility of heteronormative archetypes as well as the development of alternatives born of non-heterosexual communities. The researcher's previous work has primarily explored the dating and sexual experiences of heterosexual Black adolescents, but he has also been involved in research examining the lives of Black GBMSM as well. This work has ranged from analyzing interviews with young GBMSM for use in the refinement of an identity development model to assisting in the development of a sexual health intervention for Black men who have sex with men and women.

While he has worked in various capacities on these studies, the present study was the first wherein he led the development of the interview guide and conducted interviews with GBMSM himself.

For the duration of the development and implementation of the dissertation study, the researcher worked in an HIV clinic with a caseload primarily composed of young Black GBMSM living with HIV. Through this work, he worked with members of this community in individual and group therapy where questions related to their identities were explored. Further, work with these clients often included exploration of the ways that youth, race, gender, geography, and HIV status proscribed life opportunities generally as well as the impacts these factors may have on the ability to pursue intimate relationships.

The researcher was motivated to pursue the present line of research because he had observed what appeared to be a societal compulsion to associate Black men's sexuality with pathology. He saw this compulsion in the focus on young Black GBMSM's risk for HIV and potential to transmit HIV absent a consideration of their romantic and sexual selves more generally. In contrast, the researcher was also skeptical of work that attempted to lionize oppressed people for their strength and resilience in the face of oppression. The researcher considered such narratives to be similarly reductive and primarily produced to abate a level of guilt had by the liberal researchers who conducted research with these populations. The researcher was purposeful in the present study, in that he wanted to consider the full humanity of young Black GBMSM without reducing them to oppressed or resilient caricatures. With this frame in mind, he sought to

explore with care and respect the lived experience of these men in intimate relationships, aware of the risks these men must navigate but careful not to reduce these men to vectors of infectious disease.

Prolonged Engagement. As part of the data collection process, the researcher spent extended amounts of time in the communities from which the data was collected. This prolonged engagement was intended to allow the researcher to better identify salient aspects of the situation which could color responses or the researcher's analysis of the responses (Houghton, Casey, Shaw, & Murphy, 2013). Further, this kind of engagement was intended to allow the researcher to identify potential sources of distortion and document their potential influence.

The researcher's time with the community being interviewed was primarily in the context of providing therapy in HIV clinics that offered a range of services to clients living with HIV. Although these programs served the psychological needs of clients living with HIV, they were not primarily mental health clinics. As such, those who received their services approximated a population of people living with HIV who are receiving care, irrespective of mental health status. In addition to his time working in HIV clinics, the researcher had quarterly meetings with the study's CAB comprised of Black GBMSM living with HIV.

During the process of coding and analysis, the researcher listened to interview recordings and read the entirety of the interview transcripts in order to more fully orient himself to the language and style used by the respondents in

their discussion of their identities, experiences, HIV status, dating, and sexual engagement. This thorough reading allowed the researcher to identify aspects of the phenomenon that may not have been immediately apparent before exposure to the transcribed material. Further, this thorough reading of all transcripts ensured that codes would be informed not only by the material present in a particular interview, but that they would be informed by a more thorough understanding of the respondent group being analyzed.

Member Checking. Member checking is a process of continuous informal testing of information by exposing members of the respondent community or stakeholders in that community to the data which has been collected (Houghton, Casey, Shaw, & Murphy, 2013; Lincoln & Guba, 1985). The feedback of these persons allows the researcher to know whether the information gathered is reflective of shared understandings as well as ensuring that the researcher understands the material as it was presented. For example, a researcher may misunderstand the meaning of particular responses given the vernacular of the respondent community or contextual factors which may not have been readily apparent from the transcribed data.

For the present study, the researcher utilized a subset of respondents (seven of the twenty men) to review initial themes based on their respective interviews in order to ensure the themes represented their experience. They were shown the themes drawn from their statements and given the opportunity to clarify any statements that were misunderstood by the researcher. In addition, the CAB reviewed themes drawn from the aggregated, de-identified data as a form of

member checking. This dual approach to member checking helped to ensure that both the micro-level statements offered by participants and the macro-level aggregation of the experiences of all participants were appropriately interpreted.

Peer Debriefing. Peer debriefing, presentation of codes and coded material to professional peers, is an oft used strategy to ensure that the researcher's interpretation of the data is not biased by the particularities of his/her experience (Houghton, Casey, Shaw, & Murphy, 2013; Lincoln & Guba, 1985). In order to minimize such bias in the present analysis, the researcher established a team of professional peers with whom he could meet to present the codes he developed. The members of the peer debriefing team were all current or former colleagues of the researcher, and each member was familiar with qualitative research methods. Four of the six members had previous experience with research on the sex and sexuality of young Black men living with HIV. Two members were chosen without such experience, because they could offer a perspective on the researcher's analysis that was not biased by previous exploration of the extant literature. Members of the peer debriefing team had a range of educational backgrounds, from master's level coursework to the completion of a PhD. Three members of the peer debriefing team worked in the provision of services to young GBMSM living with HIV.

The peer debriefing team met with the researcher to discuss how well his codes and themes fit the interview data from which it was drawn. Further, they explored the researcher's interpretation of the data in order to ensure it was

logical. Their feedback was used to clarify interpretations of the data and better articulate the experiences captured by the study’s themes.

While both the peer debriefing team and CAB gave feedback on the researcher’s analysis of data, no individuals held positions on both the formal peer debriefing team and the CAB. A chart of all feedback meetings is included as Table 2. For each meeting, the involved party and purpose are given.

Table 2

Feedback Meetings

Project Stage	Involved Parties	Purpose
Guide Development	CAB	Assessing study feasibility/development of questions
	Mentors	Assessing study feasibility/development of questions
	CAB	Assessing invasiveness of study questions
	CAB	Adjusting wording for clarity/understanding
Guide Development/ Data Collection	Pilot Participants	Broad feedback on guide
Analysis	Selected Participants	Member Checking
	CAB	Member Checking
	Debriefing Team	Peer Debriefing

Negative Case Analysis. Given that phenomena are complex, negative case analysis allowed the researcher to consider alternative explanations for patterns in the data (Lincoln & Guba, 1985). Negative case analysis is the consideration of cases and instances that do not fit the larger pattern manifest in the data. By exploring the differences presented by these data, the researcher sought to find if explanations alternative to the researcher’s initial conclusions better explained the phenomena generally and/or if there were multiple

presentations of the phenomena. This examination of the negative helped the researcher develop a more nuanced description of the experiences of dating and sex among young Black GBMSM living with HIV.

Results

The results below illustrate the diversity of experiences identified by study participants. In order to respond to the present study's research questions specifically and methodically, this chapter will begin with an exploration of how participants describe their general experiences of being young Black GBMSM living with HIV. Subsequently, this chapter will describe experiences specifically in the contexts of dating relationships and sexual relationships respectively. Finally, given that many participants described experiences related equally to both dating and sexual relationships, this chapter will detail these issues common across intimate relationships as well.

The initial exploration of how participants describe life as young Black GBMSM living with HIV will address the lived experience of being a young Black GBMSM living with HIV (Research Question I). The experience of dating relationships for young Black GBMSM living with HIV (RQ II) and how they describe healthy dating relationships (RQ III) will be explicitly addressed when detailing experiences related specifically to dating relationships. Similarly, the experience of sexual relationships for young Black GBMSM living with HIV (RQ IV) and how they describe healthy sexual relationships (RQ V) will be explicitly addressed when detailing experiences related specifically to sexual relationships. Both RQ II and RQ IV will also be addressed in the discussion of experiences common in both forms of intimate relationships.

Within each domain explored in these results, salient themes and sub-themes which emerged from the data are presented accompanied by one or more

illustrative quotes. Basic information on each participant is included as Table 3 in order to give context to their quotes. Pseudonyms have been used to ensure the confidentiality of participants.

Table 3

<i>Participants</i>			
Pseudonym	Age	Years Since Diagnosis	Sexual Orientation
Allen	25	1	Gay
Benny	22	4	Gay
Calvin	28	5	Bisexual
Darryl	29	7	Gay
Ellis	27	6	Gay
Franklin	29	2	Gay
Grant	28	2	Queer
Henry	29	10	Bisexual
Ivan	23	4	Gay
Joshua	29	6	Bisexual
Kendrick	28	6	Gay
Lamont	28	10	Bisexual
Mason	27	6	Bisexual
Nolan	23	4	Bisexual
Oscar	26	2	Gay
Patrick	29	13	Gay
Quincy	26	4	Bisexual
Rasheed	28	4	Gay
Samir	27	7	Gay
Tevin	26	8	Gay

Being Young Black GBMSM Living with HIV

In describing what it meant to be a young Black GBMSM living with HIV, participants described a range of salient aspects of their experience. It is not assumed that the experiences they describe are exhaustive of all their experiences. Rather, it is assumed that the experiences of identity described represent those that were salient in the context of understanding themselves as at once young, Black, GBMSM, and living with HIV. Major themes that emerged from these

discussions related to *broad experiences as young Black GBMSM living with HIV*, *experiences related to Black identity*, *experiences related to sexual orientation*, and *experiences related to HIV*.

Broad Experiences as Young Black GBMSM Living with HIV.

Although many of the experiences participants discussed were specific to particular aspects of their identities, they described some experiences that were either nonspecific to particular identities, a product of multiple identities, or manifested similarly across multiple identities. The subthemes that emerged in these broad experiences were *feeling the same as others* and *seeing life as more challenging*.

Participants who described feeling the same as others reported that their identities did not differentiate them from others in salient ways. They reported feeling as though these identities were not necessarily impactful on their life experiences. When asked what life was like as a young Black GBMSM living with HIV, Calvin (28 years old, bisexual) said, "I do the same things everybody else does. I live. I eat. I breathe. I sleep. I work. Pretty typical average life." Even when probed further regarding the potential impact of HIV on his life, he stated, "It's really not as different as I thought it would be." Others replied that life was "regular" or "like anybody else."

Conversely, there were participants who reported feeling that particular challenges associated with their identities made life harder than it would otherwise be. Franklin (29 years old, gay) said, "I watch my surroundings, being a young Black man in these days. And being gay makes it worse. There could be danger." Another participant, Samir (27 years old, bisexual) said, "Being gay is

already one strike. Having HIV just adds to it.” For these participants, the challenges associated with their marginalized identities were compounded by one another, making life all the more difficult.

Experiences Related to Black Identity. Many participants, when asked directly about the impact of race on their lived experience, described *no impacts of race*. They described feeling as though they were treated in fashion similar to how others were treated. In discussing his experiences growing up as a Black man, Oscar (26 years old, gay) said, “I didn't feel anything like discriminatory-wise, being Black. Everybody was always pretty cool with me. I never really had problems like that. I was the dude that everybody liked.” Interestingly, it was often the case that later in the interview these men described being impacted by differential treatment based on their race. This manifested most clearly in the experience of *feeling unattractive due to race*. Participants described having seen it communicated that other races of men were preferable. For example, although he initially stated that he had not encountered discrimination, Oscar later said, “They put it on their [online] profiles. No Blacks. It sucks to read that kind of shit. Like you don't have any value.” It appeared that participants were in a bind, trying to determine how to reconcile their self-concept with *experiences of adversity related to race*. Patrick (29 years old, gay) perhaps articulated this complexity most clearly, saying, “For me, being Black is not a hardship, but I know life would be less stressful if I wasn't Black.”

Experiences Related to Sexual Orientation. Paralleling responses related to racial identity, many participants reported *no impacts of sexual*

orientation. These participants reported that they were treated in a fashion akin to heterosexual peers and therefore did not think that their sexual orientation led to experiences that differed in meaningful ways. Darryl (29 years old, gay) remarked, “You see gay people everywhere, so it's not like it's taboo. It's kind of popular. It's not as hard as it used to be.” Another participant, Ellis (27 years old, gay) said, “In 2016, there are fewer differences between being gay and being heterosexual.” These statements suggest that there has been significant progress for gay men, and therefore there are fewer adverse circumstances for them. In contrast, other participants reported *not feeling accepted*. They described feeling that their sexual orientation placed them on the margins, thereby differentiating their experience from that of heterosexual men. Kendrick (28 years old, gay) stated, “I don't hide my sexuality, but I think life would be easier if I wasn't gay. The world accepts heterosexuals more than gays.”

A subtheme that emerged in interviews with some bisexual participants was experiencing *others' assumptions about bisexuality*. These assumptions tended to be negative and to cast bisexual men as devious, untrustworthy, and potentially HIV-positive. Joshua (29 years old, bisexual) said:

It's a negative connotation and stigma attached to our [bisexual] community. It's almost like, with the Black community, if you tell somebody you're bisexual, they automatically attach [HIV] to you, which is not necessarily the case. In some cases sometimes, it's almost easier to disclose your HIV status to someone in the gay community as opposed to disclosing your sexual status to someone who's straight.

Relatedly, another subtheme that emerged from conversation about sexual orientation was *HIV as an inevitable outcome* of being gay/bisexual. Participants talked about an expectation that they would become HIV-positive at some point given their engagement in sex with other men. Some participants discussed other people in their lives having this expectation while other participants discussed having had this expectation themselves. For example, Allen (25 years old, gay) said:

Before, I was just the cool guy. I still am, but if I disclosed [my HIV status], then it would just be like...I would feel as though they would look at me like I'm another statistic, another young, gay, Black man who contracted HIV, probably because he was gay.

For him, there was an expectation that GBMSM would eventually become HIV-positive, and sharing his status with others served to confirm that expectation.

Another participant, Benny (22 years old, gay) reported expecting to eventually become HIV-positive given his history of having had other sexually transmitted infections (STIs).

Benny: I expected it. I really did. I don't know how else to say it, but I knew somewhere down the line that I would probably have it or get it.

Interviewer: When did you know that?

Benny: Probably after my first STD.

Interviewer: How old were you?

Benny: Like 14, 15.

Benny's statement reflects the potential that young Black GBMSM, even at early ages, begin to take a fatalistic approach to HIV with a limited sense of palpable agency.

Experiences Related to HIV. While participants demonstrated some difficulty identifying experiences that related to other aspects of their identity, there appeared to be myriad salient experiences related to HIV. The prominent subthemes that emerged in these discussions were *changes in self-concept, impacts of HIV treatment, fears related to HIV status, impacts of HIV on platonic relationships, and feelings of increased responsibility.*

The changes in self-concept described by participants ran the gamut from minimal impact to decreases in self-worth that led to years-long depressions. Some participants described feeling that their HIV was visible to others due to changes in their body, like shifts in weight or skin degradation, while others discussed generally feeling less attractive because of HIV. For Franklin (29 years old, gay), the impact of HIV diminished attractiveness, but also decreased his value altogether. He said the following:

You don't think you're cute. You think it's the end of the world. Nobody's going to want you. You think you're ugly. You're bad goods. Spoiled product. You think it's over. Nobody's going to want you. They're not going to see the pretty smile or the pretty eyes or the cute face or the masculine features about you. They're going to see HIV.

Joshua (29 years old, bisexual) talked about how his pre-existing self-esteem issues were exacerbated by his HIV diagnosis, leading to a period of depression.

He said:

I had self-esteem issues prior to [diagnosis]. Everyone has a little self-esteem issues that they overcome eventually. When I initially find out that I had HIV, yeah, it bothered me a lot. It was depressing, and I just went through this whole ugly phase, I don't want to be bothered. I just wanted to be alone. Blah. Blah.

Given that the majority of participants in the study were on medication for the management of their HIV, it is perhaps unsurprising that they talked about the impact of this treatment on their experience of living with HIV. Participants described both positive and negative impacts of treatment. For example, participants talked about how treatment had reduced any physical symptoms of HIV and facilitated increases in self-esteem and self-worth post diagnosis. Describing his journey toward adherence to his medication regimen, Nolan (23 years old, bisexual) stated:

The first year, I was in denial. I would say it was a back and forth thing. I'd take it for a month or two. Then I wouldn't take it. I would say the longest, in that two year span, that I was off it for about six months. But the second year, I felt like it needs to be taken regularly, because I kept having issues. Felt like my body was falling apart. But when I took my medicine, I was okay. Everything was okay.

Describing his life after he committed to his treatment regimen, Tevin (26 years old, gay) said, “There was a shift in mindset. I wanted to get up. I wanted to put on clothes. I wanted to eat. I wanted to go outside. I didn’t want to do all those things before. I wanted to be in my room.” For Tevin, treatment allowed him to move past his depression. However, there were other participants who considered their medication a constant reminder of their HIV status. For these participants, treatment was a less positive experience. Ellis (27 years old, gay) said, “Sometimes taking my medication makes me feel depressed. It’s like, who wants a daily reminder that they’re dying?”

Participants reported a range of fears that they grappled with due to living with HIV. Some of these fears related to the individual’s physical condition. For example, participants worried about potential changes to their bodies and susceptibility to infection caused by HIV. Ivan (23 years old, gay) repeatedly described himself as “compromised” and reported having fears related to the weather and its potential impact on his health.

I have to be afraid of things that [HIV-negative people] don’t. The weather outside today could take me away. For other people, it’s fine. They can get by. If I go out and I’m not dressed right for the weather, I could get sick and die.

Other participants were more concerned with what would happen if others became aware of their HIV statuses. Calvin (28 years old, bisexual) said, “I’m worried about what will be said about me if I die from HIV. What will they say? I don’t even want to know.” Franklin (29 years old, gay) described concern about

how others would treat him if his status were known. He said, “People would treat me differently if they knew my status. They’d be afraid of getting it from me.”

While some participants voiced fears about the potential impact of HIV on their relationships with others, there were also participants who reported experiences of HIV having impacted their relationships with friends and family. Some participants described experiences of support while others reported encountering ignorance and fear. Henry (29 years old, bisexual) said, “My friends and family who are informed about HIV...they treat me well. They know they aren’t at risk.” Ellis (27 years old, gay) said, “My friends have been supportive since I told them about my diagnosis. Some of them [have] HIV, so they already know about it.” Conversely, other participants described having assumptions made about their sexual morals as well as assumptions made about their impending deaths due to their HIV statuses. Mason (27 years old, bisexual) said:

Being black and gay isn’t a problem with the gays. Being Black, gay, and HIV-positive means you’re diseased now. Nobody wants to be with you now. That whole dream of being with a man and getting married, with two kids...it’s not any more. You’re being stricken by whites for being black. You’re being stricken by Blacks for being gay. And now you’re being stricken by gays for having HIV. So now you have 3 crowds of people at you that you have to watch and be aware of. They don’t look at you as a person. They look at you as a disease.

For Mason and other participants who shared his experience, others knowing their HIV-positive status was linked to rejection and subsequent isolation.

While many participants described struggles related to living with HIV, there were also those who felt that HIV put upon them a responsibility to engage in healthier behaviors. These participants described a desire to learn more about HIV and other STIs in order to educate themselves and their partners. They also spoke about being HIV-positive as a catalyst for taking their health more seriously in general. Franklin (29 years old, gay) said, “I have to be more responsible now. I have to take my medication on a regular basis. I have to talk to people about my status. I just have to do better in general about my health.”

All themes and subthemes related to the broader meta-theme, *being young Black GBMSM living with HIV*, are summarized in Table 4.

Table 4

Hierarchical Themes – Being Young Black GBMSM Living with HIV

Theme	Subthemes
Broad experiences as young Black GBMSM living with HIV	Feeling the same as others Life as more challenging
Experiences related to Black identity	No impacts of race Feeling unattractive due to race Experiences of adversity related to race
Experiences related to sexual orientation	No impacts of sexual orientation Not feeling accepted Others’ assumptions about bisexuality HIV as an inevitable outcome
Experiences related to HIV	Changes in self-concept Impacts of HIV treatment Fears related to HIV status Impacts of HIV on platonic relationships Feelings of increased responsibility

Experiences in Dating Relationships

When participants were asked to talk about their experiences in dating and romantic relationships as young Black GBMSM living with HIV, they had a range of ways they understood what that could mean. For some, dating relationships were necessarily non-serious engagements where the primary focus was getting to know another individual and potentially having fun together. For others, dating was intimately tied to monogamy and long-term prospects for love. In order to have a shared language, the researcher encouraged the participants to think of dating as all of these things in the context of their interviews. They were encouraged to talk about their experiences in any relationship that was romantic in nature whether or not it was serious, monogamous, or long-term. Many of these relationships included sexual interaction, but the key component necessary for exploration in this section was the existence of a romantic component. Participants' responses were many, and the salient themes which emerged from these conversations were *dating experiences related to Blackness*, *the impacts of HIV on new relationships*, *the impacts of HIV on existing relationships*, and *qualities of healthy dating relationships*.

Dating Experiences Related to Blackness. When discussing the impact of race on their dating relationships, there were two salient subthemes which emerged in interviews. One subtheme related to the reasons these young Black GBMSM primarily dated intra-racially, and the other subtheme related to what happened when they did not.

When participants talked about *reasons for racial homophily*, they often talked about their proximity to other BGBMSM. They identified living and

working in racially homogenous environments as the principal reason their partners tended to be of the same race. When interviewing Calvin (28, bisexual), he wavered for a moment in his belief that his spaces were primarily racially homogenous. As he thought through it aloud, he recognized that, while he inhabited some racially heterogeneous spaces, the majority still remained primarily Black.

Calvin: I've majority have dated black guys, or black people in general.

Interviewer: Why is that?

Calvin: Why? I don't know, probably because my environment, probably. Well I can't say that. I went to interracial schools. I don't necessarily know if that has anything to do with it. Probably at the convenience of the environment, people that I work for, with or been in the same circle with, or you know, networked in the same circle. Words exchanged, people started liking each other, and stuff like that. I think that's the biggest thing.

In addition to the majority of his spaces being Black, Calvin's response also highlighted that the close connections he built were primarily with other Black people. As such, the development of romantic relationships with other Black men was logical.

Although most participants talked about primarily dating intra-racially, when participants talked about *experiences dating non-Black men*, they tended to

describe the experiences as akin to their experiences dating Black men. In many ways, these experiences implied a larger narrative that dating men is difficult given aspects of maleness that supersede race. Partly in jest, Darryl (29 years old, gay) said that there were no good men of any race.

Interviewer: What's been your experience dating outside your race?

Darryl: It's about the same. There's assholes and jerks. There's liars.
It's the same. It's really the same.

Interviewer: Are there any good ones?

Darryl: I don't know where they at. You let me know where they at,
I have no idea where they at. They're on an island
somewhere. I have no idea.

Later in his interview though, Darryl noted a difference in how he had theretofore engaged with non-Black partners versus Black ones. When the interviewer asked if there were differences in his experiences of disclosure with Black versus non-Black partners, he stated, "I have not really had an experience disclosing myself to any people outside of my race." Although it is unclear to what degree this marks a meaningful difference in Darryl's experiences with Black versus non-Black partners, it does demonstrate at least subtle differences of which he may not have been previously aware.

Impacts of HIV on New Relationships. Participants talked about the potential impact of their HIV-positive status on their dating relationships in multiple ways. Some participants talked about how HIV had caused shifts in their levels of interest in dating. Many of these *changes in interest* were decreases,

particularly in the time immediately following participants' HIV-positive diagnoses. However, participants' experience of interest were dynamic, as participants often talked about decreases, but also described a rejuvenation of their interest in dating as they grew more comfortable with their HIV-positive status. Samir (27 years old, gay) described such an initial loss in interest and the time it took for him to return to a more normative level:

At first, I was scared to date, because I didn't think anyone would want me, especially with the depiction of what being Black and gay and HIV-positive looks like. Now, it doesn't impact my willingness to date. It took 2 good, strong years to want to date again.

Though Allen (25 years old, gay) indicated that he was in a long-term relationship at the time of his interview, he stated that he would not be interested in trying to date again should that relationship end. He felt that the obligation of disclosure would make dating too difficult.

Interviewer: If you were single again, how would HIV impact your willingness or desire to date?

Allen: I really wouldn't want to date.

Interviewer: You wouldn't want to date if you were single again? Why?

Allen: Because then, getting to know somebody and having to say that, having to disclose that, is my biggest thing. Because I don't want to. I don't to have to tell somebody that. I barely want to have it myself. I barely want to tell myself that. I barely want to take the medicine.

In addition to discussing their levels of interest in dating, participants were also asked to think about how HIV impacted their potential for future dating relationships. As they discussed their *possibilities for future dating*, participants evidenced disparate perspectives on what could or would be possible for them. While some described a concern that they would not be able to find a new partner if they were so interested, others described a belief that they could easily find a dating partner if they so chose. Oscar (26 years old, gay) described feeling as though his sexual value would be decreased if his HIV status were known and therefore he would lose the opportunity to find a dating partner:

I feel like everybody still likes me and wants to fuck me, but if they found out [my HIV status], then I'd become instantly unattractive to them. They wouldn't want to date me.

In contrast, Benny (22 years old, gay) described having great hope for his future relationships due to new medical advances like pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP). He said, "I see endless possibilities, especially now with the emergency new medicine and technologies and stuff."

Lamont (28 years old, bisexual) echoed Benny's hope:

There's people out there that don't look at the fact that you have HIV. They don't care. It's something that they feel like, if they want to be with you, that you're going to deal with together. And you deal with it together. So, yeah, there's hope.

For Lamont, the existence of men willing to partner with him and be a support in his journey with HIV signaled that future dating relationships were definitely possible.

Impacts of HIV on Existing Relationships. A number of participants were in romantic relationships when they were diagnosed as HIV-positive and were able to continue those relationships¹¹. In their interviews, they described changes in those relationships that occurred after their positive diagnoses.

One of the most salient themes was *fear of contamination*. Participants talked about their fear of contaminating their partner with germs and their partners' fears about being contaminated by the participant's germs. Sometimes this fear was overt, as when Allen (25 years old, gay) and his partner became hyperaware of the potential for fluid exchange.

Non-sexually, there really aren't that many differences [in our relationship since my diagnosis], besides having to make sure my toothbrush doesn't touch my toothpaste. My guy wipes the seat down after I use the bathroom or before he uses the bathroom, which he never really did before. I have to worry about getting him contaminated or anything like that, like with my blood. If I cut myself, because we use the same utensils, I have to put alcohol on them or he has to put alcohol on them before he uses them, which we never had to do before. That's pretty much it. It's sad, depressing. That's really the only way I can describe it. It's depressing

¹¹ Four participants reported having partners with whom they had been since the time of their positive diagnosis. At the time of the participants' diagnoses, all four of their partners reported being HIV-negative. One participant's partner later tested positive for HIV, though it was not clear whether it was transmitted from the participant.

because it makes me think about my status. It's also depressing that I have to go through these measures to ensure somebody else that I love's safety.

While some of the practices that Allen described were sensible for minimizing the impact of any bloodborne pathogens (e.g., sterilizing shared utensils, avoiding contact with one another's blood), others were less grounded in the science of HIV transmission (e.g., wiping down the toilet before or after use). Consequently, the focus on potential transmission was so high that it made Allen consistently hyperaware on his HIV status and thereby impacted his mood. Quincy (26 years old, bisexual) described less overt communication of fear from his partner, stating:

He would grab the condoms before me. You could see that as him being okay with it, but I felt it was like, "Yeah. Get the condoms. I don't want to catch HIV from you." Sometimes when I'd wash the dishes, he'd say, "Oh. You don't use bleach water when you wash the dishes?" Why would I? And he'd say, "Oh. Just to kill germs." And I'd say, "HIV germs?"

For Quincy, there was something about his partner's words that led him to feel that he was concerned about contamination, and it imbued even mundane tasks like washing the dishes with a level of shame or rejection.

In discussing their existing relationships, participants described HIV as having a particularly negative impact on the quality of their sex lives with existing partners. Participants described both *decreased sexual frequency* and a *decreased repertoire of sexual behaviors* in their existing relationships. Participants described their partners losing interest in engaging in sex with them as well as the

participant having worries about engaging in sex with their partners. Further, some of the sexual acts which had been commonplace in their relationships before their HIV diagnoses became rare or altogether unavailable. Ellis (27 years old, gay) demonstrated how a reduced repertoire of sexual behaviors led to less frequent sex altogether.

Ellis: Sexually, we don't really have sex anymore. He's scared of coming in contact with my pre-cum. We can't do certain stuff. He can't suck my penis, because he's scared of coming in contact with my fluids and things like that. We hardly ever do it anymore. Maybe it's because of me, and I don't want to.

Interviewer: Do you not want to?

Ellis: No, I kind of do, but I just feel like I'm protecting him kind of. I don't really like to use condoms, and adjusting to using condoms was hard for me. So we just kind of stopped, and now all we do really is just masturbate together, so we really don't even come into sexual contact intercourse-wise. I rarely even suck his penis anymore.

Related but in addition to the ways that sex itself was diminished in their relationships, participants described *decreased feelings of intimacy* due to HIV. They described feeling that HIV and the associated loss of consistent physical contact had made them less emotionally close to their partners. Rasheed (28 years

old, gay) described feeling that the inability to engage with one another's semen had diminished the intimacy in his relationship with his partner.

[The impact of HIV] has been terrible. It impacted the health of it all, because now, we seem distant, without that closeness and that exchanging of bodily fluids, I want to say, or even the option be able to. It's depressing that you can't do everything that you once used to do, or that you can't enjoy every part of your partner like you used to or that they can't enjoy you in the ways that you used to. Sharing bodily fluids, that was a major thing before.

Participants also described how HIV had led to *feelings of insecurity*. They described feeling unsure of the future of the relationship and worried about potential infidelity due to their HIV status. Allen (25 years old, gay) worried that the limited sexual activity in his relationship would eventually lead to infidelity.

Allen: The sexual side of [our relationship], it's not healthy, because we have restrictions and limitations on what we can and cannot do, so that, in my mind, causes him to have a want and desire for something he can't get from me, which will probably lead to cheating or something.

Interviewer: Does "probably" mean "has" or "could" lead to cheating?

Allen: "Probably" means eventually it's going to happen, whether it has or hasn't now. It more than likely will somewhere down the line, only because I've wanted to experience somebody who would let me suck their dick or some shit

like that. I know what I wanted to do, so I'm pretty sure he wanted to do the same shit too.

While the bulk of salient subthemes related to existing relationships were focused around how HIV could lead to the potential loss of the relationship or diminished quality of the relationship, some participants also talked about how it led to a *decreased ability to end the relationship*. More specifically, participants talked about feeling as though their partner were the only person who would be with them and feared ending the relationship and subsequently being alone. For some participants, this idea was primarily inborne. For others, it was enforced or reinforced by their partners. Ellis (27 years old, gay) talked about feeling as though his partner was no longer motivated to treat him well, because Ellis was HIV-positive and would not be able to leave him.

Sometimes I wonder, "Why are you with me?" It's like, we can only get along for a certain period of time and that's it. It's weird. We've been going through this for a long time, and that's probably why he is the way he is. Like, "I can say and do whatever I want, because, Guess what? You're still going to be here."

Qualities of Healthy Dating Relationships. After discussing the breadth of their experiences in dating relationships, participants were asked to describe the qualities of a healthy dating relationship. Their responses indicated three central aspects of a healthy dating relationship: *communication*, *safer sex practices*, and *safety from domestic violence*.

Participants described clear and honest communication with one's dating partner as central to a healthy relationship, as it allowed partners to understand the needs and wants of the other person. Franklin (29 years old, gay) was concise in his description of a healthy relationship, but centered the importance of mutual and honest communication.

A healthy relationship is seeing each other on the regular. That's one.

Communication. Listening. Good sex. And being there for each other.

That's basically all I can ask for in a relationship. And don't lie to me.

Mason (27 years old, gay) stated that he thought communicating about relationship issues was healthy, even if the context was an argument. He said, "I think [people in] healthy relationships express their feelings with each other, whether it be in an argument or civil conversation. Getting stuff out in the open would be healthy."

Participants often referenced the importance of maintaining the safety of their bodies in relationships through engaging in safer sex practices and avoiding instances of domestic violence. For Kendrick (28 years old, gay), these were the central markers of a healthy relationship.

A healthy relationship? A calm, relaxed relationship where there's no domestic violence. Where you guys are on a healthy track as far as health goes. Like, you basically living your life safe. Nobody's getting beat up in the relationship. There's no STDs being passed back and forth. Y'all are practicing safe sexual habits, like using condoms and stuff like that.

Darryl (29 years old, gay) echoed his statements and also highlighted that he did not want to perpetrate nor receive physical violence.

Thinking about a whole lot of different healths. [A healthy relationship] needs to be conducive to a healthy mental state for me. Physical wise, I don't want to have to be whooping on you, because you're whooping on me. And healthy as far as communication goes. Then we get into the physical healthiness and whatever is going on between the two parties, like sex.

For Darryl, a healthy relationship needed to be healthy in multiple ways in order to ensure the health and wellness of both participants.

All themes and subthemes related to the broader meta-theme, *experiences in dating relationships*, are presented in Table 5.

Table 5

Hierarchical Themes – Experiences in Dating Relationships

Theme	Subthemes
Dating experiences as related to Blackness	Reasons for racial homophily Experiences of dating non-Black men
Impacts of HIV on new relationships	Changes in interest Possibilities for future dating
Impacts of HIV on existing relationships	Fear of contamination Decreased sexual frequency Decreased repertoire of sexual behaviors Decreased feelings of intimacy Feelings of insecurity Decreased ability to end the relationship
Qualities of healthy dating relationships	Communication Safer sex practices Safety from domestic violence

Experiences in Sexual Relationships

While participants had a range of perspectives on the meaning of a dating relationship, there was consensus on the meaning of a sexual relationship. Participants defined such a relationship as one wherein genital contact occurred, generally with the goal of orgasm. They defined these relationships as potentially ongoing, potentially occurring once, or inhabiting some space between these extremes. Many of the participants' sexual relationships were also romantic in nature. However, the themes described in the present section are specific to the sexual aspect of those relationships. The salient themes which emerged from these conversations were *sexual experiences related to Blackness*, the *relationship between HIV and sexual desire*, *impacts of HIV on sexual intercourse*, *fear of hurt if a partner becomes HIV-positive*, and *sexual risk negotiation*.

Sexual Experiences Related to Blackness. When discussing the association between sexual relationships and being Black, participants described two salient subthemes, *White men's disinterest in Black partners* and *being fetishized by White partners*.

More specifically, participants reported having experiences wherein White men expressed an explicit dispreference for Black sexual partners and/or wherein White men expressed a preference for Black partners that was predicated on a reduction of Black men to primarily having sexual utility. Allen (25 years old, gay) described his beliefs regarding White men's disinterest in Black sexual partners and how that leads him to primarily engage with other men of color.

There's a lot of discrimination in the community. A lot of white dudes don't like to have sex with Black guys. They'd rather fuck a Latino or Indian dude, so I fuck with a majority of Black people, maybe even some Latinos.

In seeming contrast, other participants talked about being pursued by White partners, but specifically due to stereotyped assumptions about Black men's sexual performance. A statement from Grant (28 years old, queer) demonstrates how uncomfortable and reductive he found that kind of interest.

They always want me to dominate them. They have this idea of the dominant Black top, and I have no desire to be that fantasy. They say stuff like "Destroy me" or "Give me that Black cock," and it can start to feel gross. They expect you to have some huge porno dick and to use it for their pleasure. No thanks. That's some bullshit.

Statements like Grant's illustrate how being young Black GBMSM being pursued as a fetish can be as negative an experience as being rejected due to their Blackness, as neither experience deems these men valuable or recognizes their full humanity.

Relationship between HIV and Sexual Desire. Participants endorsed a number of ways in which contracting HIV impacted their desire to engage in sexual relationships. Participants described contracting HIV as causing *changes in sexual drive*. For some participants, contracting HIV led to a reduction in their visceral urges to engage in sex. They reported feeling sharp declines in these urges. They described limited motivation to engage in sex and a general

disinterest in sexually arousing material and contexts. Calvin (28 years old, bisexual) said simply, “My sex drive just went away when they told me I was positive.” Darryl (29 years old, gay) said, “Smoking marijuana helps, but, in general, I wasn’t that interested in sex after they told me. It was the least of my concerns.” In contrast, Oscar described a heightened sexual drive due to limited outlets for his sexual energy.

The desire is actually still the same. I want to say it's grown more fierce. I want it even more now, because I know I can't do what I used to do [before I was HIV-positive], just have unprotected sex without disclosing.

In addition to changes in their visceral drive for sexual interaction, participants also described *feeling a loss of sexual freedom*. They described having enjoyed a level of freedom in their sexual relationships before becoming HIV-positive that they felt was diminished or altogether lost due to the diagnosis. The potential consequences of engaging in sex loomed large in these discussions, as when Nolan (23 years old, bisexual) said, “[Before HIV, life] was cool. I got to do whatever I wanted with whomever I wanted, without really worrying about any repercussions. Now there are limitations on everything.”

Impacts of HIV on Sexual Intercourse. In addition to what participants said about how HIV had impacted their desire to have sex, they also described how HIV had impacted the experience of engaging in the act of sex.

A number of participants described sex as having become a more anxiety provoking activity due to their HIV-positive status, particularly when they experienced *increased scrutiny by partners*. Participants described feeling as

though partners, especially HIV-negative partners, would often take extra precautions and vet the participant more thoroughly before sex in order to ensure the participant was of minimal risk to them. Rasheed (28 years old, gay) reported asking himself, “Will they double check my dick to make sure there's not open sores or cuts or scrapes, no matter how microscopic they may be?” He worried that his HIV status would cause partners to physically inspect his penis (and potentially reject him) as they prepared to engage in sex. He feared the impact this would have on the sexual act and his willingness to risk embarrassment so consistently to pursue sex.

While many participants described worrying about how they would be scrutinized, some also expressed worries about how HIV would cause *changes in the range of available/acceptable sexual behaviors* for them and their partners. In fact, when asked how HIV had changed the kind of sex he was having, Rasheed reported consistently asking himself, “Will they fuck me? Will they pull out? Will they put a condom on? Will they let me suck their dick? Will they suck my dick?” He described being very unsure of what was even available to him after he was diagnosed as HIV-positive. Joshua (29 years old, bisexual) reported initially being unable or unwilling to assert his own needs due to his HIV status.

I felt like I was lucky to be having any sex at all, so I let them do whatever they wanted. If they wanted me to bottom, I bottomed. I didn't want to mess it up by asking for anything else.

Another set of participants described reducing their range of sexual behaviors specifically for the purpose of reducing risk to partners. When asked about how

HIV had impacted how he engaged in sex, Samir (27 years old, gay) said, “I wouldn't fuck anybody raw, and I wouldn't let nobody fuck me raw or suck my dick for that matter. I'd just be paranoid [about infecting them].” A third contingent of participants described a move toward better meeting their sexual needs after their HIV-positive diagnoses. Patrick (29 years old, gay) described being able to have more intimate relationships since his diagnosis, because he has been more willing to request the full range of sexual acts that he enjoys.

Patrick: If anything, I've added [new sexual behaviors since diagnosis.]. Nothing's stopped.

Interviewer: What was added?

Patrick: Getting my dick sucked. Eating ass. Getting my ass ate more. Being a top. Penetrating someone else. Nipple play on me and on others more. Kissing. I kiss more. Before I never really kissed. It really wasn't a must for me to kiss. I kiss more now. I kiss a lot more.

When asked what facilitated this shift, he described a conversation with himself after he had begun to manage his HIV more effectively.

I said to myself, as I was getting myself together and taking my regimen on time and on a good basis and being more aware of my HIV status, I'm going to ask for what I want [sexually]. And if I don't get it, then we're not going to be together.

For Patrick and men like him, diagnosis with HIV presented an opportunity to reassess sexual wants and needs and move toward more consistently giving priority to these wants and needs.

Fear of Being Hurt if a Partner Becomes Positive. Many participants described experiences of being afraid that a partner would do harm to them if HIV were transmitted to that partner in their relationship. Some participants reported a *fear of being publicly outed as positive* if one of their sexual partners should become positive during the course of their relationship. Benny (22 years old, gay) described particular concern for being outed as positive after a partner's seroconversion due to the potential reach of social media.

If he becomes positive while we're together, he could tell anybody anything. Like, with social media, people can get on there saying anything they want. The damage is done regardless of what the repercussion is, so you have to be very careful now. You got to be careful what you text. Screenshots. Now it's like you could be tight. You can be thinking you can find someone. You're inboxing them or texting them. But if you make them mad, you'll go on social media and there's a screenshot of it, in your own words, from your own phone, so you can't ... it's really sticky. It's scary really.

In addition to fears of unwanted disclosure of their HIV status, participants described *fear of legal retribution* (criminal or civil proceedings) and *fear of being killed* if their partners were to contract or believe they contracted HIV from

the participant. Kendrick (28 years old, gay) described a combination of these fears.

Kendrick: I literally have possibly broken a rule and could be arrested by having sex with somebody and not divulging it, and now it feels like I'm just not safe. A part of me is always wondering what if that person ... I'm undetectable and I pulled out or something, but what if that person gets it and they come after me or something? It's always a fear in my heart.

Interviewer: Come after you in what way?

Kendrick: Want to kill me or something. I've had feelings like that before, where it's just like... [He sighs.] And now it makes me not want to mess around with people for that very reason. All because I don't like using condoms and I can't enjoy people and people can't enjoy me, and if we do and I don't say anything, then I could go to jail or somebody might want to kill me. You know what I'm saying?

Sexual Risk Negotiation. Given the potential transmissibility of HIV and exposure of either partner to other STIs, participants described a number of experiences related to assessing and responding to potential risk in sexual encounters. Participants talked about risk assessment as a key piece of determining how they would engage in sex with partners. While talking about *assessment of a partner's level of risk*, participants described potential strategies

for determining how likely condomless sex with a given partner could expose the participant to additional strains of HIV or other STIs. They reported attempting to determine a partner's level of honesty in order to vet the information offered by potential partners. Further, participants described assessing the general health status of partners and the risk behaviors in which the individual was prone to engage. When asked the factors which determined his use or disuse of a condom with HIV-positive partners, Calvin (28 years old, bisexual) said, "I guess if they're on medication, and how honest they are." When asked to further explore his decision making process with other HIV-positive partners, he described assessing their social circles, particularly whether they engaged in or were friends with others who engaged in intravenous drug use. He marked those behaviors as particularly high risk.

Interviewer: Is there anything that makes you more likely to use a condom with another positive guy?

Calvin: It depends on their circle of friends, are they running with people who are on drugs that shoot up, because if you're messing with needles ... hepatitis and blood to blood contact, different things that people indulge in that are not sexual that makes them risky to me, that would ... if I knew they were running in certain circles I wouldn't.

In describing his assessment of risk with HIV-negative partners, Darryl (29 years old, gay) described having difficulty believing a partner is HIV-negative given his beliefs about their typical sexual behavior. Further, he reported believing that

HIV-positive men were lower risk partners given their engagement in medical care.

You'd be surprised that a lot of these negative people are out here fucking, have sex way more reckless than the people who are not, so then I don't know how negative you really are, because I don't know the last time you've taken a test, and I don't know how accurate it is. There's just so many underlying things you could have been doing that I have no idea about. You can produce me the [HIV test] results in the last 3 months the same day, but that does not mean you are. It really doesn't make a difference. It makes me almost want to increase [condom] usage because I have no idea about- at least this person [who is HIV-positive] I know that they got something and they're taking care of it. They're following up, they have a regimen, you can hear them on the phone with their doctor, you on the other hand, "Oh I don't have nothing I'm good" and you out here fucking like 41 going north. Makes me sometimes a little more leery, especially if you're younger, 19, 20, 21.

Assessment of risk was intimately tied to the kinds of sexual behaviors in which a participant was willing to engage. As such, as they discussed assessment of risk, they often also described *adjustment of sexual behaviors as prevention*. In describing these adjustments, they talked about strategies to ensure no transmission of HIV or other STIs to a partner or from a partner to the individual. Some of the strategies described were unequivocal use of condoms for penetrative sex and engaging in sex with individuals the participants knew well. Lamont (28

years old, bisexual) described his approach to prevention as committing to using a condom, even in situations where his judgment was impacted by alcohol or other substances, and only engaging in sex with dating partners.

[Since becoming positive,] even if I'm intoxicated, I use condoms, and I don't have sex with random people. By random, I mean someone you're not in a relationship with, not just random people you meet off the street.

Many participants talked about engaging in oral sex as a lower risk activity.

However, some determined that a barrier method would lower the risk of this activity all the more. Benny (22 years old, gay) described oral sex as an activity he could engage in with all partners, but, as he spoke about it, he determined that it could be a higher risk activity than he had first thought.

Oral sex is kind of almost one of those things where it can be [with any partner]. Then again I don't know, because I don't need any breakouts. I mean, there's other things you can get from oral sex. Genital warts.

Herpes. You can even get chlamydia and Gonorrhea. Viral infections.

Franklin (29 years old gay) described no desire to use a barrier for anilingus, but was insistent on using a barrier for fellatio. He said, "I'm not a big fan of a dental dam for anal oral sex, but when you're sucking someone's penis, I think you should use a condom. It's just safer."

Another aspect of sexual risk negotiation that stemmed from assessment of risk was using *partner selection as prevention*. More specifically, participants talked about the ways that they chose sexual partners for and with whom there would be the least risk if they were to engage in condomless anal sex. For many

participants, a major aspect of his process was serosorting, choosing to only engage in sex with other persons of the same HIV status. A second aspect of this process was choosing partners who were engaged in medical care. Therefore, they were unlikely to expose the participant to a variant strain of HIV with different medication resistances. Mason (27 years old, bisexual) described talking to potential partners about their regimens in order to determine if condomless sex would be a healthy option for them.

I ask [partners] what medicines they take and if they are resistant to certain things, and I think maybe if we have the same strain, that we can do it without condoms. I mean, it sounds kind of legit. If you have the same strain, you're taking the same medicine. Even if you're taking different medicine, as long as you have the same strain and you're resistant to the same [medications], it's like eating your own pre-cum. It can't hurt you really, because you have the same type.

An alternative approach to partner selection as prevention was choosing partners who were HIV-negative but consistently used PrEP. Participants described engaging with these partners as lower risk and less likely to have additional negative aspects, like ignorance, stigma, and associated rejection. Oscar (26 years old, gay), talked about the combination of PrEP and his own adherence to treatment as a dual approach to reducing risk associated with condomless sex.

I guess if a person like me was undetectable and the other person maybe was on PrEP or something, we could be a little bit more open sexually. We

wouldn't have to worry about HIV like that, so we could really be close and it would be safe.

Qualities of Healthy Sexual Relationships. After discussing the range of experiences they had in sexual relationships, participants were asked to describe the qualities of a healthy sexual relationship. There were two salient subthemes which emerged from these discussions.

Much like their assessment of healthy dating relationships, participants identified *communication* as an important aspect of a healthy sexual relationship. They described clear and honest communication as an important part of ensuring the health of these relationships. However, this communication was more specific in nature than that described as important in healthy dating relationships. When asked how he defined a healthy sexual relationship, Rasheed (28 years old, gay) highlighted the importance of communication about sexual desires and experiences.

Anything healthy has honesty and communicating. Likes. Dislikes. Sexual history. Like, are you having sex with just me right now, or are you not? When's the last time you've been involved with someone?

Some participants also described a healthy sexual relationship as one wherein there were *safer sex practices*. For these participants, a healthy sexual relationship was one which placed importance on engaging in sex that was minimally risky to both sexual partners. Tevin (26 years old, gay) said simply, "Jacking off together is safe sex." Franklin (29 years old, gay), however, spoke in detail about how he defined safer sex and how it was integral to healthy sex.

Healthy sex, to me...I'm not a fan of the dental dam, but I think healthy sex is when two people take showers and they use condoms, all the way through from the beginning to the end. For oral sex too. Especially if you don't know them. If you're in a relationship, maybe, but if you're still getting to know someone, you should use a condom when you're being penetrated and when you're doing oral sex.

All themes and subthemes related to the broader meta-theme, *experiences in sexual relationships*, are presented in Table 6.

Table 6

Hierarchical Themes – Experiences in Sexual Relationships

Theme	Subthemes
Sexual experiences as related to Blackness	White men's disinterest in Black partners Being fetishized by White partners
Relationship between HIV and sexual desire	Changes in sexual drive Feeling a loss of sexual freedom
Impacts of HIV on sexual intercourse	Increased scrutiny by partners Changes in the range of available/ acceptable sexual behaviors
Fear of hurt if partner becomes HIV-positive	Fear of being publicly outed as positive Fear of legal retribution Fear of being killed
Sexual risk negotiation	Assessment of partner's level of risk Adjustment of sexual behaviors as prevention Partner selection as prevention
Qualities of healthy sexual relationships	Communication Safer sex practices

Experiences Related to both Dating and Sexual Relationships

Although participants were asked to think about and discuss dating and sexual relationships separately, they also described experiences that were relevant to any non-platonic relationships in which they engaged. Salient themes which emerged in this area were *selecting partners* and *navigating disclosure in relationships*.

Selecting Partners. Participants described a range of important considerations in selecting their partners for any potentially romantic or sexual relationships.

Preferences were a key consideration in determining who would be an appropriate romantic or sexual partner. These preferences were the characteristics of individuals that the participant thought would lead to a successful relationship. Participants discussed a range of preferences that they considered important, including the individual's gender, discretion around sexual orientation, and HIV status. While most gay participants simply indicated interest in men without much clarification or specificity and most bisexual participants indicated interest in men and women similarly, Calvin (28 years old, bisexual) was more specific in the types of individuals he would be open to engaging with.

Calvin: I'd like to meet a trans man.

Interviewer: Are you opposed to male to female trans folks?

Calvin: Me personally? No, that's not up my alley.

Interviewer: So trans women are not an option?

Calvin: Not up for consideration.

Interviewer: But anyone who identifies as a male right now is possibly an option?

Calvin: Mm-hmm (affirmative)

When discretion was discussed by participants, it was consistently stated that they preferred a partner who was not identifiable as gay or bisexual in public. Darryl (29 years old, gay) stated:

I don't prefer feminine guys. I prefer guys that are discreet about what they do, meaning that they use some type of discretion and don't necessarily have to wear their sexuality on their sleeve. It's not everyone's business to know that you're some big flaming homosexual. I mean, if that's how you carry yourself, I have no problem with it. But as far as to be with me, I don't particularly care for that.

There was more flexibility in participants' perspectives on preferred HIV status of partners. Most participants stated that their preferred partners could be HIV-negative or positive. Few voiced a hard preference. When asked if he would prefer a positive or negative partner, Franklin (29 years old, gay) said, "It doesn't matter. If they're HIV-negative or positive, it doesn't matter." However, he was able to articulate the specific positive and negative aspects of each kind of partner, in his experience.

I'll say, if [my partner is] HIV-positive, it's a relief, because you can be like, "I'm HIV-positive" and if they say, "Okay, I am too." It's like... [He sighs with relief.] Okay. I think that's the plus side. The down side of dating someone that's not positive is that they don't have it, so you have to

be aware. You have to make sure they're protected. That's my only minus for them. From my experience, I can't see any negatives to dating another positive person. I think they may be the best partner for a positive person, because they know what you're going through in a sense. So yeah, I don't think there's any negatives. I would say a negative person, in my experience, pushes you more and is more concerned about your regimen and you taking your pills and being safe than a person that's not. A person that is positive, they don't really care about your pills. They're not quick to get a condom or all that stuff. A negative person is. I would say that's a plus for the negative and a down for the positive. They're not as aware. They're not as on it as they should be.

For Franklin, an HIV-positive partner was an optimal fit, because they could understand his experience. However, he considered their potential laxness around safety less optimal. He considered dating negative partners a challenge given the necessity of ensuring their safety, but often found them very interested in maintaining safety. Ultimately though, he was open to either.

Participants also described a range of experiences in *finding partners*. In attempting to locate suitable partners, participants described having greater ease accessing sex than more serious relationships. They reported that anonymous sex, in particular, was an accessible option. However, they reported that more long-term relationships proved elusive given the specter of rejection based on HIV status. Some participants reported a desire to seek out positive partners in order to ameliorate that factor, but found it a challenge to locate other positive guys who

could be potential partners. Speaking with Oscar (26 years old, gay) revealed that he has found it particularly challenging.

Oscar: [Positive guys] are hard to find. Not everyone wants to be open about it, and I have been on BGC, Adam4Adam, Grindr and Scruff. Nobody displays that.

Interviewer: What about a dating site for people who are positive?

Oscar: I can't find one. I can't. I've looked. I've even looked online for chat support groups and I haven't found any. There was one, but they recently stopped it in September or October. They ended the chat portion of it, so I don't even know where any of that is, but I've looked. I've Googled it.

As stated, a number of participants found it difficult to locate potential partners. A salient factor in this process was the *role of HIV in the potential partner pool*. Participants described a range of perspectives on the role of HIV in their pools of potential partners. Some considered finding an individual who would be amenable to having an HIV-positive partner a challenge. Franklin (29 years old, gay) said simply, “You’ve got to find someone who will be able to handle this. It’s not a walk in the park.” In this statement, he acknowledges the challenge put upon a potential partner to deal with the complexity of having an HIV-positive partner while recognizing that it makes his pursuit of a partner that much more difficult. In contrast, other participants did not see HIV as a limiter on their pool of potential partners. For some, this was related to their having not yet disclosed their HIV status. For others, it was related to a change in the perspective

of HIV-negative men, particularly less fear of HIV-positive partners. Benny (22 years old, gay) posited that pre-exposure prophylaxis (PrEP) could be part of this change in perspective, though he did not think enough people knew about it as yet.

Benny: I don't think necessarily some people care. It's not a factor for some people.

Interviewer: When you say don't care, do you mean...?

Benny: About people's status. Because either they have [HIV] and they take care of themselves, or they're taking PrEP now. It's more effective than a condom, at least if the person that's taking PrEP, they're taking it every day consistent.

Interviewer: So do you think PrEP is a major factor in how guys negotiate HIV risk?

Benny: Now, it's not a major factor yet, because a lot of people are not educated on it. People are just really now starting to get...I've known about it for a couple of years now. Everyone's like, it's this new thing. This shit has been going on. This is not new. A lot of people, again, don't know about it.

Navigating Disclosure in Relationships. Disclosure was an oft discussed topic in the context of considering any romantic or sexual relationship.

Participants discussed a range of experiences and considerations related to disclosing their HIV-positive status to partners and potential partners. In

discussing their *willingness to disclose*, the most common narrative was one wherein disclosure had been minimal. Participants reported that they had disclosed to very few other people at all and particularly few potential partners. Darryl (29 years old, gay) described having only disclosed his status to potential partners who had already disclosed an HIV-positive status to him.

Interviewer: How many partners have you disclosed to since your diagnosis?

Darryl: Maybe two or three, maybe three.

Interviewer: What have those experiences been like? Have they been good, bad, mixed...?

Darryl: They were fine. They disclosed to me first so I didn't have anything to worry about.

When asked what made these disclosures easier, Darryl further explained:

Because it was a commonality already. I didn't have to worry about...it's almost like quid pro quo. I don't really have to worry about you breaching my source of security, because you also worrying about the same thing.

For Darryl, disclosing to another person living with HIV lessened the possibility of them disclosing his status later, because they risked Darryl disclosing their status. As such, it was a low risk disclosure.

Participants talked at length about assessing and considering the risks associated with their disclosures. In discussing these risks, participants identified both *interpersonal risks* and *intrapersonal risks* associated with disclosure. Interpersonal risks were potential negative effects on social relationships after a

participant disclosed his HIV-positive status. Intrapersonal risks were potential negative effects on the participant's self-concept after he disclosed his HIV-positive status. Interpersonal risks included potential loss of the current (prospective) relationship, being accused of having transmitted HIV to someone, and threats of being outed as HIV-positive. Allen (25 years old, gay) reported feeling that a private disclosure put him at risk of having his status widely disclosed.

Fags is messy. They will run back and tell everybody else, so then nobody else is going to want to date me. So then I'm going to be the motherfucker that be like, "Oh girl, watch out, he cooked," or "He got that shit." That's really how it is.

Patrick (29 years old, gay) reported having to rely on his knowledge of the Illinois AIDS Confidentiality Act in order to stop someone from disclosing his status widely.

I had to use my knowledge of knowing my rights regarding HIV. I let it be known, if you say this and that, I can do this and this. They would say, I'm going to go on Facebook and tell everybody that you have HIV. And I said, "I'm going to go to the police and tell them that you're telling people about my diagnosis, and that's basically harassment. And you're bullying me." Especially if they're doing it on Facebook and all these other social media apps, I'll go contact a lawyer and press charges.

Intrapersonal risks related more to participants having negative feelings about themselves after a disclosure. Participants talked about feeling "like a statistic"

when they disclosed or worrying that the disclosure would have been a waste if the prospective partner retracts their interest after learning of the participant's HIV-positive status. Joshua (29 years old, bisexual) said, "If I disclose to you and you don't even cross into the potential category, it's like I wasted my time, I'm getting old. I don't have a lot of time anymore." For him, disclosure was necessarily for those partners with whom things could potentially become serious. The loss of that potential due to disclosure felt like a waste.

While participants described an array of potential risks of disclosure, they also talked about *benefits of disclosure*. The central benefits they described were being able to avoid rejection if their status is freely shared and the ability to be sought out by men comfortable with HIV-positive partners. Rasheed (28 years old, gay) reported being publicly out about his HIV status and stated, "I put it on my [dating app] profiles, so I don't have to weed through the guys who aren't interested. I am who I am. They can take it or leave it." Another benefit reported by participants was potentially gaining another person invested in the participant's health. Kendrick (28 years old, gay) described liking when a partner takes this kind of interest in his health after disclosure.

It can be nice, because they'll like remind you to take your meds. "Did you take your meds today?" "Oh. No. I forgot." "Well, you better take them." "Thanks, babe." That kind of thing is nice.

In addition to their exploration of specific risks and benefits of disclosure, participants also spoke more broadly about the *disclosure decision making process*. In describing their decision making processes, participants often

highlighted the unpredictability of it all. Quincy (26 years old, bisexual) described never knowing how a disclosure will turn out.

You never know what they're going to do. They could be fine with it, or they could be like, "Oh, okay. Let me call you back." And then you call them and their number is changed. Or they become ghost.

Participants also talked about considering the legal mandates related to disclosure. Some described feeling an obligation to disclose only if they intended to engage in condomless sex¹² while others reported a desire to disclose whether or not condoms were used. When describing his decision making process, Patrick (29 years old, gay) stated:

If you're in a relationship, I think you should be honest with that person [about your HIV status]. I don't think you should lie about that. In a sense, you don't have to tell them. You could just use a condom until the day y'all die. But I just think it's better knowing. They're going to see your medicine. I just think it's better that way. I don't want to hide something like that, because it's part of me. And I'm not embarrassed of it anymore. So why not?

Lamont (28 years old, bisexual) argued that early disclosure was best and even stated that it was easiest to disclose early rather than waiting.

It's easier, because there's always this fear of talking to new people, because, unfortunately, you're going to have to tell them one way or

¹² The Illinois Criminal Transmission of HIV statute states that criminal transmission of HIV has occurred if an individual "engages in sexual activity with another without the use of a condom, knowing that he or she is infected with HIV."

another. Of course, you could get into a relationship and just use condoms and not even tell them, but I think it's only right that if you get with someone, you tell them. I think that should be part of the conversation when you're getting to know them. What's your favorite color? What's your mom's name? I'm HIV-positive.

For Lamont and others with similar sentiments, disclosure was an unavoidable difficulty that was better met head-on than left to deal with later.

All themes and subthemes related to the broader meta-theme, *experiences related to both dating and sexual relationships*, are presented in Table 7.

Table 7

Hierarchical Themes – Experiences Related to both Dating and Sexual Relationships

Theme	Subthemes
Selecting partners	<ul style="list-style-type: none"> Preferences Finding partners Role of HIV in potential partner pool
Navigating disclosure in relationships	<ul style="list-style-type: none"> Willingness to disclose Interpersonal risks Intrapersonal risks Benefits of disclosure Disclosure decision making process

Discussion

The purpose of this study was to examine the breadth of experiences in dating and sexual relationships reported by a sample of young Black GBMSM living with HIV. Given that the research which had examined the experiences of this population heretofore had focused primarily on the potential for these men to transmit HIV to others and ways to limit such transmission, it was important to explore more broadly how intimate relationships were experienced by these men. Accordingly, this study sought to offer a more textured analysis of these men's experiences, creating space for complexity, contradiction, and nuance.

This chapter is organized to expand upon the preceding results. This chapter will begin by summarizing participants' broad experiences as young Black GBMSM living with HIV. Next, it will examine how these identities have impacted these men's experiences in dating and sexual relationships. Subsequently, this chapter will explore the implications of the study's findings with particular respect to how they fit within the existing research literature and how they can be used to positively impact the population. After a discussion of the implications of this study, a discussion of the strengths and limitations will follow. The chapter will conclude with a consideration of directions for future study.

Major Findings

The young Black GBMSM in the study reported a broad set of experiences related to dating and sexual relationships. They described experiences of challenge and learning to overcome challenges, particularly in relation to the

impacts of HIV. The following summaries are a composite of the responses offered by the participants in order to present the essence of their myriad responses.

Being Young Black GBMSM Living with HIV. When participants were asked to talk about what it meant to live life as someone who was at once young, Black, same-sex-attracted, and living with HIV, some participants reported that these identities had no impact on their experiences. They described feeling as though they were not meaningfully different from others and that they had been treated similarly to individuals who did not share their identities.

In contrast, a great many participants described life as young Black GBMSM as challenging, given experiences of being devalued, rejected, and stereotyped due to their identities. Consistent with previous work that demonstrated such marginalization (Bird & Voisin, 2013; Rood et al., 2012), these experiences ranged from being made to feel unattractive due to their Blackness to internalizing a belief that HIV was inevitable for young Black GBMSM. Despite these indignities, participants talked about valuing their identities. However, they evidenced a particular challenge in trying to understand their identities as something other than a burden, while continuing to experience such adversity due to their identities. In many ways, this is demonstrative of what DuBois (1989) termed double consciousness, trying to reconcile one's view of the self with the view of the dominant culture. Given that the dominant culture's view of young Black GBMSM is often reductive and oppressive, it creates a particular

challenge for young Black GBMSM who would prefer to view themselves and their identities more positively.

When participants began to explore what it meant to live with HIV, the burdens attached to that identity were less equivocal. Similar to participants in the SUMS Study (Halkitis, Wolitski, & Gomez, 2005), participants described HIV as compromising their bodies, limiting how they viewed themselves, and challenging their ability to continue living. Perhaps one of the most profound experiences described was Ivan's fear that being ill-prepared for the weather could be sufficient to bring on his death. For so many of the participants, HIV had irrevocably changed their lives, adding another strike against them. While participants did not mince words about the burdens associated with being HIV-positive, their narratives of living with HIV did not stop at those burdens. Potentially due to the vast improvement in treatment in the modern era of the HIV epidemic, participants talked about treatment in a way that differed greatly from SUMS participants. They described engagement in treatment as a first step toward rebuilding their bodies and their senses of self. In addition, some described taking charge of their health in a way they would not have if they had not become HIV-positive. It is perhaps most accurate to describe participants' experiences living with HIV as complex, because its burdens are not washed away but, for some, are coped with in ways that allowed participants to grow.

Experiences Dating as Young Black GBMSM living with HIV. The young Black GBMSM interviewed in this study evidenced a range of dating relationship types. Some were short-term and necessarily non-serious while others

were years long with intentions for marriage. Some appeared monogamous while others seemed more monogamish (Parsons et al., 2011; Parsons et al., 2012). Despite the fact that the young Black GBMSM in the study theoretically had the option to marry, they did not evidence a greater push for heteronormative relationship progression than did participants in studies that predated marriage equality (cf. Blumstein & Schwartz, 1983; Adam, 2006). Participants ranged in the number of dating relationships they had had since diagnosis, and a subset had tested positive during their current relationships although their partners were at the time still negative for HIV. The existence of relationships wherein one partner contracted HIV while the other did not demonstrated some degree of openness in participants' relationship agreements. However, details about their specific agreements were not explored in the present study. Although participants evidenced a fair amount of diversity across their experiences with and in dating relationships, a commonality was that HIV predominated the conversation as participants described their experiences in dating relationships.

A major subtheme of participants' experience with HIV was the specter of disclosure. Research has consistently demonstrated that disclosure is a difficult process due to the potential for subsequent rejection (Bailey & Hart, 2005; Carr, 1989; Herek, Capitano, & Widaman, 2002). Participants' responses were consistent with these findings. They described disclosure as having risks of rejection by friends and family, potential for being demeaned, and the possibility of being outed as HIV-positive after disclosing. Given the risk attached to this decision, participants described taking care in how and to whom they disclosed.

For some, disclosure was a marker of growing close to a partner and moving toward a serious relationship. Accordingly, when those disclosures led to a dissolution of the budding relationship, the resulting hurt was that much greater. The fraught nature of disclosure made it a very difficult process for some participants. However, there were also participants who pushed back against the possible pitfalls of disclosure by increasing their comfort with their status and by knowing their rights related to disclosure. For those participants who became sufficiently comfortable to freely share their HIV status with others, the risk of rejection was lessened. Moreover, the opportunity was created for individuals comfortable with an HIV-positive partner to more readily identify them.

While disclosure of HIV status was a major factor in participants' initiation of dating relationships (and sexual relationships as well), many described being halted even before attempting a relationship due to the psychological effects of being diagnosed as HIV-positive. For these participants, diagnosis led to a period where dating was unfathomable. Consistent with findings of a 2014 study by Harper and colleagues, participants reported feelings of low self-worth, poor mood, and other markers of depression after diagnosis. They experienced diminished sense of pleasure in general which made any activity unpalatable. Fortunately, participants described growing more comfortable with dating as they came to terms with their status and initiated treatment. In addition, the growing use of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) by HIV-negative GBMSM provided some participants with additional hope for their dating possibilities. Given that these

other men were afforded a high level of protection from HIV transmission by the medications, participants posited that these men would be more amenable to dating someone living with HIV, thereby expanding the participants' pool of potential viable partners.

While there is a growing literature exploring the transmission of HIV from one partner to another in a dating relationship (Mustanski, Newcomb, & Clerkin, 2011; Sullivan, Salazar, Buchbinder, & Sanchez, 2009), there is no such literature examining the complexities of circumstances where one partner tests positive and the other remains negative. The experiences of the present study's participants in such relationships demonstrate the necessity of such research. The subset of this study's participants in longer term relationships that predated their HIV diagnosis described particularly challenging circumstances that meaningfully differentiated their experiences dating from those of their peers. These participants described a fear that no other man would be willing to date them if their existing relationship should at some point end. As such, they were willing to tolerate diminished relationship quality and poor treatment in order to avoid being alone. They described diminished quality of the sex in their relationships, including less frequent sex, fewer pleasurable activities during sex, and a loss of intimacy. However, these participants' fear of being alone would not allow them to end these arguably unhealthy relationships. In fact, this fear led to these men participating in behavior that appeared to hurt their self-esteem (e.g., treating exposure to benign fluids as contamination) in hopes of improving the quality of the relationship.

Healthy Dating Relationships for Young Black GBMSM Living with HIV. Research examining the quality of relationships for GBMSM has identified a range of qualities as important for relationship health. These have included factors like relationship commitment, mutual respect, trust, intimacy, passion, satisfaction, and supportive communication (Doyle & Molix, 2015; Mohr & Fassinger, 2006). Participants in the present study only identified two factors: communication and safety.

Participants described consistent, clear, and honest communication as a central pillar of healthy dating relationships. They described a desire for communication about wants and needs as well as a commitment to communicating in times of disagreement. A number of participants described difficulties with honesty as a primary challenge of dating other men and posited that they would have far more successful relationships if their male partners were able to be consistently honest about their needs, their wants, and their behaviors. While termed communication in their responses, this subtheme actually encapsulates aspects of trust and mutual respect as well, given the importance placed upon honesty in communication.

Perhaps due to the salience of HIV in discussions, participants consistently highlighted the relationship between safety and the health of a dating relationship. Many participants talked about safety in terms of reducing sexual risk in their relationships. They described a desire not to cause harm to their partners through the communication of HIV or another STIs. They also described a desire to have their own health protected from potential STIs communicated from their partners.

In addition to safety from STIs, participants also drew a connection between the health of dating relationships and the absence of abuse. Much in line with how they understood sexual safety as bi-directional and co-constructed by both partners, participants also tended to describe the desire for an emotionally and physically safe relationship as upon both partners to create. They described a desire not to have violence enacted upon them and not to enact violence upon their partners. This subtheme, like communication, seems to contain elements of the trust and mutual respect identified in the literature as well.

Experiences with Sex as Young Black GBMSM Living with HIV. As with dating relationships, participants reported a range of experiences related to sex and sexual relationships. While they did not talk about sex as necessarily tied to the confines of a long-term relationship, the participants in the present study did not endorse some of the sexual experiences highlighted in previous studies. For example, SUMS participants talked about sex as an escape from the challenges of their day-to-day lives (Bird & Voisin, 2013; Halkitis & Wilton, 2005) as well as sex being primarily about physical connectedness absent an emotional intimacy (Wilton, Halkitis, English, & Roberson, 2005). While participants may have had such experiences, the absence of their mention is conspicuous.

Given that HIV dominated conversation about sexual relationships, it is perhaps less conspicuous that participants did not explore with much depth how their racial identities and responses to those identities shaped their sexual experiences. There was limited exploration of expectations related to Black

masculinity and the ways such expectations framed behavior. However, there was explicit discussion of the ways that racialized sexual stereotypes and associated fetishism manifested in their relationships. Consistent with historical constructions of the Black male as hypersexual, feral, and dominant¹³ (hooks, 2001; Farkley, 1997), participants described being fetishized by White partners who sought them out to serve as a racialized sexual fantasy. Participants described being reduced by these partners to their racialized genitalia, making them what Collins (2005) termed a “buck” or “Black Buck.” In seeming contrast, participants also talked about facing rejection from White partners who reported a disinterest in engaging Black men sexually. It is this liminal status that facilitated racial homophily for a number of participants. Rather than existing in a space rife with the opportunity for varying forms of degradation and dehumanization, they opted for seeking sexual relationships with other Black men.

Similar to the way HIV diminished participants’ interest in dating relationships in the time immediately following diagnosis, many participants described HIV as curbing their interest in sexual behavior as well. They described attempting to cope with this loss of interest, but most said their desire for sexual interaction did not return until they had begun to come to terms with their diagnosis to some degree (e.g., determining that HIV did not have to substantially shorten their lives, beginning consistent adherence to treatment). Others required the use of marijuana to manage the associated stress and thereby facilitate a

¹³ The notion of dominance must be examined carefully in this context, as the dominance is performed more than it is real. The presumed dominance of Black men is in the service of their White partners’ pleasure rather than as an act that would confer actual power to the Black man.

resurgence of their sexual interest. Bruce, Harper, and Fernandez (2013) found a quarter of their sample of young Black GBMSM living with HIV utilized marijuana for the purposes of coping with stress post-diagnosis. Given that this question was not asked directly or consistently throughout interviews in the present study, it is unclear the proportion of participants in this study who utilized this strategy.

After participants regained an interest in sexual relationships, they had to navigate finding partners they desired and that would be comfortable engaging sexually with an HIV-positive person. Some participants reported that HIV had no impact on their pool of potential sexual partners. They cited multiple reasons for this lack of impact, including potential partners not being concerned about exposure to HIV, using condoms consistently no matter the reported HIV status of their partners, or utilizing PrEP as a means of maintaining safety. In contrast, other participants described worrying about disclosing their status to potential partners. They described fear of being mistreated or rejected due to their status by HIV-negative men, and, accordingly, many participants described having to think through whether serosorting would be the best option for successful sexual relationships. Consistent with previous research identifying difficulties with HIV-negative partners as leading to serosorting (Frost, Stirratt, & Oullette, 2008), participants often described HIV-positive sexual partners as better informed about HIV. They also described HIV-positive partners as less likely to perpetuate stigma and more likely candidates for condomless anal intercourse without risk of negative outcomes. In a contrast to the extant literature (Parsons & Vicisio, 2005),

participants did not identify public and commercial sex environments as avenues for finding partners to whom they would not have to disclose. In fact, the primary method participants seemed to identify for avoiding disclosure was avoiding relationships altogether.

Many participants described feeling as though they would never be able to engage in sex the way they once did due to the specter of transmitting HIV to a sexual partner. The consequences of potential transmission loomed large for these participants, citing fears identified in previous research like being outed, sued, prosecuted, or killed if a partner were to become positive (Frost, Stirratt, & Oullette, 2008). These fears are perhaps heightened given the recent high profile prosecution and vilification of a young Black GBMSM living with HIV after being accused of intentionally exposing partners to HIV (McCullom, 2015; Murphy, 2015). In 2014, Michael Johnson, a 23 year old young Black GBMSM attending college in Missouri, was accused of intentionally exposing multiple partners to HIV. Subsequent to his accusation, his status was made public when photos of him were attached to articles about the accusations and subsequent prosecution. A number of articles described him as predatory and implied that he sought to hurt others by not readily disclosing his HIV status (cf. Murphy, 2015; Weich, 2015). On July 13, 2015, he was sentenced to 30 years in prison, though the jury in his trial had recommended a 60 year sentence. Michael Johnson's case illustrates the way that multiple identities intersect to create more challenging

circumstances, as Johnson was cast as a predatory Black man who used his large penis¹⁴ to prey upon young White men at his college.

Unsurprisingly, participants talked at length about mitigating risk, both to themselves and to their partners. On some occasions, risk mitigation meant determining how and if condoms or other barriers would be used. On other occasions, risk mitigation meant opting for sexual behaviors with less risk of HIV transmission, like oral sex. When discussing mitigation of risk, participants again visited the topic of partner selection. They described considering other HIV-positive men as less risky sexual partners (Frost, Stirratt, & Oullette, 2008), particularly if these men were adherent to treatment and/or had shared medication resistances. However, they also discussed the viability of HIV-negative men who were using PrEP as a means of managing their own risk. Interestingly, relatively few men talked about adherence to their own medication regimens as a means of lowering risk to partners. However, 90% of men in the sample reported being on HAART and 75% reported undetectable viral loads. As such, the risk to their partners was being mitigated, even if this was not salient during their interviews.

A number of risk navigation strategies identified in the literature failed to show up in the present study. For example, no participants described strategic positioning (McDaid & Hart, 2010) as a means of reducing risk in their sexual relationships. In fact, one participant talked about transitioning from primarily receptive partner to primarily insertive partner after diagnosis, because he began to prioritize his own sexual needs over his partners'. Further, no participants

¹⁴ The size of Johnson's penis was referenced multiple times during his trial in the testimony of accusers, citing his penis size as part of the reason that condoms were not used.

reported identifying as barebackers or consciously intending to engage in condomless anal intercourse without consideration of HIV communicability (Carballo-Diéguez et al., 2009; Parsons & Bimbi, 2007). It is possible that social desirability precluded such a disclosure. However, participants shared a range of deeply personal information with the researcher, so it may be unlikely that social desirability precluded discussion of bareback identities.

Healthy Sexual Relationships for Young Black GBMSM Living with HIV. Research examining the health of sexual relationships has tended to examine three factors: sexual communication, frequency of sexual activity, and sexual risk (Lehmiller, VanderDrift, & Kelly, 2012; Starks & Parsons, 2013). Participants in the present study identified both sexual communication and sexual risk management as key aspects of a healthy sexual relationship. They described a desire for clear and honest communication about preferred sexual behaviors, unpreferred sexual behaviors, sexual history, and sexual risk factors. In addition, they asserted the necessity of safer sex practices in healthy sexual relationships.

An interesting outlier in the conversations about healthy sexual relationships was Allen (25 years old, gay) who described a healthy sexual relationship as one wherein he could have condomless sex. Given that the ability to mutually engage with seminal fluid in his relationship had been a marker of intimacy for him, it is possible that his association of condomless sex with a healthy sexual relationship is indicative of associating unfettered intimacy with a healthy sexual relationship. If this interpretation is to be taken, it is interesting that no other participants identified such unfettered intimacy as necessary for a healthy

sexual relationship. However, given that Allen's dating relationship had been his primary sexual relationship for the 8 years preceding his interview, it is possible that a healthy sexual relationship and a healthy dating relationship were indistinguishable for him. Unfortunately, the relationship between health and condomless sex was not further explored in his interview, so it is difficult to definitively know how/why he made this association or to draw definitive conclusions.

Challenges Specific to Young Black GBMSM Living with HIV. The young Black GBMSM in the present study endorsed a number of challenging experiences highlighted in the extant literature regarding individuals living with HIV (e.g. disclosure, depression after diagnosis; Harper et al., 2014; Paiva, Maria, & Filipe, 2011). In addition, they described a number of challenging experiences that appeared more specific to the intersection of two or more of their identities.

While many participants stated that race had no particular impact on their lived experience, the impacts of anti-Black racism were apparent in their narratives. Consistent with previous work examining the perception of Black maleness and masculinity (Collins, 2005; hooks, 2004), young Black GBMSM in the study described being reduced by some White partners to a sexualized racial caricature. Rather than being engaged with as full persons, they were presumed to be Black bucks who could meet the needs of White men who desired to be dominated. While this fetishism was based in racist assumptions about Black male sexuality, there was also an intersectional aspect to be considered. This racist fetishism also served to undercut and invalidate the sexual identities of some

participants. For example, young Black GBMSM who identified themselves as receptive partners were still expected to be insertive, because that is what fit the narrative about Black men's sexuality.

Another way that anti-Black racism served to circumscribe the intimate relationships of young men in the study was related to the rejection they experienced from White partners. Participants described seeing online dating profiles with language like "No Blacks" and meeting individuals in-person who would express an explicit dispreference for Black men. While these experiences of explicit racism are often described by White GBMSM as preferences (Callander, Newman, & Holt, 2015), they demean Black GBMSM, reinforce a notion that Black GBMSM are of low value, and isolate Black GBMSM in a way that is less apt to happen for other races and ethnicities¹⁵. As such, these experiences of dehumanization can be understood as directly resulting from the intersection of these men's identities.

Experiences of fetishism and sexual racism served to add to an intersectional experience that, for many participants, was already fraught with isolation and dehumanization. In addition to these racist experiences in the context of attempts at intimate relationships, young Black GBMSM described feeling rejected and demeaned in the larger world due to anti-Black racism. They described feeling rejected within Black spaces due to their same-sex attraction. And they described rejection within sexual minority spaces due to HIV status.

¹⁵ A study by Phillips, Birkett, Hammond, and Mustanski (2016) found that Asian MSM were similarly homophilous to Black MSM. However, it was not established whether that homophily was a result of anti-Asian sexual racism or another factor.

Accordingly, there were few, if any spaces, where the reaction of others to one or more of these men's identities did not engender feelings of not belonging. This kind of isolation could account for some of the decisions young Black GBMSM in the study described. For example, the men who were diagnosed with HIV in the context of their existing dating relationship described experiences that bordered on abusive yet reported a desire to remain in these relationships. In a context wherein support appears limited and opportunities for being affirmed appear unlikely, remaining in these relationships seem sensible. In a context of isolation that is perpetuated by those around them, retaining access to a semblance of support may be adaptive and necessary for self-preservation.

Strength and Resilience in a Context of Challenges. Although the challenges experienced by the young Black GBMSM in the study were many and the consequences of these challenges were vast, many of the men nonetheless demonstrated incredible strength and resilience in their narratives. As has been often stated (cf. Harper et al., 2014; Wilson & Harper, 2013), there is a need to highlight these narratives of resilience as they offer a useful complementary or counter narrative to the deficit-oriented research that is more easily fundable and published. The findings of the present study add to this growing area of research.

One of the clearest examples of this strength evidenced in the young Black GBMSM interviewed for this study was in their descriptions of their trajectories post-diagnosis. Many described an initial depression. During this time, they tended to isolate and had limited interest in social connection or intimate relationships. However, as time went on, these men described a desire to assert

more control over their lives, and it was this move which allowed a change in their circumstances and outlooks. Consistent with findings by Harper and colleagues (2014), the young Black GBMSM in the study began to become more conscious about their health status and engage in HIV treatment. Harper and colleagues (2014) identified this enacting of healthier behavioral practices as one of the resilience processes that allowed young Black GBMSM living with HIV to function and move toward thriving post-diagnosis. After participants in the present study began to enact these healthier behavioral practices, they also began to develop a sense of hope and optimism about future relationships and a sense of agency in present ones. This reconfiguring of their self-concept was a necessary step in these men's empowerment and move toward surmounting the challenges that face individuals who are multiply maligned, oppressed, or marginalized.

Another example of strength demonstrated by the men in the study was their ability to parse their notion of their value from others' notion of their value. More specifically, participants talked about knowing that having their identities would mean facing challenges, but they were still able to value themselves despite this. Despite the many counter narratives which would argue that they were damaged or deficient, young Black GBMSM in the study found ways to see their own beauty and potential. This ability is indicative of a level of critical consciousness that is arguably necessary for survival within a society that is hostile to these men's existence. This finding was consistent with research by Reed and Miller (2016) wherein they found that Black gay and bisexual men were

often able to identify and reject problematic stereotypes attributed to them. Further, they were able to articulate positive conceptualizations of their identities.

It is noteworthy that, despite the kinds of challenges visited upon the men in the study because of the intersection of their identities, these young Black GBMSM were able to retain a clear notion of what healthy relationships could and would look like. They were able to assert the necessity of healthy communication and safety in relationships. Given that communication is one of the areas that poses greatest challenge within intimate relationships (Stanley, Markman, & Whitton, 2002; Vangelisti, 2016), this cognizance is a good sign. It portends that these men are at least aware of what challenge they must address if they desire to have healthy intimate connections. It is also worth noting that participants' description of safety was nuanced in that it addressed both the individual's safety and the safety of his partner. Young Black GBMSM did not solely assert a desire to avoid having violence or illness impact them, but they also asserted a desire to protect their potential partners from violence or illness. This narrative around safety demonstrates a level of maturity and responsibility on the part of participants, as they recognize that they are capable of both hurt and being hurt. As such, they charge both themselves and their partner with maintaining the health of their intimate relationships.

Implications

The present study has a number of implications for better understanding intimate relationships for young Black GBMSM living with HIV. First, it raises questions about how best to engage the issue of multiple marginality given the

difficulty of understanding oneself and one's experiences through an intersectional lens. Secondly, the findings of this study challenge the one-dimensional approach to understanding young Black GBMSM living with HIV as primarily vectors of disease rather than as full beings with complex experiences that extend beyond their potential for viral transmission. Further, the findings of this study illustrate the necessity of a broadening of our understanding of "safe sex." Lastly, the findings of this study raise questions about how best to support this population through research and the development of interventions.

Intersectional Theory in Empirical Research. It is the case that much of the intersectional work that has examined the experiences of Black gay and bisexual men has applied the intersectional lens post-facto (cf. Anderson & McCormack, 2010; Brennan et al., 2013). In these studies, Black men who also identify as gay or bisexual are observed, interviewed, or surveyed; then the researcher examines how the experiences of these men differ from other men who are Black and heterosexual or White and same sex attracted. As such, the researchers' engagement with and understanding of intersectionality is the primary way in which the construct enters the analysis. While this approach is justifiable in that intersectionality has been a fairly academic concept and articulating one's intersectional experiences explicitly is a challenge for most, this was not the intended goal of the present study¹⁶. In the present study, the

¹⁶ In addition to the generally abstract nature of the concept of intersectionality, the developmental level of participants must be taken into account. Given that the men interviewed for the study were in the emerging adulthood stage of development, they were still working to concretize their identities. As such, the task of thinking about their identities in a complex and interconnected way may have been a greater challenge than initially considered by the researcher.

researcher endeavored to allow participant's understanding of their own identities to be the primary source of intersectional perspective. However, one of the more conspicuous findings of this study was that it was a challenge for participants to explicitly conceptualize themselves as at once young, Black, same sex attracted, and HIV-positive.

Although research has demonstrated that the confluence of these identities places these men at significant risk for difficult and idiosyncratic life experiences (Bowleg et al., 2013; Halfors et al., 2007; Stirratt, Meyer, Ouellette, & Gara, 2008), it is not clear that the relationship between these identities and experiences was consistently conscious or perceptible to members of the sample. Participants often addressed intersectionality later in their interviews, speaking to the ways that race and sexual orientation or HIV and sexual orientation intersected to create particular experiences in their relationships. However, participants demonstrated particular difficulty when asked explicitly about experiences that rose from the intersection of their identities. This suggests that intersectionality may be too abstract or academic a construct to directly address with individuals without some form of scaffolding. In order to understand what this means for intersectional analysis, it is necessary to put the present study in the context of others like it. In 2012, Lisa Bowleg examined Black gay and bisexual men's perspectives on and experiences of intersectionality in an attempt to address the dearth of empirical studies utilizing the construct. She found that the men she interviewed were able to both explicitly and implicitly identify the ways that their sexual orientation interacted with their Black maleness to produce particular kinds of experiences.

However, the participants also evidenced that their identities as Black men were primary in their minds. This is similar to how HIV seemed to be the predominant identity addressed by participants in the present study and suggests that the most saliently marginalized identity is the one which is most readily discussed in intersectional lines of inquiry. It is also the case that the present study may have primed participants for their identities as HIV-positive men given that it addressed issues of dating relationships and sex, areas that are explicitly impacted by HIV status.

While the construct of intersectionality has moved increasingly into the mainstream lexicon due to a number of popular press articles and a degree of consciousness raising among progressives utilizing new media platforms, it has yet to join the common vernacular. As such, in order to directly address issues of intersectionality in empirical research, the primary intersectional lens may have to continue to be the researcher's for the time being. However, there may be ways to improve research methods in order to elicit participants' own understanding of intersectional experiences more directly. Such methods will be addressed later in this chapter when implications for research are discussed.

Understanding Young Black GBMSM Living with HIV as Full

Beings. The primary purpose of the present study was to expand research examining young Black GBMSM living with HIV by purposefully focusing on more than their potential for transmitting HIV to others. The findings of this study suggest that such analysis is necessary, given the complex challenges that these men encounter when trying to pursue what is understood as a normative or even

essential part of human experience: romantic and sexual intimacy (Maslow, 1943). Accordingly, these findings raise questions about how we understand the experience of being at once young, Black, same sex attracted, and living with HIV, both as they related to intimate relationships and to existence more broadly.

Participants in the present study described significant changes to their self-concept after diagnosis, including believing they had diminished in beauty or value. Some described feeling that their HIV status was visible, even when there were no perceptible symptoms or indicators of their status. A connection can be drawn between these changes in self-concept and participants' perceptions of HIV before they were diagnosed. The majority of the participants reported not having known much about HIV before their diagnosis. As such, their mental model of a person living with HIV was more akin to society's caricature of an HIV-positive person (i.e., someone sickly and dying; Bird & Voisin, 2013) than to the current medical understanding of life with HIV (i.e., living with a chronic, but manageable disease). Participants' notion of self may be related to a phenomenon termed meta-stereotypes. These meta-stereotypes are opinions about one's group (in this case, persons living with HIV) believed to be held by members of another group (in this case, persons not living with HIV; Klein & Azzi, 2001). In a study of 122 people living with HIV, Gordijn and Boven (2009) found that negative thoughts about how HIV-positive individuals were stereotyped by HIV-negative others led to increased isolation and depressive symptoms. Given that most people living with HIV (and all of the young Black GBMSM in the present study) were at one point were HIV-negative, their meta-stereotypes are based on experience as

much as assumption. Accordingly, this population is at high risk for internalizing these negative self-concepts, given that they may assume others hold these beliefs and they may have yet to let go of the beliefs themselves. As such, attempts to understand young Black GBMSM living with HIV necessarily must contend with understanding how their self-concept is impacted by not only what is true about living with HIV, but also others' perception of that life and the individual's pre-existing perceptions of that life.

One of the more surprising aspects of the present study were the findings related to participants in dating relationships that existed before their HIV diagnoses. Although research has consistently found that GBMSM in relationships evidenced better mental health outcomes than single GBMSM (Parsons et al., 2012), the men in the study who were in relationships that predated their HIV diagnosis described experiences more challenging than other participants and evidenced a great deal of emotional fatigue. As stated earlier, these findings suggest that this subgroup's experiences may be a different phenomenon altogether than the experiences of young Black GBMSM living with HIV who are embarking upon new dating and sexual relationships. Given the extended nature of these men's feelings of low worth and beliefs of limited opportunity for intimacy outside of their existing relationships, they may be at greater risk for depression as well as emotional abuse. These men's experiences are in direct conflict with the penchant for casting individuals living with HIV as a threat to individuals who are not living with the disease. In fact, these men's experiences highlight how their HIV status places them at risk for a particular

kind of victimization at the hands of HIV-negative individuals. If young Black GBMSM living with HIV are to be understood more fully, it will be necessary to attend to and consider this aspect of their experience and the potential negative outcomes of it.

It is possible to review participants' responses and surmise that there were many contradictions in how they described life. On the individual level, some participants would assert that their identities were not relevant to their lived experiences, but later detailed circumstances in which they were impacted by racism or health stigma. In the aggregate, there were participants who offered somber narratives of being young Black GBMSM living with HIV while others persisted in describing growth and maturation in spite of their challenges. While these could be construed as contradictory experiences, an alternative understanding of this diversity of narratives is that these young Black GBMSM living with HIV have incredibly complex and varied lives. Given the intersection of multiple stigmatized identities and the hegemonic narratives attached to these identities, these men must negotiate myriad conflicting notions of who they are, should be, and can be (Jamil, Harper, & Fernandez, 2009; Moore, 2005). They exist in a world where Blackness, same sex attraction, and a positive HIV status are markers of risk, though it is often the response to their Blackness, same sex attraction, and HIV status which place them at greatest risk (CDC, 2007; Flores et al., 2010). Accordingly, one could expect great diversity in perspective, even within a given individual, given the weight of how much must be considered when thinking about what life is like.

Reconceptualizing Safer Sex. Often, when people (whether laypersons or researchers) reference “safe sex,” they are implicitly referencing sex with a condom. While historically the conflation of sexual safety and condom use was essentially correct, the development of new prophylactic technologies has expanded the options for safer sex. In addition to their potential use of barrier methods like condoms and dental dams, participants in the present study discussed the potential roles of PrEP and treatment as prevention (TasP) in their safer sex approaches.

An increasing amount of research has demonstrated the safety and effectiveness of antiretroviral prophylaxis for the prevention of HIV seroconversion, with multiple studies finding an effectiveness above 90% (Baeten et al., 2012; Grant et al., 2010; Grohskopf et al., 2013). Further, a study of 1,603 HIV-negative GBMSM and trans women found that transmission of HIV was at 0% for participants who took PrEP at least 4 days per week (Grant et al., 2014). Given the building mass of data supporting PrEP as a means of reducing risk of HIV transmission, government health organizations have begun to voice support for PrEP as well (FDA, 2015). In addition to the oral medication currently available, there are long-acting antiretroviral medications being developed for use as PrEP (Dunne, 2016). Northwestern University is currently working to develop an implantable device that would administer cabotegravir, an investigational new drug under development for the treatment of HIV, as a form of long-acting PrEP. Taken together, the mass of data supporting the utility of PrEP and the increasing

institutional support for PrEP indicate that it must be considered when conceptualizing safer sex.

Just as the data for PrEP as a viable means of prevention has grown tremendously in the past decade, so has the evidence for TasP. TasP is the idea that transmission of HIV can be prevented by HIV-positive individuals adhering to their medication regimens in order to reach an undetectable viral load. The findings of the PARTNER Study (Rodger, 2014), a two-year study of nearly 800 couples with HIV-discordant statuses, suggested that the potential for transmission when HIV was suppressed was incredibly low. There were no reported transmissions of HIV between partners in the study. Findings from the Opposites Attract Study (Grulich et al., 2015), a two year study of 234 couples with HIV-discordant statuses, were similar. There were no reported transmissions of HIV between partners in the study. Accordingly, TasP appears also to be a necessary consideration when discussing safer sex for young Black GBMSM living with HIV.

Informing Future Research. The findings of the present study serve as a step toward broadening and deepening understandings of dating and sexual relationships for young Black GBMSM living with HIV. As such, they also illuminate multiple avenues for further inquiry. Some of these avenues are additional questions to explore and others are methodological adaptations to build upon and/or clarify the present findings.

Participants' meta-stereotypes served to create feelings of isolation and support negative ideas about themselves. Accordingly, it would be useful to

explore in depth the texture of these meta-stereotypes. Research should examine how these meta-stereotypes develop, how they are maintained, and what sorts of factors hasten their dissolution. In order to understand this phenomenon, it will be important to examine the pre-existing beliefs of young Black GBMSM regarding persons living with HIV in addition to the kinds of attitudes and beliefs regarding HIV that they received from other sources. Additional useful information will be the individual's level of contact with persons living with HIV before diagnosis and general level of health literacy. Better understanding these factors may serve to inform how best to limit the negative impacts of meta-stereotypes after diagnosis.

Participants described a multitude of challenges associated with dating and sexual relationships for young Black GBMSM living with HIV. While it is important to understand the ways that marginalization can limit or otherwise negatively impact the experiences of oppressed communities, this is not and cannot be the full narrative. Such work is often conducted with a goal of demonstrating to those with power that oppression and marginalization are harmful. However, this narrow analysis fails to acknowledge the fullness of the communities examined and is what Eve Tuck (2009) termed "damage-centered research." The central risk of such work is that it narrowly defines communities by their experiences of oppression. In order to avoid engagement in damage-centered work, future work examining the intimate relationships of young Black GBMSM living with HIV should explore the potential for post-traumatic growth and the positive experiences borne of these individuals' identities. Given that

many participants talked about their experience with HIV as a journey wherein they matured and gained strength over time, a lens of post-traumatic growth is fitting. There exists a literature exploring post-traumatic growth in individuals living with HIV. However, this work has primarily been in the context of treatment adherence and reduction of trauma symptoms (Cadell, Regehr, & Hemsworth, 2003; Hefferon, Grealy, & Mutrie, 2009; Sherr, Nagra, Kilubya, Catalan, Clucas, & Harding, 2011). Accordingly, work which examined the role of post-traumatic growth in the context of these men's intimate relationships could help to elucidate their strengths. In addition to a post-traumatic growth lens, future research would benefit from overt questioning regarding the positive experiences related to being young Black GBMSM living with HIV. It is easy to implicitly draw narratives of struggle or challenge when interviewing populations impacted by marginalization. As such, explicit focus on the potential for positive experiences creates space for participants to explore that aspect of their life experience.

Another route to better understanding intimate relationships for young Black GBMSM living with HIV would be to adjust the qualitative methodology. The approach taken in the present study, single interviews with participants, is time- and cost-effective and therefore facilitative of completing the study more quickly. However, the potential difficulty of the intersectionality construct and the complexity of these men's experiences could benefit from the intensive data collection and analysis afforded by a case study approach.

In a case study approach (Creswell, 2007; Yin, 2003), data is gathered from a variety of sources, though with a smaller sample. This more intensive focus allows the phenomenon to be explored with greater detail and through a variety of lenses. While one approach to case study focuses on a singular individual and gathers intensive data related to that person's experiences, a more appropriate approach for understanding intimate relationships for young Black GBMSM living with HIV would be to study one dyad, a small sample of individuals, or a small sample of dyads. In order to allow the opportunity for increasing depth of rapport and a mutual building of understanding related to intersectionality, multiple interviews with the individuals or dyads would be best. This would give the researcher an opportunity to gain a keen understanding of the particularities of each participant's experiences. The repeated interviews would allow opportunities for ongoing clarification of understanding and build in a level of member checking that would strengthen the study's trustworthiness. Further, a given participant's perception of and perspective on relationships may shift over time. Repeated interviews allow for an exploration of shifts and nuances in participants' perspectives and experience. Repeated interviews also create the opportunity for covering material that was not initially salient to participants. For example, in the present study, little attention was given to intra-racial dynamics (e.g., colorism, intra-racial identity expectations) or experiences more specific to younger GBMSM (e.g., navigating interactions with older partners). Multiple interviews allow an opportunity to explore these less salient topics after participants have covered topics which were more salient to them. In addition to

gathering data from the individual participants, additional data could be gathered by interviewing friends, family, and other key informants about what they have observed in terms of the participants' intimate relationships. Having this mass of data would allow the researcher to craft a much clearer and delineated description of how intimate relationships function for young Black GBMSM living with HIV.

Informing Practice and Intervention Development. In addition to raising questions about theory and approaches to research with young Black GBMSM living with HIV, the findings of the present study have clear implications for the delivery of services to this population. These findings suggest opportunities for improving the delivery of sexual health information related to HIV, increased sex positivity related to populations living with HIV, and strengthening the care provided to this population by mental health professionals.

Findings of this study demonstrate opportunities for the strengthening of sexual health education curricula. Specifically, curricula would benefit from a broadening of how persons living with HIV are understood. Curricula in Chicago, where this study was conducted, have recently been amended to include instruction about gender expression and sexual orientation, but still only address STIs and HIV in the context of prevention (City of Chicago, 2013). Discussion of HIV only in the context of prevention continues to uphold the stigmatized nature of living with HIV. As such, materials which explore how persons living with HIV engage in treatment and other health-positive behaviors would strengthen this curriculum. Given that sexual health education programs are developmentally gradated in Chicago, older students may also benefit from material which

explores sexual options for persons living with HIV, including information about PrEP, PEP, and TasP. Though minors cannot consent to preventive HIV services in Illinois (Culp & Caucci, 2013), rates of HIV infection are rising among GBMSM as young as 13 years old. Accordingly, it may be beneficial to provide preventive treatment information to students before high school. This early education will allow for a more informed public and potentially a reduction in dated information about HIV transmission and life post-diagnosis. Given that curricula and protocols differ between states and/or districts, it is hard to state specific methods for improving sexual health education more broadly. However, key considerations should be the incorporation of materials that accentuate there is life after an HIV diagnosis, treatment has improved dramatically over the course of the epidemic, and there are multiple ways for persons living with HIV to have fulfilling and enjoyable intimate relationships.

In addition to school-based sexual health education, public health campaigns could be used to facilitate healthier intimate relationships for young Black GBMSM living with HIV. These programs could provide increased education about sexual options for persons living with HIV and provide access to education for partners of persons living with HIV as well. Such programs would be valuable for increasing the knowledge base of persons living with HIV and broaden their pool of potential partners by dispelling myths and half-truths about transmission risk. In addition, these campaigns should work to normalize the sex, sexual desirability, and sexual viability of persons living with HIV¹⁷. Absent

¹⁷ The developers of such public health campaigns must be careful in their deployment of these campaigns, as attempts to represent young Black GBMSM living with HIV have the potential to

concerted efforts to reframe public understandings of people living with HIV, it is likely that reductionist and degrading caricatures of these individuals will be hard to extinguish beyond any given individual's microsystem.

In addition to programs more focused on understanding and valuing persons living with HIV, public health campaigns also have the opportunity to educate the public about the myriad advances the field has seen in treatment and prevention of HIV. Public health campaigns like PrEP4Love in Chicago (AIDS Foundation of Chicago, 2016) have been able to begin educating the public about PrEP in an attempt to normalize and propagate its use. However, these efforts could be strengthened by also having programs publicizing the advances made in HIV treatment (e.g., pill burden reduction, side effect reduction) and the viability of TasP as a component of safer sex approaches.

Participants in the present study reported a number of experiences which would benefit from the intervention of a mental health professional, including diminished self-worth after diagnosis, symptoms of depression, loss of agency in intimate relationships, and potential experiences of emotional abuse. In order to meet the needs of this population, it is therefore prudent for mental health professionals who serve them to become better acquainted with the contexts of these experiences. While many clinicians work with clients who struggle with self-worth and depression, the narratives which underlie these experiences in young Black GBMSM living with HIV are persistent and often perpetuated by

stigmatize this population. In this work, it will be important to ensure widespread distribution of these materials across communities without reinforcing a notion that conflates being a young Black GBMSM with necessarily having an HIV-positive status.

society. As such, the clinician is not simply contending with the individual's notion of self; the clinician is contending with a context which is toxic to but inescapable for the client. In order to best meet the needs of such clients, the clinician should engage in a process of conscientization (Freire, 2000) with the client. This raising of the client's critical consciousness will help the client resist societal narratives about their marginalized identities and recognize the oppressive nature of these narratives. This development of greater critical consciousness will serve to strengthen the client against internalizing these narratives about the client's viability for intimate relationships, but also more generally for their value as humans. Further, clinicians serving this population can work to empower these individuals by promoting safe opportunities for self-help, advocacy, and sharing of their narratives.

In addition to building skills to combat societal narratives, the findings of this study suggest that clinicians who serve young Black GBMSM living with HIV should assess for and be attentive to potential signs of lost agency or emotional abuse in relationships. Given the power differential created by a difference in HIV status, young Black GBMSM living with HIV may be at a higher risk for victimization. As such, clinicians serving them should be conscious of that potential and they should assess for abuse, with an eye toward the multiple ways this could manifest in the relationships of young Black BMSM living with HIV.

While clinicians can have particular utility to this population in the context of providing therapy services, they can also be of use to this population by

pushing back against policies which contribute to poor mental health outcomes for young Black GBMSM living with HIV. More specifically, the criminalization of HIV exposure serves to maintain the stigma associated with an HIV-positive serostatus and the maintenance of a negative self-concept for HIV-positive individuals. First, these policies perpetuate the notion that individuals living with HIV are primarily vectors of disease. Secondly, these policies attach criminal penalties to exposing others to HIV in a way that is dissimilar from other communicable diseases (e.g. Herpes, syphilis, flu; Newman, 2012; Perone, 2013). Thirdly, placing the onus of responsibility primarily onto the person living with HIV positions them as the sole person in a sexual encounter with agency (Burriss & Cameron, 2008). This excuses the other partner for having to take responsibility for their own sexual decision making and perpetuates the idea that HIV transmission is an act that is done to someone rather than an event that occurs as a consequence of multiple parties' behavior. Further, the widespread nature of HIV stigma potentially limits the impartiality of judges and jurors in cases of criminal HIV transmission (Burriss & Cameron, 2008), and reviews of trial transcripts has demonstrated bias in these cases (Weait, 2007). This bias is particularly salient in cases where the HIV-positive person is also otherwise marginalized (e.g. a person of color, a person of lower socioeconomic status). As such, the likelihood of young Black GBMSM being impacted by these laws in disparate and prejudicial ways is high. Accordingly, it is upon the professionals invested in this community's health and wellness to push against such policies.

While the findings of the present study identify a number of ways to improve services for and policies related to young Black GBMSM living with HIV, they also highlight the importance of existing resources like TheBody.com and Poz.com. These sites are spaces where individuals living with HIV can receive information in order to better understand life with HIV. Further, Poz.com is one of many sites with a personals section to facilitate individuals with HIV finding suitable partners. These resources should be widely shared with young Black GBMSM living with HIV and supported in order to ensure their longevity and continued access for the community. As these sites gain greater visibility though, it will be important to ensure that they remain safe spaces. Virtual spaces where HIV-positive serostatus is disclosed have the implicit risk of undesired disclosures. For example, individuals in a given geographic community may search the personals section on a site dedicated to HIV-positive individuals in order to learn who in their community is living with HIV. These individuals may then disclose these individuals' status to third parties without permission. Accordingly, online dating sites that are geared toward HIV-positive individuals must stress to potential users that there are risks associated with use, and these risks must be weighed against the potential value of the sites.

Strengths and Limitations

The present study has both strengths and weaknesses which should be considered when examining its results and when considering future exploration of dating and sexual relationships for young Black GBMSM living with HIV.

A major strength of the study was having an interview guide that was designed specifically for the purposes of understanding the nuances of the participants' experiences in dating and sexual relationships in the context of their identities. In addition to being informed by the literature on dating and sexual experiences for individuals with one or more of these identities, the interview guide was informed by feedback from community members (i.e., the Community Advisory Board) in addition to professionals who serve the community. As such, it was highly specified to the population and therefore positioned to gather more robust and nuanced data. While HIV still predominated conversation, the tailored nature of the interview guide ensured opportunities to explore how other identities impacted participants' experiences.

A second major strength of the present study was the extensive time the researcher spent with members of the population and in spaces familiar to the population. The researcher's prolonged exposure to the community allowed him to build strong rapport with participants and feel comfortable creating a conversational atmosphere conducive to openness and vulnerability. Given the nature of the material discussed in the study's interviews, this rapport was necessary in order to access personal narratives and experiences participants might be uncomfortable sharing with someone they viewed as a "stranger" or "outsider."

Likely a result of both the aforementioned strengths, perhaps the central strength of the present study was the richness of the data offered by the participants. The semi-structured interview format used to gather data allowed

respondents to offer as much information as they felt comfortable, and many of the participants were interested in having an opportunity to speak at length about their experiences. Given the potential range of experiences participants could have had, they were asked generally to talk about what dating and sex had been like for them as young Black GBMSM living with HIV. This broad questioning allowed participants to discuss the aspects of their experiences they found most relevant and allowed areas of content to emerge that had not been initially considered by the researcher. For example, while the researcher expected to talk with participants in serodiscordant relationships, he had not expected to speak to multiple participants in serodiscordant relationships that had begun before seroconversion. As such, he had not considered the potential challenges associated with one partner undergoing seroconversion during a dating relationship while the other maintained a negative status. In addition to the emergence of unexpected areas of content, the open approach taken in the interviews for this study facilitated participants becoming sufficiently comfortable to share deeply personal experiences that could have otherwise been missed (e.g., feeling substantial loss of intimacy due to diminished or fully eliminated contact with partners' seminal fluid). The level of depth the participants were willing to offer provided ample material to analyze and allowed the researcher to articulate textured descriptions of this population's experiences.

A methodological strength of the present study is the size of the sample. The central relevance of sample size in qualitative data analysis is the pursuit of saturation. In an analysis of sixty in-depth qualitative interviews related to

participation in sexual health research, Guest, Bunce, and Johnson (2006) found that saturation was reached after the first twelve interviews. Further, they found that meta-themes were identifiable as soon as the completion of six interviews. As such, in-depth interviews with 20 young Black GBMSM living with HIV represents a sample of more than ample size to thoroughly explore their experiences.

Conversely, the diversity of the sample may limit what can be learned from the study's findings. More specifically, the socioeconomic demographics of the study's participants may not accurately represent the diversity of the population and therefore the narratives described may be particular to a demographic with a lower socioeconomic status. Only 25% of participants in the study had completed college, and the mean annual income was \$26,000. As such, participants may not have the buffers of privilege afforded to men who shared many of their identities but have higher levels of education and/or incomes.

In addition, participants for this study were recruited in Chicago, a city wherein racial segregation is high. Chicago is ranked as the most segregated metropolitan area in the United States, with nearly 80% of Black citizens living in primarily Black neighborhoods (Grabinsky & Reeves, 2015). As such, the racial experiences of participants in this study may be specific to individuals who live in cities wherein neighborhoods are overwhelmingly racially homogenous and intimate contact between persons of different racial backgrounds is less common.

Conclusion

Given the cataclysmic impact of HIV on same sex attracted men in the 1980s and 1990s, research related to HIV has tended to focus on prevention of transmission. As such, more thorough examinations of the sexuality of individuals living with HIV have been scarce. Beginning in the late 1990s, the Seropositive Urban Men's Study (SUMS; 2003) sought to examine as thoroughly as possible the intimate relationships of GBMSM living with HIV. However, data collection for SUMS began just as HAART transformed what it meant to live with HIV. While proximal death had seemed an inevitable conclusion before HAART, the epidemic was preparing to shift toward one of chronic disease in the United States. As such, it was necessary to revisit a thorough analysis of intimate relationships for GBMSM living with HIV.

In the 2010s though, the population most impacted by HIV is not GBMSM generally, but GBMSM who are young and Black. Although research examining the lives of this population has tended to follow the trend of narrowly focusing on risk of transmission (cf. Feldman, 2010; Sullivan et al., 2009; van Kestern et al., 2007), there is a slowly growing literature which examines the lived experiences of this population more broadly. It could be argued that researchers have been saying for years that individuals living with HIV are more than vectors of disease. Too often this assertion has been made in the discussion section of their studies, but this body of new works represents a move toward instead building studies upon this assertion.

In recent years, researchers like Matthews and colleagues (2016) have produced work which challenges how the HIV syndemic is understood in relation

to Black GBMSM. Earlier work by Greg Millett and colleagues (2007) challenged the notion that Black GBMSM were differentially impacted by HIV due to a higher rate of risk behaviors. Millett and colleagues identified the role of isolated social and sexual networks in the rate of HIV incidence among Black GBMSM. Matthews and colleagues (2016) extended this work by challenging researchers to not only examine the effects of these isolated sexual networks, but also the hegemonic structures which propagate the isolation of Black GBMSM. This challenge is a necessary step forward in humanizing Black GBMSM generally but particularly Black GBMSM living with HIV. This challenge demands a consideration of the fact that these men are human beings being impacted by the systems in which they live, many of which are antagonistic to these men's existence.

In addition to the research which works to complicate how we understand the HIV epidemic and its relationship to Black GBMSM, there are researchers examining avenues for improving the quality of life for Black GBMSM living with HIV. For example, Boone and colleagues (2016) conducted a study examining the role of multiple forms of stigma (i.e., related to sexual identity and HIV respectively) in Black GBMSM's experiences of psychological distress. They found that the gay-identified men in their sample experienced increased psychological distress related to internalized homophobia, and the HIV-positive men in their sample experienced increased psychological distress related to internalized HIV stigma. While perhaps unsurprising, these findings highlight specific avenues for interventions intended to improve quality of life for Black

BGMSM living with HIV. Another study examining factors which could be shifted in order to improve the quality of life for this population was conducted by Dale and colleagues (2015). In their study, Dale and colleagues sought to better understand how poverty and stressors related to poverty placed Black GBMSM living with HIV at risk for violence. They found that living in areas of high poverty was associated with a higher incidence of experiencing hate crimes and other forms of discrimination. These findings are particularly relevant to understanding the kind of stressors that impact this community and highlight the impacts of SES on the lived experience of Black BGMSM.

The findings of the present study fit into a third category of research examining Black BGMSM living with HIV absent a narrow focus on transmission risk. This third category of research includes studies which seek to broaden understandings of this population's internal experience and day-to-day life. For example, a study by Bruce, Harper, and the Adolescent Trials Network for HIV/AIDS Interventions (2012) explored the future life goals of gay and bisexual emerging adults living with HIV¹⁸. Among the findings of this study were that many of these men desired long term relationships and children in their future. In a world where young Black BGMSM can face incarceration for engaging in sex, it is important to understand that many of them maintain goals and dreams related to healthy intimate relationships. In many ways, the findings of the present study follow directly from such an understanding.

¹⁸ Though their sample was not solely Black, the majority of the participants (31 of 54) did identify as African American or Black.

The findings of this study demonstrate that young Black GBMSM are far more complex than their potential to spread disease. In fact, the findings of the present study present four considerations for individuals interested in understanding or impacting young Black GBMSM living with HIV. First, a narrow focus on these men as primarily vectors of disease is one of the factors which continues to harm them. The specter of transmission colludes with stigma, dated understandings of HIV, and ignorance to limit the ways young Black GBMSM living with HIV can engage in intimate relationships. Secondly, stigma, ignorance, and the devaluation of young Black GBMSM living with HIV puts them at risk for victimization by partners and limits their willingness or ability to exit unhealthy intimate relationships. Thirdly, an accurate narrative of young Black GBMSM's experiences must be nuanced. It must attend to the impacts of intersectional oppressions experienced by these men, but must also recognize the incredible strength evidenced by these men as they navigate this oppression. Despite the challenges identified by participants in the present study, these young Black GBMSM living with HIV demonstrated that they still manage to become close with others and build intimacy. Lastly, although these men live in a world that tends to view them myopically and with limited expectation for their success or thriving, young Black GBMSM still manage to find connection and maintain hope for what kinds of connections may yet be possible in their futures.

As the landscape for prevention and intervention continues to grow with modern prophylactic technologies and improvements in health education provide for a more informed public, it would appear that young Black GBMSM may have

all the more opportunity for intimacy. As the collective consciousness of those around them is raised and a priority is placed on seeing these men as the full and complex human beings they are, there is hope that these men will have every chance to live and love, unfettered, without fear or shame.

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Appendix A

Screening Questionnaire

**DATING AND SEX FOR YOUNG BLACK GBMSM LIVING WITH HIV
SCREENING QUESTIONS**

1. How old are you? _____ years
If not 18 to 29, check ineligible.
 Ineligible
2. Were you born as biologically male or female? _____
If not male, check ineligible.
 Ineligible
3. Do you currently identify as male or female? _____
If not male, check ineligible.
 Ineligible
4. Do you consider yourself to be either Black or African American? _____ [If not] do you consider yourself to be bi-racial or of mixed race, with at least one African-American or Black parent? _____
If "no" to both questions, check ineligible.
 Ineligible
5. In the past 12 months, have you engaged in or desired to engage in dating or sex with another man? _____
If "no," check ineligible.
 Ineligible
6. Are you currently living with HIV? _____
If "no," check ineligible.
 Ineligible

CLOSING

Ineligible: Participants for this study are selected based on the questions you were just asked. Based on your answer(s), you are not eligible to participate. Thank you though for taking the time to speak with me about our study.

Eligible: Thank you very much for the information you provided. Based on your answers, you are eligible to participate in the HEART Study. That means that if you want to participate in the research, you may. Do you think you might be interested in taking part in this project?

[If no, thank the participant for his time. If yes, review the consent form with him and schedule an interview time.]

Participant Name: _____ Date of Birth: ____/____/_____

Researcher Name: _____ Signature: _____

Date: ____/____/_____

Appendix B

Demographic Questionnaire

DATING AND SEX FOR YOUNG BLACK GBMSM LIVING WITH HIV
DEMOGRAPHIC QUESTIONNAIRE

1. What name would you like to be called during the interview?
2. How old are you?
3. At what age were you diagnosed with HIV?
4. Are you currently under a doctor's care for your HIV?
5. Are you currently taking medication to manage your HIV?
6. What were your most recent viral load and CD4 count?
7. How would you describe your sexual orientation?
8. What is the highest level of education you have completed?
9. What is your job or occupation?
10. What is your current yearly income level?
11. When you were growing up, what were the highest levels of education completed by your parents?
12. When you were growing up, what were your parents' jobs or occupations?
13. When you were growing up, what were your parents' yearly income levels?
14. In the past 12 months, how many dating relationships have you been involved in? How many have been with men?
15. Are you currently involved in at least one dating relationship? How many? How many are with men?
16. In the past 12 months, how many sexual relationships have you been involved in? How many have been with men?
17. Are you currently involved in at least one sexual relationship? How many? How many are with men?

Appendix C

Semi-Structured Interview Guide

**DATING AND SEX FOR YOUNG BLACK GBMSM LIVING WITH HIV
INTERVIEW GUIDE**

Overall Research Question: What is the experience of engaging in dating and sexual relationships for young Black GBMSM living with HIV?

First, I would like to tell you about the interview we'll be doing today. The interview will help me learn from you what the experience of dating and sex is like as a young Black [sexual orientation] man living with HIV. As we talk, feel comfortable saying as much as you would like. The more you tell me, the better I'll be able to understand your experience. I understand that dating and sex can be sensitive subjects. Know that I am here to listen and learn, not to judge. I am simply interested in gaining a better understanding of this experience. There are no right or wrong answers to these questions. All that is important is that you share the truth of your experience. And again, as we discussed, everything you say will be kept completely confidential.

[Turn on recorder.]

PART I: Being a Young Black GBMSM Living with HIV

Let's begin with some general questions.

1. Tell me about yourself.
 - a. What does it mean to be a young Black [sexual orientation] man living with HIV in the US?
 - b. What does it mean to you?
 - c. What does it seem to mean to other people?
2. How would life be different if any of those things were changed? Being young? Being Black? Being [sexual orientation]? Living with HIV?

Part II: Dating Life

Next I would like to delve into your experiences with dating relationships.

1. When I say "dating relationships," what does that mean to you?
2. What have dating relationships been like for you, as a young Black [sexual orientation] man living with HIV?
 - a. What kind of partners do you pursue?
 - b. What kind of partners pursue you?
3. How do you think the various parts who you are and what you do impact your dating experience? [*if respondent is unclear about meaning*] What I'm referring to is your age, your race, sexual orientation, and HIV status.

- a. Impact on desire/willingness to date?
 - b. Impact on feelings of attractiveness?
 - c. Impact on partner selection?
 - d. Impact on health of the relationship?
4. When I say “healthy dating relationship,” what does that mean to you?
- a. What would constitute a healthy dating relationship for you?
 - b. What, if anything, could help to ensure the health of your dating relationships?

PART III: Sex Life

In the next part of the interview, I want to focus more specifically on your experience of sexual relationships.

- 1. When I say “sexual relationships,” what does that mean to you?
- 2. What have sexual relationships been like for you, as a young Black [sexual orientation] man living with HIV in the US?
 - a. What kind of partners do you pursue?
 - b. What kind of partners pursue you?
- 3. How do you think the various parts who you are and what you do impact your sexual relationships? [*if respondent is unclear about meaning*] What I’m referring to is your age, your race, sexual orientation, and HIV status.
 - a. Impact on desire/willingness to date?
 - b. Impact on feelings of attractiveness?
 - c. Impact on partner selection?
 - d. Impact on particular sexual behaviors he engages in?
 - e. Impact on health of the relationship?
- 4. When I say “healthy sexual relationship,” what does that mean to you?
 - a. What would constitute a healthy sexual relationship for you?
 - b. What, if anything, could help to ensure the health of your sexual relationships?

PART IV: Closing

- 1. We’ve talked about a lot today, and I thank you for how much you have been willing to share with me. So, with all that said, what do you think your dating relationships will be like going forward? Your sexual relationships?

That was my last question. Thank you for sharing with me. Your contribution will certainly help me better understand this experience.

[Turn off the recorder, and thank the respondent for his time.]

Appendix D

Finalized Thematic Map

A Qualitative Exploration of the Dating and Sexual Relationships of HIV-Positive
 young Black GBMSM
Hierarchical Themes & Codes

Meta-Theme

- *Theme* – theme definition
 - Subtheme – subtheme definition
 - “Representative Quote”

Being young Black GBMSM Living with HIV

- *Broad experiences as young Black GBMSM living with HIV* – experiences that were either nonspecific to particular identities, a product of multiple identities, or manifested similarly across multiple identities; not specific to any kind of intimate (dating or sexual) relationship
 - Feeling the same as others – experiences that demonstrated that the individual was not different from non-marginalized others
 - Calvin: I do the same things everybody else does. I live. I eat. I breathe. I sleep. I work. Pretty typical average life.
 - Mason: What’s it like being me? Like being anybody else. Life is life. You know?
 - Life as more challenging – experiences that demonstrated that the individual’s life was harder than non-marginalized others
 - Franklin: I watch my surroundings, being a young Black man in these days. And being gay makes it worse. There could be danger.
 - Samir: Being gay is already one strike. Having HIV just adds to it.
- *Experiences related to Black identity* – experiences that were related to the individual’s identity as a Black man; not specific to any kind of intimate (dating or sexual) relationship
 - No impacts of race – experiences that demonstrated that Blackness did not impact their lived experience

- Others' assumptions about bisexuality – experiences related to having characteristics ascribed to the individual solely due to their bisexual sexual orientation
 - Joshua: It's a negative connotation and stigma attached to our [bisexual] community. It's almost like, with the Black community, if you tell somebody you're bisexual, they automatically attach [HIV] to you, which is not necessarily the case. In some cases sometimes, it's almost easier to disclose your HIV status to someone in the gay community as opposed to disclosing your sexual status to someone who's straight.
- HIV as an inevitable outcome – experiences related to a belief that all gay/bisexual men will eventually become HIV-positive
 - Allen: Before, I was just the cool guy. I still am, but if I disclosed [my HIV status], then it would just be like...I would feel as though they would look at me like I'm another statistic, another young, gay, Black man who contracted HIV, probably because he was gay.
 - Benny: I expected it. I really did. I don't know how else to say it, but I knew somewhere down the line that I would probably have it or get it.
 Interviewer: When did you know that?
 Benny: Probably after my first STD.
 Interviewer: How old were you?
 Benny: Like 14, 15.
- *Experiences related to HIV* – experiences that were related to individual's identity as a person living with HIV
 - Changes in self-concept – experiences related to changes in how the individual perceived himself
 - Franklin: You don't think you're cute. You think it's the end of the world. Nobody's going to want you. You think

you're ugly. You're bad goods. Spoiled product. You think it's over. Nobody's going to want you. They're not going to see the pretty smile or the pretty eyes or the cute face or the masculine features about you. They're going to see HIV.

- Joshua: I had self-esteem issues prior to [diagnosis]. Everyone has a little self-esteem issues that they overcome eventually. When I initially find out that I had HIV, yeah, it bothered me a lot. It was depressing, and I just went through this whole ugly phase, I don't want to be bothered. I just wanted to be alone. Blah. Blah.
- Impacts of HIV treatment – experiences related to how taking treatment for HIV impacted the individual
 - Nolan: The first year, I was in denial. I would say it was a back and forth thing. I'd take it for a month or two. Then I wouldn't take it. I would say the longest, in that two year span, that I was off it for about six months. But the second year, I felt like it needs to be taken regularly, because I kept having issues. Felt like my body was falling apart. But when I took my medicine, I was okay. Everything was okay.
 - Tevin: The first year, I was in denial. I would say it was a back and forth thing. I'd take it for a month or two. Then I wouldn't take it. I would say the longest, in that two year span, that I was off it for about six months. But the second year, I felt like it needs to be taken regularly, because I kept having issues. Felt like my body was falling apart. But when I took my medicine, I was okay. Everything was okay.
 - Ellis: Sometimes taking my medication makes me feel depressed. It's like, who wants a daily reminder that they're dying?

- Fears related to HIV status – experiences that demonstrated particular fears that rose from living with HIV
 - Ivan: I have to be afraid of things that [HIV-negative people] don't. The weather outside today could take me away. For other people, it's fine. They can get by. If I go out and I'm not dressed right for the weather, I could get sick and die.
 - Calvin: I'm worried about what will be said about me if I die from HIV. What will they say? I don't even want to know.
 - Franklin: People would treat me differently if they knew my status. They'd be afraid of getting it from me.
- Impacts of HIV on platonic relationships – experiences related to how HIV changed relationships with family and friends
 - Hendry: My friends and family who are informed about HIV...they treat me well. They know they aren't at risk.
 - Ellis: My friends have been supportive since I told them about my diagnosis. Some of them [have] HIV, so they already know about it.
 - Mason: Being black and gay isn't a problem with the gays. Being Black, gay, and HIV-positive means you're diseased now. Nobody wants to be with you now. That whole dream of being with a man and getting married, with two kids...it's not any more. You're being stricken by whites for being black. You're being stricken by Blacks for being gay. And now you're being stricken by gays for having HIV. So now you have 3 crowds of people at you that you have to watch and be aware of. They don't look at you as a person. They look at you as a disease.
- Feelings of increased responsibility – how HIV led to a desire to engage in healthier behaviors; includes increases in HIV and STI

education post-diagnosis and other health-positive behaviors, like treatment adherence

- Franklin: I have to be more responsible now. I have to take my medication on a regular basis. I have to talk to people about my status. I just have to do better in general about my health.

Experiences in Dating Relationships

- *Dating experiences as related to Blackness* – experiences in dating relationships impacted by the individual’s Black identity
 - Reasons for racial homophily – reasons the participant primarily dated other Black men
 - Calvin: I’ve majority have dated black guys, or black people in general.
Interviewer: Why is that?
Calvin: Why? I don't know, probably because my environment, probably. Well I can't say that. I went to interracial schools. I don't necessarily know if that has anything to do with it. Probably at the convenience of the environment, people that I work for, with or been in the same circle with, or you know, networked in the same circle. Words exchanged, people started liking each other, and stuff like that. I think that's the biggest thing.
 - Experiences of dating non-Black men – experiences in dating relationships with non-Black partners
 - Interviewer: What's been your experience dating outside your race?
Darryl: It's about the same. There's assholes and jerks. There's liars. It's the same. It's really the same.
Interviewer: Are there any good ones?

Darryl: I don't know where they at. You let me know where they at, I have no idea where they at. They're on an island somewhere. I have no idea.

- Darryl: I have not really had an experience disclosing myself to any people outside of my race.
- *Impacts of HIV on new relationships – dating experiences impacted by the individual's HIV-positive status*
 - Changes in interest – changes in the individual's interest in dating
 - Samir: At first, I was scared to date, because I didn't think anyone would want me, especially with the depiction of what being Black and gay and HIV-positive looks like. Now, it doesn't impact my willingness to date. It took 2 good strong years to want to date again.
 - Interviewer: If you were single again, how would HIV impact your willingness or desire to date?
Allen: I really wouldn't want to date.
Interviewer: You wouldn't want to date if you were single again? Why?
Allen: Because then, getting to know somebody and having to say that, having to disclose that, is my biggest thing. Because I don't want to. I don't to have to tell somebody that. I barely want to have it myself. I barely want to tell myself that. I barely want to take the medicine.
 - Possibilities for future dating – individual's beliefs for how future dating relationships could or would be
 - Oscar: I feel like everybody still likes me and wants to fuck me, but if they found out [my HIV status], then I'd become instantly unattractive to them. They wouldn't want to date me.
 - Benny: I see endless possibilities, especially now with the emergency new medicine and technologies and stuff.

- Lamont: There's people out there that don't look at the fact that you have HIV. They don't care. It's something that they feel like, if they want to be with you, that you're going to deal with together. And you deal with it together. So, yeah, there's hope.
- *Impacts of HIV on existing relationships* – experiences related to how things changed after becoming HIV-positive while in a relationship
 - Fear of contamination – experiences related to a partner not wanting to engage with the individual's potential germs (i.e., HIV) and/or the individual's fears of exposing a partner to his germs (i.e., HIV)
 - Allen: Non-sexually, there really aren't that many differences [in our relationship since my diagnosis], besides having to make sure my toothbrush doesn't touch my toothpaste. My guy wipes the seat down after I use the bathroom or before he uses the bathroom, which he never really did before. I have to worry about getting him contaminated or anything like that, like with my blood. If I cut myself, because we use the same utensils, I have to put alcohol on them or he has to put alcohol on them before he uses them, which we never had to do before. That's pretty much it. It's sad, depressing. That's really the only way I can describe it. It's depressing because it makes me think about my status. It's also depressing that I have to go through these measures to ensure somebody else that I love's safety.
 - Quincy: He would grab the condoms before me. You could see that as him being okay with it, but I felt it was like, “Yeah. Get the condoms. I don't want to catch HIV from you.” Sometimes when I'd wash the dishes, he'd say, “Oh. You don't use bleach water when you wash the dishes?”

Why would I? And he'd say, "Oh. Just to kill germs." And I'd say, "HIV germs?"

- Decreased sexual frequency – experiences related to a reduction in how often their dating partner desired to engage in sex
 - Ellis: Sexually, we don't really have sex anymore. He's scared of coming in contact with my pre-cum. We can't do certain stuff. He can't suck my penis, because he's scared of coming in contact with my fluids and things like that. We hardly ever do it anymore. Maybe it's because of me, and I don't want to.

Interviewer: Do you not want to?

Ellis: No, I kind of do, but I just feel like I'm protecting him kind of. I don't really like to use condoms, and adjusting to using condoms was hard for me. So we just kind of stopped, and now all we do really is just masturbate together, so we really don't even come into sexual contact intercourse-wise. I rarely even suck his penis anymore.

- Decreased repertoire of sexual behaviors – experiences related to how the sexual acts in which the couple engaged changed after diagnosis
 - [see above]
- Decreased feelings of intimacy – experiences related to how HIV has made the couple feel less close
 - Rasheed: [The impact of HIV] has been terrible. It impacted the health of it all, because now, we seem distant, without that closeness and that exchanging of bodily fluids, I want to say, or even the option be able to. It's depressing that you can't do everything that you once used to do, or that you can't enjoy every part of your partner like you used to or that they can't enjoy you in the ways that you used to. Sharing bodily fluids, that was a major thing before.

- Feelings of insecurity – experiences of feeling unsure of the future of the relationship due to HIV
 - Allen: The sexual side of [our relationship], it's not healthy, because we have restrictions and limitations on what we can and cannot do, so that, in my mind, causes him to have a want and desire for something he can't get from me, which will probably lead to cheating or something.
Interviewer: Does “probably” mean “has” or “could” lead to cheating?
Allen: “Probably” means eventually it's going to happen, whether it has or hasn't now. It more than likely will somewhere down the line, only because I've wanted to experience somebody who would let me suck their dick or some shit like that. I know what I wanted to do, so I'm pretty sure he wanted to do the same shit too.
- Decreased ability to end the relationship – experiences related to feeling unable to end the relationship on his own terms
 - Ellis: Sometimes I wonder, “Why are you with me?” It’s like, we can only get along for a certain period of time and that’s it. It’s weird. We’ve been going through this for a long time, and that’s probably why he is the way he is. Like, “I can say and do whatever I want, because, Guess what? You’re still going to be here.”
- *Qualities of healthy dating relationships*
 - Communication – the importance of communicating clearly with one’s dating partners
 - Franklin: A healthy relationship is seeing each other on the regular. That’s one. Communication. Listening. Good sex. And being there for each other. That’s basically all I can ask for in a relationship. And don’t lie to me.

- Mason: I think healthy relationships express their feelings with each other, whether it be in an argument or civil conversation. Getting stuff out in the open would be healthy.
 - Safer sex practices – the importance of engaging in sex that is minimally risky to both dating partners
 - Kendrick: A healthy relationship? A calm, relaxed relationship where there's no domestic violence. Where you guys are on a healthy track as far as health goes. Like, you basically living your life safe. Nobody's getting beat up in the relationship. There's no STDs being passed back and forth. Y'all are practicing safe sexual habits, like using condoms and stuff like that.
 - Safety from domestic violence – the importance of safety from physical and emotional abuse in dating relationships
 - Darryl: Thinking about a whole lot of different healths. [A healthy relationship] needs to be conducive to a healthy mental state for me. Physical wise, I don't want to have to be whooping on you, because you're whooping on me. And healthy as far as communication goes. Then we get into the physical healthiness and whatever is going on between the two parties, like sex.

Experiences in Sexual Relationships

- *Sexual experiences as related to Blackness* – sexual experiences impacted by the individual's Black identity
 - White men's disinterest in Black partners – experiences of being impacted by White men's dispreference for Black sexual partners
 - Allen: There's a lot of discrimination in the community. A lot of white dudes don't like to have sex with Black guys.

They'd rather fuck a Latino or Indian dude, so I fuck with a majority of Black people, maybe even some Latinos.

- Being fetishized by White partners – experiences of feeling pursued primarily due to racialized sexual features by a White partner; experiences of having a White partner reduce him to a racial caricature for sexual purposes
 - Grant: They always want me to dominate them. They have this idea of the dominant Black top, and I have no desire to be that fantasy. They say stuff like “Destroy me” or “Give me that Black cock,” and it can start to feel gross. They expect you to have some huge porno dick and to use it for their pleasure. No thanks. That’s some bullshit.
- *Relationship between HIV and sexual desire* – experiences related to how HIV has impacted desire to engage in sexual relationships
 - Changes in sexual drive – experiences of having changes to sexual drive after HIV diagnosis
 - Calvin: My sex drive just went away when they told me I was positive.
 - Darryl: Smoking marijuana helps, but, in general, I wasn’t that interested in sex after they told me. It was the least of my concerns.
 - Oscar: The desire is actually still the same. I want to say it's grown more fierce. I want it even more now, because I know I can't do what I used to do [before I was HIV-positive], just have unprotected sex without disclosing.
 - Feeling a loss of sexual freedom – experiences related to feeling limited sexual freedom due to HIV
 - Nolan: [Before HIV, life] was cool. I got to do whatever I wanted with whomever I wanted, without really worrying about any repercussions. Now there are limitations on everything.

- *Impacts of HIV on sexual intercourse – how HIV has impacted the experience of engaging in sex*
 - Increased scrutiny by partners – experiences where the individual was subject to increased scrutiny by partners due to their HIV status
 - Rasheed: Will they double check my dick to make sure there's not open sores or cuts or scrapes, no matter how microscopic they may be?
 - Changes in the range of available/ acceptable sexual behaviors – changes to the kinds of sexual behaviors in which the individual was able to engage due to HIV status
 - Rasheed: Will they fuck me? Will they pull out? Will they put a condom on? Will they let me suck their dick? Will they suck my dick?
 - Joshua: I felt like I was lucky to be having any sex at all, so I let them do whatever they wanted. If they wanted me to bottom, I bottomed. I didn't want to mess it up by asking for anything else.
 - Samir: I wouldn't fuck anybody raw, and I wouldn't let nobody fuck me raw or suck my dick for that matter. I'd just be paranoid [about infecting them].
 - Patrick: If anything, I've added [new sexual behaviors since diagnosis.]. Nothing's stopped.

Interviewer: What was added?

Patrick: Getting my dick sucked. Eating ass. Getting my ass ate more. Being a top. Penetrating someone else. Nipple play on me and on others more. Kissing. I kiss more. Before I never really kissed. It really wasn't a must for me to kiss. I kiss more now. I kiss a lot more.
 - Patrick: I said to myself, as I was getting myself together and taking my regimen on time and on a good basis and

being more aware of my HIV status, I'm going to ask for what I want [sexually]. And if I don't get it, then we're not going to be together.

- *Fear of hurt if partner becomes HIV-positive* – experiences of being afraid that a partner would do harm due to the individual if HIV were transmitted
 - Fear of being publicly outed as positive – fear of one's status being exposed widely
 - Benny: If he becomes positive while we're together, he could tell anybody anything. Like, with social media, people can get on there saying anything they want. The damage is done regardless of what the repercussion is, so you have to be very careful now. You got to be careful what you text. Screenshots. Now it's like you could be tight. You can be thinking you can find someone. You're inboxing them or texting them. But if you make them mad, you'll go on social media and there's a screenshot of it, in your own words, from your own phone, so you can't ... it's really sticky. It's scary really.
 - Fear of legal retribution – fear of criminal or civil proceedings
 - Kendrick: I literally have possibly broken a rule and could be arrested by having sex with somebody and not divulging it, and now it feels like I'm just not safe. A part of me is always wondering what if that person ... I'm undetectable and I pulled out or something, but what if that person gets it and they come after me or something? It's always a fear in my heart.

Interviewer: Come after you in what way?

Kendrick: Want to kill me or something. I've had feelings like that before, where it's just like... [He sighs.] And now it makes me not want to mess around with people for that very reason. All because I don't like using condoms and I

can't enjoy people and people can't enjoy me, and if we do and I don't say anything, then I could go to jail or somebody might want to kill me. You know what I'm saying?

- Fear of being killed – fear of mortal danger after transmission or perceived transmission
 - [see above]
- *Sexual risk negotiation* – experiences of assessing and responding to potential risk to the individual or his partner in a sexual encounter
 - Assessment of partner's level of risk – strategies used to determine the level of sexual risk to the individual posed by the partner, including making inferences about status and overt questioning to assess risk
 - Interviewer: How do you determine if you're going to use a condom?
Calvin: I guess if they're on medication, and how honest they are.
Interviewer: Is there anything that makes you more likely to use a condom with another positive guy?
Calvin: It depends on their circle of friends, are they running with people who are on drugs that shoot up, because if you're messing with needles ... hepatitis and blood to blood contact, different things that people indulge in that are not sexual that makes them risky to me, that would ... if I knew they were running in certain circles I wouldn't.
 - Darryl: You'd be surprised that a lot of these negative people are out here fucking, have sex way more reckless than the people who are not, so then I don't know how negative you really are, because I don't know the last time you've taken a test, and I don't know how accurate it is.

There's just so many underlying things you could have been doing that I have no idea about. You can produce me the [HIV test] results in the last 3 months the same day, but that does not mean you are. It really doesn't make a difference. It makes me almost want to increase [condom] usage because I have no idea about- at least this person [who is HIV-positive] I know that they got something and they're taking care of it. They're following up, they have a regimen, you can hear them on the phone with their doctor, you on the other hand, "Oh I don't have nothing I'm good" and you out here fucking like 41 going north. Makes me sometimes a little more leery, especially if you're younger, 19, 20, 21.

- Adjustment of sexual behaviors as prevention – changes in an individual’s sexual behaviors in order to reduced risk of STI transmission to or from a partner; includes changes to condom use and changes to sexual acts performed
 - Lamont: [Since becoming positive,] even if I’m intoxicated, I use condoms, and I don’t have sex with random people. By random, I mean someone you’re not in a relationship with, not just random people you meet off the street.
 - Benny: Oral sex is kind of almost one of those things where it can be [with any partner]. Then again I don't know, because I don't need any breakouts. I mean, there's other things you can get from oral sex. Genital warts. Herpes. You can even get chlamydia and Gonorrhea. Viral infections.
 - Franklin: I’m not a big fan of a dental dam for anal oral sex, but when you’re sucking someone’s penis, I think you should use a condom. It’s just safer.

- Partner selection as prevention – selection of partners who will pose least risk to the individual’s sexual health and to whom the individual will pose least risk; specific to choices made related to risk reduction; includes consideration related to partners, regardless of HIV status
 - Mason: I ask [partners] what medicines they take and if they are resistant to certain things, and I think maybe if we have the same strain, that we can do it without condoms. I mean, it sounds kind of legit. If you have the same strain, you're taking the same medicine. Even if you're taking different medicine, as long as you have the same strain and you're resistant to the same [medications], it's like eating your own pre-cum. It can't hurt you really, because you have the same type.
 - Oscar: I guess if a person like me was undetectable and the other person maybe was on PrEP or something, we could be a little bit more open sexually. We wouldn't have to worry about HIV like that, so we could really be close and it would be safe.
- *Qualities of healthy sexual relationships*
 - Communication – the importance of communicating clearly with one’s sexual partners
 - Rasheed: Anything healthy has honesty and communicating. Likes. Dislikes. Sexual history. Like, are you having sex with just me right now, or are you not? When's the last time you've been involved with someone?
 - Safer sex practices – the importance of engaging in sex that is minimally risky to both sexual partners
 - Tevin: Jacking off together is safe sex.
 - Franklin: Healthy sex, to me...I'm not a fan of the dental dam, but I think healthy sex is when two people take

showers and they use condoms, all the way through from the beginning to the end. For oral sex too. Especially if you don't know them. If you're in a relationship, maybe, but if you're still getting to know someone, you should use a condom when you're being penetrated and when you're doing oral sex.

Experiences Related to both Dating and Sexual Relationships

- *Selecting partners* experiences related to selecting partners with whom there could be a successful intimate relationship

- Preferences – characteristics of a potential partner that were preferred by the individual

- Calvin: I'd like to meet a trans man.

Interviewer: Are you opposed to male to female trans folks?

Calvin: Me personally? No, that's not up my alley.

Interviewer: So trans women are not an option?

Calvin: Not up for consideration.

Interviewer: But anyone who identifies as a male right now is possibly an option?

Calvin: Mm-hmm (affirmative)

- Darryl: I don't prefer feminine guys. I prefer guys that are discreet about what they do, meaning that they use some type of discretion and don't necessarily have to wear their sexuality on their sleeve. It's not everyone's business to know that you're some big flaming homosexual. I mean, if that's how you carry yourself, I have no problem with it. But as far as to be with me, I don't particularly care for that.
- Franklin: I'll say, if [my partner is] HIV-positive, it's a relief, because you can be like, "I'm HIV-positive" and if they say, "Okay, I am too." It's like... [He sighs with

relief.] Okay. I think that's the plus side. The plus side of dating someone that's not positive is that they don't have it, so you have to be aware. You have to make sure they're protected. That's my only minus for them. From my experience, I can't see any negatives to dating another positive person. I think they may be the best partner for a positive person, because they know what you're going through in a sense. So yeah, I don't think there's any negatives. I would say a negative person, in my experience, pushes you more and is more concerned about your regimen and you taking your pills and being safe than a person that's not. A person that is positive, they don't really care about your pills. They're not quick to get a condom or all that stuff. A negative person is. I would say that's a plus for the negative and a down for the positive. They're not as aware. They're not as on it as they should be.

- Finding partners – experiences related to locating and/or meeting suitable potential partners
 - Oscar: [Positive guys] are hard to find. Not everyone wants to be open about it, and I have been on BGC, Adam4Adam, Grindr and Scruff. Nobody displays that.
 - Interviewer: What about a dating site for people who are positive?
 - Oscar: I can't find one. I can't. I've looked. I've even looked online for chat support groups and I haven't found any. There was one, but they recently stopped it in September or October. They ended the chat portion of it, so I don't even know where any of that is, but I've looked. I've Googled it.
- Role of HIV in potential partner pool – experiences related to how HIV has impacted the pool of available and/or suitable partners

- Franklin: You've got to find someone who will be able to handle this. It's not a walk in the park.
- Benny: I don't think necessarily some people care. It's not a factor for some people.

Interviewer: When you say don't care, do you mean...?

Benny: About people's status. Because either they have [HIV] and they take care of themselves, or they're taking PrEP now. It's more effective than a condom, at least if the person that's taking PrEP, they're taking it every day consistent.

Interviewer: So do you think PrEP is a major factor in how guys negotiate HIV risk?

Benny: Now, it's not a major factor yet, because a lot of people are not educated on it. People are just really now starting to get...I've known about it for a couple of years now. Everyone's like, it's this new thing. This shit has been going on. This is not new. A lot of people, again, don't know about it.

- *Navigating disclosure in relationships* – experiences related to disclosing one's HIV-positive status to partners and potential partners
 - Willingness – how willing an individual has been to disclose their HIV-positive status
 - Interviewer: How many partners have you disclosed to since your diagnosis?

Darryl: Maybe two or three, maybe three.

Interviewer: What have those experiences been like? Have they been good, bad, mixed...?

Darryl: They were fine. They disclosed to me first so I didn't have anything to worry about.
 - Interviewer: What makes disclosure easier with other poz folks?

Darryl: Because it was a commonality already. I didn't have to worry about...it's almost like quid pro quo. I don't really have to worry about you breaching my source of security, because you also worrying about the same thing.

- Interpersonal risks – potential negative effects on social relationships after disclosing HIV status
 - Allen: Fags is messy. They will run back and tell everybody else, so then nobody else is going to want to date me. So then I'm going to be the motherfucker that be like, “Oh girl, watch out, he cooked,” or “He got that shit.” That's really how it is.
 - Patrick: I had to use my knowledge of knowing my rights regarding HIV. I let it be known, if you say this and that, I can do this and this. They would say, I'm going to go on Facebook and tell everybody that you have HIV. And I said, “I'm going to go to the police and tell them that you're telling people about my diagnosis, and that's basically harassment. And you're bullying me.” Especially if they're doing it on Facebook and all these other social media apps, I'll go contact a lawyer and press charges.
- Intrapersonal risks – potential negative effects on self-concept after disclosing HIV status
 - Joshua: If I disclose to you and you don't even cross into the potential category, it's like I wasted my time, I'm getting old. I don't have a lot of time anymore.
- Benefits of disclosure – potential positive outcomes of disclosing HIV status
 - Rasheed: I put it on my [dating app] profiles, so I don't have to weed through the guys who aren't interested. I am who I am. They can take it or leave it.

- Kendrick: It can be nice, because they'll like remind you to take your meds. "Did you take your meds today?" "Oh. No. I forgot." "Well, you better take them." "Thanks, babe." That kind of thing is nice.
- Disclosure decision making process – the process through which the individual decides whether to disclose their status to partners and potential partners
 - Quincy: You never know what they're going to do. They could be fine with it, or they could be like, "Oh, okay. Let me call you back." And then you call them and their number is changed. Or they become ghost.
 - Patrick: If you're in a relationship, I think you should be honest with that person [about your HIV status]. I don't think you should lie about that. In a sense, you don't have to tell them. You could just use a condom until the day y'all die. But I just think it's better knowing. They're going to see your medicine. I just think it's better that way. I don't want to hide something like that, because it's part of me. And I'm not embarrassed of it anymore. So why not?
 - Lamont: It's easier, because there's always this fear of talking to new people, because, unfortunately, you're going to have to tell them one way or another. Of course, you could get into a relationship and just use condoms and not even tell them, but I think it's only right that if you get with someone, you tell them. I think that should be part of the conversation when you're getting to know them. What's your favorite color? What's your mom's name? I'm HIV-positive.