Strengths and Resiliencies of Black MSM in New York City Who Maintain HIV-Seronegativity

Jagadisa-devasri Dacus

The Graduate Center, City University of New York

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STRENGTHS AND RESILIENCIES OF BLACK MSM IN NEW YORK CITY WHO MAINTAIN HIV-SERONEGATIVITY

by

Jagadisa-devasri Dacus

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

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This manuscript has been read and accepted for the Graduate Faculty in Social Welfare
in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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THE CITY UNIVERSITY OF NEW YORK
ABSTRACT

Strengths and Resiliencies of Black MSM in New York City who Maintain HIV-Seronegativity

by

Jagadisa-devasri Dacus

Advisor: Harriet Goodman, Ph.D.

Abstract:

Black gay, bisexual, and other men who have sex with men (MSM) carry the greatest burden of the HIV epidemic in the United States. Because Black MSM’s identities lie at the intersection of race and sexual orientation, they are more likely to experience negative social determinants of health, which have been associated with greater HIV acquisition. However, the majority of Black MSM maintain seronegativity, but few public health studies have identified what contributes to their seronegativity maintenance. In order to address this gap in knowledge, I explored maintained HIV-seronegativity among a cohort of Black MSM in New York City (NYC). Guided by social work’s strengths-based approach, I employed constructivist grounded theory building on sensitizing concepts from extant theories to explicate how Black MSM demonstrate resilience amidst high seroprevalence in NYC. Results from this study suggest that their unique strategies, strengths, and resiliencies are indubitably interconnected with their intersecting identities as Black men. Their strengths and resiliencies for maintained seronegativity originate from survival strategies that Black people have employed for generations.
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CHAPTER 1: PROBLEM FORMULATION AND STATEMENT OF RESEARCH

Blacks in the United States have experienced an HIV/AIDS health disparity that has not improved since the beginning of the epidemic in the early 1980s (Centers for Disease Control and Prevention [CDC], 2017a; Kaiser Family Foundation [KFF], 2017). Among American Black populations, Black gay, bisexual, and other men who have sex with men (MSM) are the subpopulation most affected by HIV/AIDS (CDC, 2017b; KFF, 2017). Since the identification of HIV infection primarily from sexual contact particularly among gay, bisexual, and other MSM, Black MSM have carried the greatest burden of the epidemic. This is significant because Black MSM’s race and sexual orientation identities co-occur. Because of this co-occurrence, Black MSM have more negative social determinants of health such as poverty, insufficient healthcare, lack of education, and increased incarceration rates; these are all known HIV risk factors. Researchers have termed these factors as syndemics (Singer & Clair, 2003; Singer, 2009), which is when multiple afflictions positively interact and contribute to the excess burden of HIV infection within a population.

HIV Seroprevalence among Black MSM

For more than 35 years, the HIV/AIDS epidemic has been a pervasive public, social, and sexual health problem in the US. HIV, the virus that causes AIDS, is an example of how a sexually transmitted infection left untreated and unattended can have a devastating impact on a national scale. The original groups identified as most heavily affected by HIV/AIDS were the 4Hs: homosexuals (gay men), hemophiliacs, Haitian immigrants, and heroin injectors (Gallo, 2005). With the exception of hemophiliacs, they remain at risk and continue to be some of the most marginalized and disenfranchised groups today. Blacks were among these original “high risk” groups (Black AIDS Institute, 2012; Gallo, 2005), and this population has experienced the
greatest burden of HIV infection (KFF, 2017).

During the initial years of the epidemic, physicians paid little attention to HIV’s affect in Black communities. This was an example of the historical neglect of Black people by the medical establishment. Researchers did not include Black MSM in the early reports and drug trials because HIV was initially documented in White gay men and labeled “gay cancer” and then gay-related immune disease (GRID) (CDC, 1981; Friedman-Kien et al., 1981; Gottlieb et al., 1981; Siegal et al., 1981). Originally, physician-researchers only considered the epidemic among White gay men. Gottlieb, the lead author of the historic 1981 HIV/AIDS report, speculated that if the two additional documented cases of AIDS patients, who were Black men (one of whom was gay), had been included in the report, “…I think it might’ve made a difference [in the epidemic] among gay black men” (Villarosa, 2017, para. 19). Gottlieb explained that the two cases were not included because they were discovered after the report had been finalized and that he and his colleagues were already, “working in the dark,” to understand what has happening with those early cases (Villarosa, 2017, para. 20).

From the beginning of the epidemic, public health and social sciences researchers paid scant attention to the health and well-being of Black MSM. Earlier recognition among Black MSM could have led to prevention efforts from the outset (Black AIDS Institute [BAI], 2012; Millett & Peterson, 2007; Villarosa, 2017). Earlier attention could have resulted in more advocacy, resources, government intervention, access to prevention (BAI, 2012; Millett, 2015; Villarosa, 2017), and lower seroprevalence in Black MSM. This is especially true for Black MSM who maintained seronegativity, which is the phenomenon of interest for this research. How and why Black MSM maintain HIV-seronegativity are important questions that this
research seeks to answer. Their strengths and resiliencies for maintaining seronegativity warrant explication.

The last U.S. Census (United States Census Bureau, 2010) found that Blacks represented approximately 14% of the total population; however, half of the estimated 1.2 million people living with HIV in the US are Black (CDC, 2017b). These HIV data were continually collected from 37 states and 5 US dependent areas with long-term, confidential name-based HIV infection reporting. These data indicate Blacks’ infection rates are eight times higher than rates are among Whites (CDC, 2013b, 2017a). One in 16 Black men and 1 in 32 Black women will receive an HIV diagnosis during their lifetimes (CDC, 2013a, 2013b, 2017a).

Among all groups classified by behavioral risk, seroprevalence rates are highest for gay, bisexual, and other MSM. Infection rates in MSM have continued to increase since the early 1990s (CDC, 2005, 2006, 2008, 2009, 2012, 2015, 2017d) due to increased rates among Black and Latino MSM (CDC, 2017b). Whereas MSM are estimated to be 2% of the US population, they accounted for 67% of all new infections and 55% of all persons living with HIV in 2013 (CDC, 2017b).

By 2010, there were an estimated 10,600 new infections among Black MSM (CDC, 2013c), and in 2015, Black MSM accounted for nearly 12,000 cases of all HIV diagnoses among MSM (CDC, 2017b). In context, Black MSM are only 0.2% of the US population (amfAR, The Foundation for AIDS Research [amFAR], 2015a) and represent more new infection rates than their non-Black counterparts (CDC, 2008a, 2008b, 2013c, 2013d, 2015, 2017b). Even more troubling, HIV infection rates among Black MSM aged 13-24 are higher compared to their age, racial, and ethnic peers (CDC, 2017a). Because Black MSM are more likely to be HIV-positive as compared to the general Black population (CDC, 2013d, 2017c; Millett et al., 2012), “Black
MSM in the United States now experience rates of HIV infection that rival those among the general population in the developing world” (Peterson & Jones, 2009, para. 4). These researchers’ declaration still rings true as indicated by a recent Black AIDS Institute report (BAI, 2012) and by extant federal public health epidemiological reports. Additionally, by the time Black MSM reach age 25, one in four will be HIV-infected, and by age 40, 60% will be HIV-positive (BAI, 2012). Further, a recent CDC study has predicted that 50% of all Black MSM will be diagnosed with HIV within their lifetime (CDC, 2017b, 2017c). These statistics paint a grim picture for Black MSM. Researchers have speculated that even if interventions would lower Black MSM’s seroprevalence rates, it would be decades before a decrease in their infection rates would actually occur (Millett, 2015). Given the effort towards the eradication of HIV, the US government’s inability to reduce seroprevalence among Black people is a failure (amfAR, 2015b, p. 1).

The CDC estimates 13% of HIV infected people are unaware of their seropositive status (2017e). This modest percentage is an artifact of public health campaigns promoting increased routine HIV testing and counseling. However, more than a decade ago, awareness did not focus on MSM. In 2006, preliminary data from the MSM HIV-testing component of the National HIV Behavioral Surveillance System (NHBS-MSM; CDC, 2006) indicated that of the MSM surveyed ($N = 10,000$), most (90%) had never been tested, and 25% ($n = 2,500$) were infected with HIV. Of that group, 48% were unaware of their HIV status. Of the MSM who tested positive for HIV, seropositive prevalence was highest among Blacks at 46% (CDC, 2006). Only one quarter ($n = 2,500$) of the MSM in the study were Black, which highlighted the increased urgency with which HIV/AIDS public health officials needed to address and prioritize HIV in Black MSM. Additionally, in 2006, groups of Black gay male HIV/AIDS health and human service providers
from cities with high HIV-infection rates in Black MSM (Atlanta, Baltimore, Chicago, Los Angeles, Miami, New York, Washington, DC) and HIV behavioral and social scientists mobilized to draw more attention to the large numbers of those infected.

**Public Health Response**

Considerable research has focused on the risk factors for HIV infection in Black MSM. These include high-risk sexual contact with other men (i.e., condomless anal intercourse [CAI]) followed by injection drug use (CDC, 2005, 2006, 2008a, 2008b, 2009b, 2009c, 2013a, 2013b, 2013c, 2013d, 2015, 2017a, 2017b). However, the remaining Black MSM who test and maintain seronegativity has not received much attention. Since the aim of primary HIV prevention is to keep seronegative people uninfected, this group of Black MSM warrants study. After an extensive review of the literature on seronegative Black MSM, I found the public health literature barely addresses maintained seronegativity in Black MSM.

Few public health studies have identified what contributes to maintained seronegativity in Black MSM. Understandably, prior research has centered on how Black MSM acquire and transmit HIV across the life course. Some studies have theorized that the existence of such high seropositive incidence and seroprevalence in Black MSM is a result of the combination of CAI, STI prevalence, lesser uptake of antiretroviral therapy, and intraracial sexual partnering (Millett, Flores, Peterson, & Bakeman, 2007; Sullivan et al., 2014). More recent research has focused on seroprevalence (Millett, Flores, et al., 2007) and more specifically, the “less risk, more effect” phenomenon (Millett, 2015). This phrase has been used to explain why Black MSM are more likely than non-Black MSM to be diagnosed with an STI even though they have fewer lifetime male sex partners, lower rates of substance abuse, less drug use associated with HIV infection, and are more likely to test for HIV (Hussen et al., 2013). This research has focused on
intervention development and implementation in Black MSM populations and concentrated on transmission risks. These evidence-based interventions (EBIs) have demonstrated efficacy among Black MSM at high-risk for HIV (CDC, 2009). However, a significant limitation of these EBIs is that their design does not support the behavior of Black MSM who are at low-risk and/or are already engaging in protective strategies and behaviors. My examination of the public health literature and my research offer a necessary critique related to the dearth of public health initiatives that address HIV prevention through the lens of seronegative Black MSM.

**Statement of the Research**

In order to address this gap, there is a need for further exploration of HIV-negative Black MSM’s strengths and resiliencies to understand the phenomenon of their seronegativity maintenance. This research proposes that biological (e.g., physical development), psychological (i.e., thoughts, emotions, and behaviors), social (i.e., socioeconomic and cultural), and spiritual (i.e., religiosity and belief practice) factors all play a significant role in human functioning in the context of disease prevention. This is a common approach in behavioral and social science research used to understand disease acquisition. It posits that health is best understood in terms of a combination of biological, psychological, social, and spiritual factors rather than purely in biological terms (Hatala, 2013; Santrock, Baxter, & Oatis, 2015). For this study, I define strengths as “often untapped and frequently unappreciated reservoirs of physical, emotional, cognitive, interpersonal, social, and spiritual energies, resources and competencies” (Saleebey, 2002, p. 6). Resilience is composed of a person’s ability to function adaptively despite exposure to risks (Killian, 2004). With these operational definitions, the purpose of this study was to begin a process of inquiry into the phenomenon of maintained HIV-seronegativity in Black MSM. Knowledge gathered from this study contributes to understanding and the identification of key
variables for explaining, predicting, theorizing, and measuring maintained seronegativity in Black MSM for future research studies.

Conducting this study, I employed Gay Resilience Theory and utilized constructivist grounded theory methodology (Charmaz, 2011; Charmaz, 2006, 2014; Herrick et al., 2011; Herrick, Stall, Goldhammer, Egan, & Mayer, 2014) to identify and understand the phenomenon of maintained seronegativity in Black MSM, an under researched and understudied subpopulation. Findings from this study begin to fill the gap in our knowledge about how and why Black MSM maintain seronegativity. These findings have the potential to strengthen and guide HIV prevention policy, education, programming, and intervention development. Although there are two CDC-endorsed interventions specifically aimed at Black MSM (i.e., d-up: Defend Yourself!, Many Men, Many Voices [3MV]; [Behavioral Interventions, 2014]), this study was the first to lay the groundwork for intervention development that is not only culturally congruent, but constructed on the inductively-identified biopsychosocial and spiritual strengths and resiliencies of Black MSM. Further, this research built on recommendations from my pilot study of seronegative Black MSM (Dacus, Voisin, & Barker, 2017).

Research Questions

Studies indicate seronegative Black MSM are as likely or more likely to engage in safer sex and risk reduction practices as their racial and ethnic counterparts (Eaton, Kalichman, & Cherry, 2010; Irvin et al., 2015; Millett, Flores, Peterson, & Bakeman, 2007; Millett, Peterson, Wolitski, & Stall, 2006; Vallabhaneni et al., 2012). In order to further understand how Black MSM maintain their seronegative status, this study aimed to answer two primary research questions:

1) What are the strengths and resiliencies that contribute to the maintenance of
seronegativity in Black MSM?

2) What are the strategies and tactics, besides condom use, that Black MSM employ to maintain their seronegative status?

These questions rest on the premise that there are identifiable strengths and resiliencies found in Black MSM that remained unexplored by previous HIV prevention research. Black MSM experience multiple forms of injustice, such as homophobia, racial discrimination, multifarious forms of stigma, and social marginalization. Therefore, this population can benefit from strengths-based and social justice-oriented research. This research will inform HIV prevention efforts and address other social disparities and social determinants of health that burden Black MSM and are associated with their exceedingly high HIV infection rates (CDC, 2013a, 2013b, 2013c, 2013d, 2015, 2017a; NASW, 2008; Neaigus, Reilly, Wendel, Marshall, & Hagan, 2012).
CHAPTER 2: REVIEW OF THE LITERATURE

In the early 1980s HIV/AIDS became a public health issue when the Centers for Disease Control (CDC) documented significant cases of HIV infection and AIDS-related illnesses and mortalities among gay men (Altman, 1982). By the late 1980s, HIV and AIDS rates began to cross over into non-gay populations, which changed the face of the epidemic. By 1996, HIV became a Black disease that remains most prevalent in and disproportionately affecting Black MSM (CDC, 2013a, 2013b, 2013c, 2013d, 2015, 2017b). This review of the literature discusses HIV health disparity in Black MSM through the lenses of critical race theory and intersectionality; how policy, intervention, and research focusing on Black MSM happened slowly; and how this research yielded deficit-oriented interventions. Additionally, this review discusses the literature on Black MSM’s HIV vulnerability, risk behaviors, and seroprevalence; Gay Resilience Theory as a framework for exploring resiliencies in Black MSM; and literature that suggests factors that might serve as strengths.

Studies of Risk Behavior in Black MSM

Public health HIV prevention must strengthen its efforts to reduce HIV infection in Black MSM. My research argues the importance of examining the biopsychosocial and spiritual strengths and resiliencies as inhibitors of HIV acquisition among this group. However, few extant studies have identified such protective and health promoting factors of seronegative Black MSM. The studies that did examine protective and health promoting factors did not always look for them purposefully or they focused on Black MSM at highest risk (Ober et al., 2017). Prior research on seronegativity has suggested that Black MSM employ various strategies in order to maintain seronegativity. Studies have looked at harm reduction, seroadaptive behaviors, and cognitive and social processes.
Sexual Practices and Strategies

Parsons and colleagues (2005) found that Black MSM were engaging in risky behaviors and practicing harm reduction. They used strategies that aimed to reduce their sex-related harms without necessarily reducing the amount of sex, kinds of sexual activities, or number of partners. These practices are part of the continuum of harm reduction strategies (Carter, 2009). The continuum includes sex with HIV-positive partners who have low viral loads (i.e., virally suppressed or “undetectable”), limiting exchange of and exposure to bodily fluids, using condoms with non-primary partners, and serosorting. The serosorting strategy involves purposely selecting HIV-negative partners, so that there is seroconcordance, a relationship in which both partners are of the same HIV status, in this case, HIV-negative. It also includes seroadaptive behaviors that are used to reduce HIV risk based on knowing one’s own and one’s partner’s HIV status (McFarland et al., 2011). These include behaviors such as strategic positioning, adapting a sexual role that reduces the risk of HIV acquisition, such as being the insertive partner or “top” (Carter, 2009; Parsons et al., 2005; Vallabhaneni et al., 2012). Additionally, harm reduction consists of managed substance use: intentional drug, set, and setting practice that can involve predetermined decisions about the when, where, why, how much, and if a substance will be used prior to, for, or during sexual engagement (Carter, 2009; CDC, 2008, 2009b, 2009b).

Previous research offers suggestions about how to study maintained seronegativity in Black MSM. It identified health promoting behavioral factors such as connectedness to family and significant others (Chen, Boucher, & Tapias, 2006; Lauby et al., 2012; Schneider, Michaels, & Bouris, 2012), self-regulation (Gailliot, Mead, & Baumeister, 2008), self-constructs (Kernis, 2003), and positive self-esteem (Pyszczynski, Greenberg, Solomon, Arndt, & Schimel, 2004).

These studies also explored promoters, which are personality-related, individual, and
cultural factors. Promoters are operationalized as beliefs, moral values, traditions, language, laws or rules of behavior, characteristics, and the health states related to them (Breslow, 2002; Heine & Buchtel, 2009; Matsumoto, 2007). Millet and Peterson (2007) present social promoters. In Black MSM they identified peer discussions about HIV, attendance at social venues that are not sexually-charged, social networks of non-sexual partners, engagement with social networking sites, normative beliefs of peer networks, KAB (knowledge, attitudes, and beliefs) about HIV and the experience of living with HIV infection, and other normative beliefs (Millet & Peterson, 2007). Many of these findings are supported by behavioral health theory such as the theory of reasoned action, which states that social norms are significant instigators of behavior change (Ajzen & Albarracin, 2007; Fishbein, Ajzen, Albarracin, & Hornik, 2007). Yet, others sought to explain the HIV disparity in Black MSM by examining the HIV paradox in Black MSM.

**Less Risk, More Effect**

The HIV paradox in Black MSM, is the phenomenon described as “less risk, more effect.” This is meant to explain how Black MSM are twice as likely as White MSM to be diagnosed with an STI, even though they have fewer lifetime male sex partners, lower rates of substance abuse, and less drug use associated with HIV infection (Eaton, Kalichman, & Cherry, 2010; Millett et al., 2012; Millett, Peterson, Wolitski, & Stall, 2006; Millett, Flores, et al., 2007). In Black MSM, the primary mode of HIV transmission continues to be condomless anal intercourse (CAI) with other men followed by injection drug use (CDC, 2005, 2006, 2008a, 2008b, 2009b, 2009c, 2013a, 2013b, 2013c, 2013d, 2015, 2017b).

However, studies suggest that Black MSM are not engaging in higher risk behaviors than non-Black MSM (Millett et al., 2006; NASTAD, 2005, 2009). In fact, studies have found that they were engaging in less high-risk behaviors as compared to other MSM (BAI, 2012;
Finlayson et al., 2011; Vallabhaneni et al., 2012). In these studies, Black MSM were more likely to use condoms, report less CAI, and have had an HIV test within the last year (Hussen et al., 2013; Millett et al., 2012). The connection between higher rates of HIV acquisition and transmission in Black MSM remains unclear, although some researchers suggest that the composition of Black MSM’s social and sexual networks, and not sexual behaviors, may explain their greater seroprevalence (Bohl, Raymond, Arnold, & McFarland, 2009; Millett, Flores, et al., 2007; Millett & Peterson, 2007). Other researchers agree that it is important to understand the less risk, more effect paradox, but refute social network hypotheses and opine that they have pathologized Black MSM’s sexual networks (Matthews, Smith, Brown, & Malebranche, 2016). These researchers attribute Black MSM’s HIV disparities to social inequities such as neighborhood violence, poverty, incarceration, and racial discrimination (Matthews, Smith, et al., 2016). Still unable to explain the HIV paradox in Black MSM, other research explored theories of seroprevalence, assessment bias, behavioral phenomena, and dual identity development.

Theories of seroprevalence. When Millet and colleagues (2007) examined factors that might have contributed to high HIV-seroprevalence in Black MSM, they proposed three theories. They theorized that the combination of CAI, STI prevalence, and lesser uptake of antiretroviral therapy might have contributed to greater HIV transmission during the onset of the epidemic. Exploring Millet and colleagues’ theories, other researchers then suggested that because Black MSM tend to have sex with other Black MSM, their intraracial partnering commonly referred to as homophily (Ellis, 2008; Millett, Flores, et al., 2007; Mimiaga, Reisner, Cranston, et al., 2009; Sullivan et al., 2014) may have led to greater seroprevalence and given rise to the current racial disparity. Additionally, Oster and colleagues (2011) found that more than half of the Black MSM
in their study were less likely to report taking antiretroviral therapy as a method for decreasing viral load. This lead them to suggest that lack of treatment as prevention contributed to a high viral load in HIV-positive Black MSM, making them more infectious (Oster et al., 2011).

Assessment bias. Malebranche (2003) examined assessment bias, greater seroprevalence among sex partners, more infectious sex partners, physiology, and other factors as possible explanations for the seroprevalence disparity in Black MSM. This examination suggested that underreporting due to inappropriate tools, lack of interviewer cultural competence and training, language bias, and the use of terms unfamiliar to Black MSM might affect data collection methods. He referenced a study in which 93% of seropositive Black MSM were unaware of their seropositivity, thus creating a greater seroprevalence among sexual partners (Malebranche, 2003). Similar to Malebranche, others asserted that deferred HIV testing, treatment, and care services could have led to rapid HIV disease progression creating a greater pool of more infectious sex partners for Black MSM (Blair, Fleming, & Karon, 2002, as cited in Malebranche, 2003). Finally, Malebranche referenced how Stokes and Peterson (1998) examined Black MSM’s physiology, specifically their immune systems’ responses to stress and susceptibility to HIV as an area of further study (2003).

Behavioral phenomena. Some researchers considered behavioral phenomena. For instance, “down low” behavior was examined as a contributor to high seroprevalence in Black MSM. Down low (DL) behavior is when non-gay identified MSM are assumed vectors of HIV transmission to their female sex partners (Ford, Whetten, Hall, Kaufman, & Thrasher, 2007; Malebranche, 2008; Mimiaga et al., 2009; Morton II, 2007; Wheeler, 2006). Most studies argued that DL behavior warranted a prevention focus. However, Wheeler (2006) disputed concerns about DL behavior. He argued that these concerns were unfounded and suggested that DL men
were more likely to intentionally practice safer sex and harm reduction in order to avoid infecting their female partners. Wheeler’s study spoke to the influence of racism and homophobia (Millett & Peterson, 2007; Millett et al., 2006; Wheeler, 2004; Wilson & Moore, 2009) that fueled the “DL phenomenon” and further pathologized Black MSM. However, researchers’ investigation of DL behavior lead to discourse about how Black MSM occupied a dual minority status by being both Black and a sexual minority, and how dual minority status affected their HIV risks (Millett & Peterson, 2007).

**Dual identity development.** Considering the influence of dual minority status and HIV acquisition, some researchers focused on the effect of dual identity development on the psychosocial functioning of Black MSM, whose racial and sexual identities intersect and co-occur. Dual identity development describes how greater levels of distress, conflict with sexual orientation and sexual identity, and less life satisfaction are associated with a higher incidence of sexual risk-taking behaviors (Crawford, Allison, Zamboni, & Soto, 2002; Malebranche, 2003; Schneider et al., 2012). Combined with these influencers, studies suggest that public health efforts can be ineffective amid a climate of fear, hostility, and threats in the lives of Black MSM. This research indicates how dually stigmatized, Black MSM can be driven away from or be reluctant to seek HIV prevention services, treatment, and care (Frost, Lehavot, & Meyer, 2013; Meyer, 2003, 2010), thus contributing to the current HIV disparity in this population.
**Sociocultural Predictors**

Many Black and Black gay behavioral and social science researchers assert that too few studies of Black MSM have examined the sociocultural predictors of HIV risk (Millett, Malebranche, & Peterson, 2007; Millett & Peterson, 2007; Wheeler, 2004; Wilson & Moore, 2009). Some researchers have begun to examine intraracial and intergenerational sexual relationships. Others highlight how low socioeconomic status (SES), incarceration, and/or limited access to HIV medical interventions and treatments through structural interventions can be predictors of HIV risk (Millett, Malebranche, et al., 2007; Millett & Peterson, 2007; Oster et al., 2011). Few researchers have studied predictors of HIV risk behavioral deterrents and inhibitors. This emphasis on deficits has contributed to the paucity of research on maintained HIV-seronegativity.

**A Critical Literature Review**

Millet, Peterson, and colleagues (2006) conducted a comprehensive literature review to identify variables associated with and against the possible causes of greater seroprevalence in Black MSM. They sought to test a set of hypotheses by searching five online databases and reviewing articles published between 1974 and 2005. As part of a five-stage process, they collected evidence on the behavioral, psychological, structural, and biological indicators of greater seroprevalence in Black MSM. They hypothesized the following: (1) Black MSM are more likely than other MSM to engage in high-risk sexual behavior; (2) Black MSM are less likely than other MSM to identify as gay or to disclose their sexual identity, which may lead to increased HIV risk behavior; (3) Black MSM are more likely than other MSM to abuse substances, especially injection drugs, that increase their risk for HIV infection; (4) Black MSM are more likely than other MSM to contract sexually transmitted diseases that facilitate the
acquisition and transmission of HIV; (5) Black MSM are less likely than other MSM to be tested for HIV or to know their HIV status, and they may unknowingly expose their sexual partners to HIV; (6) Black MSM are genetically more susceptible to HIV than other MSM; (7) Black MSM are less likely than other MSM to be circumcised, increasing their risk for HIV infection; (8) HIV-positive Black MSM are infectious for a longer time than other HIV-positive MSM; (9) Black MSM are more likely than other MSM to have sex with partners known to be HIV-positive; (10) The sexual networks of Black MSM place them at greater risk for HIV infection than the sexual networks of other MSM; (11) Black MSM are more likely than other MSM to be incarcerated, which increases the likelihood of exposure to HIV; and (12) Black MSM are more likely than other MSM to engage in anorectal douching, which increases their risk for HIV infection.

Based on this review, Millet and colleagues found no scientific evidence to support their first three hypotheses about variables contributing to Black MSM’s increased HIV risk. Their unsupported hypotheses were about greater engagement in high-risk sexual behavior, the correlation of a non-gay sexual identity (i.e., down low [DL]) and high-risk behavior, and higher likelihood of substance abuse (2006). They found support for two of their hypotheses about increased HIV risk in Black MSM. These variables included high STI prevalence facilitating HIV acquisition and transmission, and lack of knowledge about HIV status because the study participants tested less frequently. Black MSM who were unaware of their HIV serostatus tended to engage in behaviors that facilitated HIV transmission in contrast to Black MSM who knew they were seropositive (also see Oster et al., 2011). These researchers concluded that infrequent or delayed testing contributed to high seroprevalence in Black MSM. This finding was augmented by recent studies about Black MSM’s HIV testing patterns (Hussen et al., 2013) and
the negative effect of perceived racial discrimination and HIV testing (Irvin et al., 2014).

For their remaining hypotheses about Black MSM’s increased HIV risk, although they sought evidence that genetic disposition, circumcision, a longer period of infectiousness, more seropositive partners, and smaller sexual networks were associated with increased risk, Millet and colleagues (2006) did not find scientific evidence that supported or refuted these associations. They also included incarceration and HIV exposure and the common practice of anorectal douching by receptive partners or “bottoms.” Moreover, their review only found partial explanations for higher seroprevalence. They concluded that due to small sample sizes and a lack of a focus exclusively on Black MSM, studies did not offer reliable findings.

**Comparison of Disparities**

In a subsequent study Millet, Peterson, and colleagues (2012) conducted a meta-analysis of 174 American-, 7 Canadian-, and 13 United Kingdom-based studies in an attempt to explain high HIV infection in Black MSM. According to them, high HIV infection was not explained by factors commonly associated with HIV transmission, such as number of sex partners, alcohol and drug use, and CAI. Their analysis compared Black MSM to other MSM in order to explicate those factors contributing to their HIV disparity. Similar to previous studies, they found less risky sexual behaviors, fewer sex partners, more condom use, and recent HIV testing among Black MSM (Millett et al., 2012). There were no significant differences between Black MSM and other MSM concerning multiple sex partners and being in serodiscordant relationships. Similar to prior studies, Millet and colleagues found Black MSM aged 13-29 were more likely to initiate sex at an earlier age (Millett, Flores, et al., 2007; Millett et al., 2006; Oster et al., 2011). Additionally, Millet and colleagues (2012) found that earlier sexual initiation is associated with more sex partners and HIV infection. Because younger Black MSM were more likely to have
older partners, this increased their chances of having sex with seropositive men.

This review of the literature offers little support for how and why Black MSM maintain HIV-seronegativity. However, the literature consistently offers a strong reason for seronegativity maintenance, which is out of fear. The literature indicates how the fear of dying from the devastating effects of AIDS-related wasting or opportunistic infections motivates many MSM to practice safer sex and to engage in risk and harm reduction (Balán et al., 2013; Grisham et al., 2012).

**Theoretical Understanding of the HIV Disparity in Black MSM**

By the late 1980s, Black MSM were disproportionately affected by HIV/AIDS (CDC, 1990; Sutton et al., 2009). Millet and Peterson (2007) posited that Black MSM were disproportionately affected as early as 1986 and likely found across the 4Hs (hemophiliacs, homosexuals, heroin users, and Haitians) that constituted the greatest at-risk groups for HIV infection and AIDS (Gallo, 2005). Among the 4Hs, Black MSM were more likely to be part of the last three risk groups, simply because they were Black men. This co-location may have contributed to their higher HIV number of seroconversions (seroincidence) before their seroprevalence rates were estimated (Millett, Flores, et al., 2007; Oster et al., 2011). As the public face of the epidemic changed from White, gay, and male to Black, and then to Black MSM, HIV prevention policies aimed at decreasing infection rates in Blacks or Black MSM did not develop accordingly. In addition to the empirical studies on HIV in Black MSM, critical race theory and intersectionality also offer theoretical insights into how HIV became a Black MSM disease.
Critical Race Theory

Harris (2012) describes critical race theory as a the instigation of a paradox: the persistence of racism despite policies and social norms that condemn it. Critical race theory posits society normalizes racism, and it is embedded in social practices and institutions. Early research on HIV acquisition and transmission in Black MSM was not devoid of racism. Blacks in general were already contending with systemic and institutional racism that were barriers to health equity long before the emergence of HIV. Black MSM were subject to the same forms of racism as their heterosexual counterparts. They were seen as Black men first and as men who engaged in same gender behaviors, second. As Black MSM seroconverted, some were reticent about and even discouraged from seeking medical services due to historical distrust of the medical establishment (Allen, 1973; Bonilla-Silva, 1997; Gamble, 1993; Malebranche, Peterson, Fullilove, & Stackhouse, 2004; Mckay, 1972; Wasserman, Flannery, & Clair, 2007; Williams, 1985).

Intersectionality

Intersectionality examines social relationships among multiple dimensions of identities (Cole, 2009; Crenshaw, 1991; Gopaldas, 2013; McCall, 2005; Syed, 2010). Some HIV-positive Black MSM not only had to contend with racism as a barrier to healthcare, but also with homophobia and heterosexism. Intersectionality suggests that the intersections of race, gender, and sexual orientation influenced the lack of early recognition of HIV in Black MSM (Millett et al., 2012, 2006; Millett & Peterson, 2007; Peterson & Jones, 2009), possibly contributing to the current HIV disparity. Because Black MSM were not diagnosed with HIV, documented as emerging cases, and not testing once HIV testing was available, public health missed an opportunity for early identification and intervention in Black MSM.
Critical Responses to the HIV Disparity in Black MSM

Black gay and bisexual men became involved in AIDS activism and social movements early in the epidemic, because they were seroconverting and dying from AIDS-related causes like their White gay counterparts. At first, Black men joined predominately White-led groups such as AIDS Coalition to Unleash Power (ACT-UP). But eventually they formed race-specific groups such as Gay Men of African Descent (GMAD), which is the oldest Black gay HIV/AIDS service organization in the US (GMAD, 2014). Through the 1990s and early 2000s, Black gay activist groups and early AIDS service organizations (ASOs) were the voices of the Black gay communities and advocated for more attention to research, resources, and treatment.

In August 2005, CDC invited policymakers, behavioral and social scientists, and other researchers, community leaders and activists, and healthcare providers to a Black MSM Consultation. The purpose of the Consultation was for invited participants to discuss crucial policy and research initiatives targeting the epidemic in Black MSM. Several attendees criticized the late consultation, since Blacks had represented the highest numbers of AIDS cases since 1996. Recommendations from the Consultation were used as guidelines for developing a series of comprehensive policy responses for CDC to operationalize (NASTAD, 2005).

In response to the Consultation, organizations such as the Black AIDS Institute (BAI), the National Alliance of State and Territorial AIDS Directors (NASTAD), and the National Minority AIDS Council (NMAC) demanded a call to action through policy, programming, research, and practice. In the report, AIDS in Blackface: 25 Years of an Epidemic, BAI suggested a comprehensive and coordinated approach to address the Black HIV epidemic, which included policy recommendations for evidence-based research, legislative responsibility, and the need to address social stigma (Wright, 2006). In the report, A Turning Point: Confronting HIV/AIDS in
African American Communities, NASTAD offered recommendations for strategic prioritization of prevention programming and resource allocation, policy education, HIV/AIDS research, strategic collaboration, and coalition and partnership building (2005). NASTAD also requested that policymakers respond to the HIV crisis among Blacks by raising awareness about HIV/AIDS among Black leadership, by increasing access to HIV/AIDS prevention and care services, supporting a comprehensive federal HIV agenda for Black communities, and encouraging state and local health departments to expand and strengthen their responses to the epidemic in Black communities in their jurisdictions (2005). Similarly, in African Americans, Health Disparities and HIV/AIDS, NMAC highlighted the importance of policies to address the underlying factors linked to HIV among Blacks: lack of housing, incarceration, and poverty (Fullilove, 2006).

Two years after the CDC’s Black MSM Consultation, the research arm of the National Black Gay Men’s Advocacy Coalition (NBGMAC), The Black Gay Research Group (BGRG), released A National Black Gay Research Agenda (National Black Gay Men’s Advocacy Coalition [NBGMAC], 2007). The report raised a central question: “Given the federal and local appropriations earmarked for HIV and AIDS research and program interventions since the introduction of the Ryan White CARE Act and other HIV-related legislation, why were Black gay men not experiencing improved health?” (2007, p.7). The Coalition’s key objective was to engage in advocacy for HIV healthcare policy on the federal, state, and local levels through the BGRG. The BGRG was created to integrate scientific evidence into the Coalition’s policy recommendations and to further the development and implementation of policies and interventions designed to reduce HIV in Black MSM (2007).
Research Focused on Behavioral Interventions

As follow up to the 2005 Black MSM Consultation, CDC operationalized the recommendations in the form of new, evidence-based HIV prevention interventions specifically developed for Black MSM. Regrettably, the evidence supporting the new interventions was deficit-informed rather than strengths-based, following a typical public health approach (Herrick, Lim, et al., 2013; Herrick, Stall, et al., 2013). It did not include the strength-based approaches suggested at the Consultation. Additionally, few interventions were specifically developed for Black MSM; most were adaptations of existing interventions.

Public health researchers have engaged in comprehensive approaches for understanding and intervening in the occurrence of high seroprevalence in Black MSM. Intervention development has been premised on the examination of Black MSM’s social and sexual networks; access to healthcare; social and structural barriers; and experiences of stigma, discrimination, and homophobia within their families and communities (Fuqua et al., 2012; Wilson & Moore, 2009). This public health research literature has informed HIV prevention efforts for Black MSM; it stems from a national public health response to rampant seroprevalence in this group of Black men, which is in response to The National AIDS Strategy (White House, 2010). The CDC, which has been at the forefront of funding for HIV-related public health research, established the HIV/AIDS Prevention Research Synthesis (PRS) Project in 1996 for this purpose.

The PRS Project was developed to conduct efficacy reviews and to summarize and translate scientific evidence from the research literature into methods and interventions to be used by AIDS service organizations (ASOs), community-based organizations (CBOs), and local and state health departments (HDs). Under the PRS Project are CDC’s evidence-based behavioral interventions (EBIs) (2009a) known as the Diffusion of Effective Behavior
Interventions (DEBI) Project. According to CDC, the DEBIs “represent the strongest HIV behavioral interventions in the literature to date that have been rigorously evaluated and have demonstrated efficacy in reducing HIV or STD incidence or HIV-related risk behaviors (e.g., unprotected sex and needle sharing) or promoting safer behaviors (e.g., being abstinent and using condoms)” (2009a, para. 1).

Development of new interventions for Black MSM lagged behind those for other affected populations (Sutton et al., 2009). To date, there are only two evidence-based DEBIs designed to prevent HIV acquisition and transmission in Black MSM. The first intervention, *d-up!: Defend Yourself*, is a cultural adaptation of another community-level intervention that was originally developed for the broader MSM population (Jones et al., 2008; Stall, 2007). *d-up!* aims to change social norms regarding condom use by enlisting influential opinion leaders who are trusted by their peers in their friendship and social networks. The other intervention, *Many Men, Many Voices* (3MV), aims to prevent HIV and STI transmission among gay and non-gay identified Black MSM. It is a multisession group intervention that addresses influencing factors such as cultural, social, and religious norms; HIV and STIs; sexual relationship dynamics, racism; and homophobia (Wilton et al., 2009). Both *d-up!* and 3MV share similar goals and activities. Both EBIs address barriers to HIV counseling and testing, treatment, and care; demonstrate cultural competency; intervene in social networks; empower and mobilize Black MSM populations to take ownership of their sexual health; and emphasize comprehensive health and wellness services.

These evidence-based interventions have proven effective with Black MSM at high- and at greatest risk for both HIV acquisition and transmission. However, a limitation of these EBIs is that they are not designed for Black MSM who are at low-risk or engaging in protective
behaviors. Yet, 3MV does support those employing harm reduction strategies. Unfortunately, there are no EBIs designed to support and reinforce the protective behaviors, social norms, and other factors that contribute to maintained seronegativity in Black MSM. This deficiency parallels the plethora of scientific research that has focused only on the acquisition- and transmission-related behaviors of Black MSM. The findings from the current study aim to prompt a reexamination and a reassessment of the current HIV prevention portfolio for seronegative Black MSM.

**Seronegativity in Black MSM**

It is important for behavioral and social science research to identify and emphasize maintained HIV-seronegativity in Black MSM. This research can align with studies in which researchers have explored plausible high-risk behavior deterrents and inhibitors such as social supports, spirituality, seroadaptive harm reduction practices, and strong racial identity in seronegative Black MSM (Irvin et al., 2015; Millett & Peterson, 2007; Schneider et al., 2012). Few studies have examined maintained seronegativity in Black MSM from the perspective of Black MSM themselves such as in studies by Dacus and colleagues (2017) and Ober and colleagues (2017). Specifically, findings from my pilot study produced the following themes about what appears to help these Black men maintain seronegativity: (a) possession of a strong sense of religious or spiritual connection to a high power, (b) having social supports from family and friends and expectations from those persons that their HIV-negative status would be maintained, and (c) exercising personal agency to maintain HIV-seronegativity such as engaging in seroadaptive harm reduction practices (Dacus, et al. 2017).
Gay Resilience Theory

Four recent studies highlight untapped resilience found in MSM. These researchers have developed a “theory of resilience among gay and bisexual men” or *Gay Resilience Theory*. It contends that many MSM possess resilience that enables them to thrive in the age of AIDS and effectively process their experiences with homophobia and heteronormativity (Herrick et al., 2011; Herrick, Stall, Goldhammer, Egan, & Mayer, 2014; Herrick, Lim, et al., 2013; Herrick, Stall, et al., 2013). According to Stall, resilient MSM are better equipped to maintain their seronegative statuses throughout the life course (personal communication, 30 June 2011).

Gay Resilience Theory capitalizes on the theoretical concept of positive deviance, the phenomenon in which people whose uncommon, but successful, behaviors or strategies enable them to find better solutions to a problem compared to their peers despite having no special resources or knowledge (Sternin & Choo, 2000; Tuhus-Dubrow, 2009). Herrick and colleagues’ theory of resilience among gay men and bisexual men has stimulated interest in the advancement of resilience as the basis for HIV prevention intervention research and development. Similar to the strengths- and assets-based premise of this study, Gay Resilience Theory questions the efficacy of current public health HIV prevention interventions that operate from a deficit-based approach. In this context, resilience is defined as, “the process of overcoming the negative effects of risks exposure, coping successfully with traumatic experiences, and avoiding the negative trajectories associated with risk” (Fergus & Zimmerman, 2005 as cited by R. Stall, personal communication, 30 June 2011).

Gay resilience theorists posit that gay and bisexual men and MSM in general, contend with tremendous health disparities. However, by not focusing on gay resilience, public health research misses the opportunity to capture and utilize the strengths embedded in Black MSM
populations and as demonstrated by the seronegative Black men. The application of this theory adds to the repertoire of HIV prevention tools and resources by refocusing on primary prevention and understanding what Black MSM do to maintain seronegativity as suggested by these studies (Herrick et al., 2014).

Gay Resilience Theory includes assets and resources as protective factors. Assets originate on the individual level and transfer and/or translate to resources in the ecological context. For example, Herrick and colleagues (2014) describe factors such as self-esteem, friends, and community involvement and their contrasting relationships to risk and protective factors. Low self-esteem and unsupportive, non-supportive, or lack of friendships are all associated with higher HIV-risk behaviors. In contrast, high self-esteem, supportive friendships, and high community involvement are associated with decreased HIV-risk behaviors. Additionally, for ease of applicability, Gay Resilience Theory is presented as a linear model (Figure 1).
Figure 1. Gay Resilience Theory’s conceptual pathways in which positive factors promote health and resilience (Herrick, Stall, Goldhammer, & Mayer, 2014)
The model illustrates the starting point, (health) adversity, and its relationship with syndemics, a model for examining multiple, concurrent negative health problems that positively interact with each other (Singer, 2009). Syndemics posits that various afflictions have an interaction that contributes to an elevated burden of HIV infection within a population. The model demonstrates how protective factors moderate the relationships between adversity and syndemics and between syndemics and HIV risk. Further, it shows how protective factors have a mediating effect on both syndemics and HIV risk.

These theorists suggest how the introduction of resilience within the context of HIV prevention interventions for seronegative MSM can include a multi-step inquiry, assessment, and an analytic process paralleling and enhancing an intervention’s efficacy (Herrick, Lim, et al., 2013; Herrick, Stall, et al., 2013; R. Stall, personal communication, 30 June 2011). By focusing on HIV-negative Black MSM’s strengths and resiliencies, researchers can begin to study, document, and analyze how strengths and resiliencies embedded in cultural and social factors specific to seronegative Black MSM can be replicated and integrated into generalizable HIV interventions for the larger Black MSM population (Bing, Bingham, & Millett, 2008).

Furthermore, Gay Resilience Theory identifies resilience at the individual, the dyad, the family, the community, and the cultural levels (Herrick, Lim, et al., 2013; R. Stall, personal communication, 25 January 2013). On the individual level, resilience factors are related to shamelessness (refusal to allow anyone to shame you in a social setting for being gay), self-monitoring, and resolution of internalized homophobia. The dyad level concerns the ability to form social bonding-relationships that promote connectedness and intimacy in a non-supportive social environment and the ability to draw support from these dyads. The family level pertains to building social support and intimacy via fictive families. On the community level, key resilience
factors are connection to health promoting aspects of gay culture. According to Stall, “social settings aside from those that are formed at 2am,” such as gay faith groups, sports teams, etc. and the formation of supportive social networks within gay culture. Additionally, on this level, resilience is associated with activism to promote goals that promote health and institution building. “The idea here is that the theory had to do more than identify factors at the individual level, because, then one ends up saying that strong people are…strong. Not very helpful” (R. Stall, personal communication, 25 January 2013).

Critical Theories

As a departure from the scientific literature on HIV prevention research, policy, intervention development, practice, and explanations for the occurrence of high seroprevalence in Black MSM, pivotal to the current study are salient theories, frameworks, and perspectives critical to the examination of HIV-negative Black MSM’s lives. What follows is a discussion of a review of the literature relevant to the examination of maintained seronegativity in Black MSM: queer theory (Butler, 1993; Eng, David, Halberstam, & Muñoz, 2005; Spargo, 1999; Sullivan, 2003) and feminist theory (Collins, 2002; Hooks, 2000; Rubin, 1984, 2011; Wyatt et al., 2013),

Queer theory. Queer theory recognizes that sexuality and gender are intersectional. Queer theory is a sociopolitical term to critique several social antagonisms. For example, race and ethnicity, gender and gender performance, socioeconomic status, and sexuality (Eng et al., 2005). According to queer theory, analyses of these intersections are important to challenge socially produced and socially established identities. This is especially true for identities that are socially, politically, and systemically oppressive such as homophobia, heteronormativity, and transphobia. Queer theory’s epistemological underpinnings demand a close examination of what
is considered “normal” (i.e., heteronormative and cisgender) and intersectional in the social world.

Queer theory aims to expand the traditional binaries such as gender, sexual orientation, and sex role(s) between intimates, which are socially “policed” (Butler, 1993; Foucault, 1976, as cited in Spargo, 1999). As a result, queer theory has enabled effective sociopolitical responses to myriad oppressions experienced by lesbian-, gay-, bisexual-, trans-, and queer-identified (LGBTQ) persons (Sullivan, 2003). For example, the advent of marriage equality is considered a liberating intersection of gender regulation and gay rights (Eng et al., 2005). As applied to the lives of Black MSM, queer theory offers a theoretical means for addressing important issues such as internalized homophobia and its relationship to HIV. Studies have identified the positive relationship between internalized homophobia and seroconversion. However, aligned with queer theory, some studies have found a negative relationship between internalized homophobia and seronegativity. These latter studies have shown that reconciliation and negotiation of internalized homophobia is associated with positive health and mental health outcomes in gay and bisexual men of color (see Herrick, Lim, et al., 2013; Meyer, 2010). Reconciled and negotiated internalized homophobia in seronegative Black MSM can be a strength and an indicator of resilience.

**Feminist theories.** In “Rethinking Sex,” Rubin offers a means of addressing sexuality through a critical, intersectional lens (1984, 2011). Feminist perspectives assert that women’s sexuality intersects on the educational, political, physical, mental, emotional, spiritual, and social levels (Collins, 2002; hooks, 2000; Wyatt et al., 2013). Historically, feminists have challenged how society essentializes sexuality, considering it to be preexisting and unevolving, that social scientists and the medical establishment dictate and reproduce (Rubin, 1984, 2011). Feminist
understandings of sexuality are pertinent to the lives and experiences of HIV-negative Black MSM. They provide HIV prevention research with a means to deconstruct internal and external notions of same-gender behaviors. For example, Black MSM’s HIV risk can increase when sex is perceived and experienced, as shameful, dangerous, destructive, and negative. Feminism can help us understand if Black MSM’s HIV risk can decrease when sex is perceived and experienced as wonderful, safe, beneficial, and positive.

**Summary**

Based on the review of the scholarly literature, more research is necessary to identify, examine, and understand maintained seronegativity in Black MSM. Public health has identified and documented Black MSM’s HIV risk behaviors, using predominately deficit-based approaches. Numerous studies have explored possible reasons for their high seroprevalence by testing theory, conducting comparative behavioral analyses, and conducting literature reviews of the scientific evidence. What is lacking is research that supports the phenomenon of maintained HIV-seronegativity in these men, which has remained largely unexplored. Specifically, there is a need for research that is strengths- and resilience-based. The current body of literature does not answer the questions of how and why many Black MSM maintain seronegativity, and this study aims to illuminate this phenomenon in Black MSM.

Unlike deficit-based approaches, this research will extrapolate protective factors and consider an array of possibilities for how and why Black MSM maintain seronegativity beyond condom use. With this strengths and resilience approach, I assert that Black MSM intentionally maintain HIV-seronegativity for other reasons entirely, which other studies have explored (e.g., Irvin et al., 2015). Through my research, answers to these important questions generated a body of knowledge that begins to fill the gaps in the prevention knowledge base.
CHAPTER 3: METHODOLOGY

The current study offers an alternate approach to HIV prevention with HIV-negative Black MSM. This study examined their maintained seronegativity using constructivist ground theory framed by Gay Resilience Theory. This is a novel approach to HIV prevention, according to my review of the prevention literature (Charmaz, 2006; Herrick et al., 2011; Herrick, Stall, Goldhammer, Egan, & Mayer, 2014). Repeatedly, public health and social and behavioral science approaches to HIV prevention in Black MSM populations have focused predominately on HIV-risk factors. With the exception of my pilot study in which Black MSM identified several protective factors (Dacus et al., 2017), a study by Hussen and colleagues (2013) about their HIV testing patterns, and a study by Ober and colleagues (2017) about their risk and harm reduction practices, HIV prevention research has followed a deficit-based approach. Research has not sought evidence to identify strengths and resiliencies among these Black men. In order to address that deficiency, the following research questions guided the study:

1) What are the strengths and resiliencies that contribute to the maintenance of seronegativity in Black MSM?

2) What are the strategies and tactics, besides condom use, that Black MSM employ to maintain their seronegative status?

By addressing these research questions, this study began to fill the gap in the HIV prevention literature about how and why the majority of Black MSM in NYC maintain seronegativity.

The overall goal of this study was to identify and understand on the individual and microsocial levels the strengths and resiliencies that contribute to maintained HIV-seronegativity in a cohort of Black MSM living in NYC. NYC has been a high HIV seroprevalence area (New York City Department of Health and Mental Hygiene [NYCDOHMH], 2015, 2017) since the
beginning of the epidemic. Although public health HIV prevention research has made strides in addressing HIV in Black MSM, we know little about these seronegative Black men’s approach to maintaining their status.

**Methodology**

**Theoretical Framework: Gay Resilience Theory**

Gay resilience theorists contend that MSM who survived the onset of the AIDS epidemic in the 1980s and maintained seronegativity are both fortunate (BAI, 2012) and formidable (Herrick, Stall, et al., 2013). Furthermore, they argue that these MSM possess significant personal attributes. These attributes are strong coping skills in the aftermath of tremendous personal and community loss, and resilience. They also possess perseverance that has enabled them to adapt to the physical health, mental health, and social crises accompanying the epidemic. These theorists have argued that some MSM, specifically self-identified gay and bisexual men, have uniquely evolved personal attributes related to resilience (Herrick, Lim, et al., 2013; Herrick et al., 2014).

According to Gay Resilience Theory, the resilient aspect of these gay men’s lives is evident in their life histories; they are able to thrive in the face of the all-pervasive HIV/AIDS epidemic. They are able to manage coming out and dealing with oppressions such as homophobia and heteronormativity. In addition, they are able to maintain seronegativity throughout the life course. Gay Resilience Theory has sparked discourse about the lack of strengths-based approaches in HIV prevention intervention research and development. The contributions from this study furthered that discourse by demonstrating that Black MSM are doing something “right” and demonstrating resilience (R. Stall, personal communication, 30 June 2011).
In this study I brought to the fore the racial nuance, experiences, and other aspects relative to Black MSM’s maintained seronegativity. My approach to explicating the phenomenon was guided by critical race theory, feminist theory, intersectionality, and findings from studies that purposefully included racial analyses that Gay Resilience Theory can only suggest, but not indicate. This limitation of Gay Resilience Theory supported the identification of new theory to supplement it. To meet this aim, I sought to build on Gay Resilience Theory by constructing theory based on my interrogation, analysis, and interpretation of how Black MSM gave meaning to, described actions about, and developed processes for maintaining seronegativity. Due to the disproportionate burden of HIV in Black MSM, it was critical to provide theoretical explanations for how the majority of them are able to maintain HIV-seronegativity. Gay Resilience Theory offered a broad explanation for how gay and bisexual men maintain seronegativity. However, the theory does not attend to the other sexual identities common among Black MSM (i.e., same gender loving [SGL] and down low [DL]). It does not offer insight into Black MSM’s specific strengths and resiliencies for maintaining seronegativity. By furthering Gay Resilience Theory using a constructivist grounded theory approach, I illuminated those strengths and resiliencies specific to Black MSM.

**Constructivist Grounded Theory**

I determined the constructivist grounded theory methodology and methods advanced by Charmaz (2006, 2014) were appropriate for this study, because Black MSM’s seronegativity maintenance strategies and tactics have been understudied using qualitative methods, and I found other studies about Black MSM that used this methodological approach. As I conducted my review of the literature, I found multiple examples, in addition to the Gay Resilience Theory article, in which researchers recommended qualitative approaches and narrative data collection
as a main source of participant information about the phenomenon of interest (for example, see De Fina & Georgakopoulou, 2015; Labov & Waletzky, 1997; Miles & Huberman, 1984; Polkinghorne, 1995; Ritchie, Lewis, Nicholls, & Ormston, 2013). Constructivist grounded theory guided my construction of theory based on my interactions with the Black MSM participants. I used its methods to render an interpretation of what seronegative Black MSM reported as their strengths and resiliencies and the social-behavioral conditions that helped them maintain seronegativity. The methods also facilitated my construction of a theory particular to Black MSM. Utilizing the elements of Gay Resilience Theory as sensitizing concepts provided a foil for the indigenous concepts that emerged from my participants (Patton, 1990). My professional practice, experiences, and interactions with and knowledge about HIV prevention with Black MSM in NYC were also sensitizing concepts in this study.

Constructivist grounded theory provided rigorous methods, including sampling and qualitative data collection to develop theory through analysis of the data (Charmaz, 2014). It provided a means of examining, comparing, and contrasting my qualitative data across participants, situations, and settings. These methods ultimately enabled me to develop theory, theoretical questions, and hypotheses (Charmaz, 2006, 2014). With this data-driven theory, I explained some strengths and resiliencies associated with maintained seronegativity among these Black men (Charmaz, 2014; Herrick et al., 2014).

This study continues a precedent of constructivist grounded theory application in studies about Black MSM. Other HIV prevention intervention research on seronegative Black MSM has employed these methods. For example, Brooks and colleagues (2011, 2012) used this method to examine Black MSM’s motivators, concerns, and barriers to adoption and acceptability of preexposure prophylaxis (PrEP) and by Hussen and colleagues (2013) who explored Black
MSM’s HIV testing patterns. Rhodes and colleagues (2010), who studied Black MSM’s online social media usage, used them as did Wilson and Moore (2009) who examined Black MSM’s experiences receiving services from HDs and CBOs. My review of these studies demonstrated that constructivist grounded theory was suitable for this study. As with other research on this population, this approach facilitated the identification of major themes (Brooks et al., 2011, 2012; Wilson & Moore, 2009), yielded typologies of HIV testing patterns, descriptions of conceptual frameworks to explain social processes (Hussen et al., 2013), and informed thematic categories related to prevention and intervention delivery (Rhodes et al., 2010). All these were relevant to my study.

The constructivist grounded theory approach recommends the methodological practice of theoretical agnosticism (Charmaz, 2014). This practice entails bracketing knowledge of extant theories in order to permit theory grounded in the data to emerge. Since I used sensitizing concepts from Gay Resilience Theory and critical and interpretive frames as part of my investigative approach, I did not practice theoretical agnosticism. However, I took a critical stance towards Gay Resilience Theory, intersectionality, critical race theory, and feminism, and concentrated my explication of the Black MSM’s maintained seronegativity on their own interpretations and insights.

Finally, I selected this methodological approach, because grounded theory values and explicitly requires that I be reflexive (Mruck & Mey, 2007). As the researcher, I needed to recognize how my location in the study influenced the range of interactions I had with the participants. I acknowledged my influence at all stages of the research process. Also, I understood where and how I affected the participants’ responses, data collection, data analysis, and interpretation of the findings (Gentles, Jack, Nicholas, & McKibbon, 2014). Moreover, I
chronicled my reflections in the aforementioned areas by including my observations as memos. In my memos, I noted when and how I modified specific interview guide questions, the iteration of the data collection and analysis processes, and how my relationships with the participants effected my role as the researcher (Gentles et al., 2014).

**Study Design**

In this study, narrative data were the main source of information I collected from the Black MSM participants. I collected the Black MSM participants’ own words to inform my understanding of their seronegativity maintenance. By relying on their own narrations of their lives, I was able to co-create meaning and constructions of data through researcher-participant interactions. These interactions enhanced the rigor of my constructivist grounded theory approach (Hall & Callery, 2001). With this data collection method, I captured each participant’s story about his ability to maintain HIV-seronegativity against high probabilities of seroconversion. As I gathered each Black man’s set of narratives, I accumulated an aggregate body of stories that corroborated one another, provided different dimensions for the same phenomenon, and helped establish patterns as an intended by-product of constructivist grounded theory’s constant comparative method (Charmaz, 2006, 2014; Oktay, 2012).

**Method**

For the purpose of this study, seronegativity maintenance, used broadly, included the following definitions. I defined seronegativity as maintaining HIV-seronegativity as documented by a seronegative HIV test result within the last six months for all Black MSM. For the Black MSM aged 50 and older, I considered their seronegativity maintenance to be *sustained*; I defined it as their ability to maintain HIV-seronegativity over the life course. This distinction was important because I considered the older Black MSM exemplars of long-term seronegativity
maintenance. I also documented their serostatus by a seronegative HIV test result within the last six months.

**Sampling Framework**

**Sampling criteria.** For inclusion in the study, participants met the following criteria. They had to be aged 21 years old or older, self-identified as Black (African American, Caribbean/West Indian, African, or multiracial/multiethnic Black), and a resident of New York City. Participants also needed to identify as cisgender men or assigned male gender at birth, report being sexually active with other men for a minimum of three years, and report being sexually active with at least one man in the last three months. Finally, participants had to provide documentation of their seronegativity as an HIV-negative test result within the last six months at the time of first interview and report no injection drug use (non-IDU) within the last year. I excluded drug injectors from the study because they use a different set of strategies to reduce their risk. Their harm reduction strategies would have introduced confounding variables, and this study focused on Black MSM’s sexual behaviors.

**Sampling Plan.** I received approval from the Hunter College Institutional Review Board (IRB) to conduct all study procedures. After receiving IRB approval, I used a purposive sampling strategy (Atkinson & Flint, 2001) to recruit a diverse cohort of Black MSM participants who could provide varying experiences of seronegativity maintenance. To this end, my sampling strategy aimed to include adult Black MSM across the life span. I sampled until I reached saturation (Baker, Edwards, & Doidge, 2012; Charmaz, 2006, 2014; Creswell, 2013), which resulted in a sample of 25 men. That is, following standard practice, I continued to sample until no new properties in my theoretical coding process emerged. I intended to align my sampling strategy with current sampling trends that consist of cohorts aged 21-30, 31-49, and 50 and older.
(see Cooley et al., 2014; Grey, Rothenberg, Sullivan, & Rosenberg, 2015; Hussen et al., 2013; Wejnert et al., 2015). This age cohort-based approach allowed for the initial recruitment. I utilized this approach so that there would be representation across the age spectrum and history of the epidemic. However, my sampling strategy shifted to a theoretical sampling strategy (Charmaz, 2006, 2014; Oktay, 2012) once it became apparent that I needed men represented by more discrete age cohorts (i.e., 20s, 30s, 40s, and 50 and older) in order to conduct intra-, inter-, and across age group analyses. Further, with a shift to a theoretical sampling approach I could triangulate data such as racial and ethnic identities, ages of their sex partners, and sources of social support and importance of maintaining HIV-negativity.

Initially, I placed an emphasis on recruiting participants who were sexually active with other men before the onset of the HIV/AIDS epidemic in the US, before 1982. The reasons for this emphasis were trifold. First, Black MSM aged 50 and older were challenging to recruit for the pilot study. Second, in the pilot study the focus group of older men yielded the most diverse assortment of narrative data. Third, a sample of older Black MSM would provide this study with exemplars of long-term, sustained seronegativity. I conceived that narratives from older Black MSM would illustrate differences not found in the younger cohorts. Specifically, I wanted to capture the processes behind their sexual practices both at the onset of the AIDS epidemic and at its height that had enabled them to survive when so many others were dying. I endeavored to sample at least one man from each decade beginning with age 50.

However, as the study progressed, I included more Black MSM aged 21-29 based on the prevention literature’s increased focus on young Black MSM (Bird & Voisin, 2013; Hall & Applewhite, 2013; Lelutiu-Weinberger et al., 2014; Lyons, Johnson, & Garofalo, 2013; Scott et al., 2014; Shah et al., 2014; Voisin, Bird, Shiu, & Krieger, 2013; Wilson et al., 2014). As a
general recruitment approach, I contacted gatekeepers and former key informants from the pilot study to identify new Black MSM participants. The gatekeepers were from my professional network of NYC’s health, mental health, and social services providers and their organizations. Although several key informants were participants from the pilot study, I did not enroll them in this study, so I could collect and analyze new data that would enable me to compare findings from this study with those from the pilot.

Data Collection

I collected demographic data using a questionnaire (Appendix A) administered at the beginning of the first interview. These data enabled me to conduct the planned analysis and to provide descriptive individual and aggregate profiles of the Black MSM participants. From August 2014 to March 2015, I collected narrative data from the Black MSM through three in-depth individual interviews to obtain detailed and nuanced information from them about their experiences. In addition to the three rounds of interviews with each participant, I conducted a fourth in-depth interview with two participants who initiated PrEP after their third interviews. The rationale for these additional interviews is detailed below. Also, I conducted three focus groups with Black MSM from the individual interviews. The focus groups served as member checking, for verification or dismissal of initial findings, and to inform further analysis.

Procedure. I developed the interview guide for the first round interviews based on my review of the Literature (Appendix B). I validated the initial interview guide with a representative sample of three HIV-negative Black MSM aged 22, 37, and 49. An additional validation step entailed a colleague who used the interview guide to interviewing me as if I were a participant in the study. The process of piloting and validating the guide with Black MSM and having a colleague interview me enabled me to refine the interview questions and to focus on the
key domains of inquiry: social support, sex partners, experience of being HIV-negative, discussion about HIV status, sexual practices, PrEP, maintaining HIV-seronegativity, and programmatic support for seronegative Black MSM. Through an iterative process, I continued to develop additional questions based on the general themes that emerged from the first round of interviews. As a result, the second and third round interview guides contained broad, general questions and questions that were specific to each individual participant.

At the first interview, I obtained written consent and verbal assent from each Black MSM participant. For each subsequent interview, I obtained their verbal assent. The participants received $50 and a New York City Subway MetroCard for their each interview. The individual participant interviews averaged two hours in length; I digitally recorded each interview. Similarly, the focus groups were two hours in length and I digitally recorded them. The participants received $50 and a New York City Subway MetroCard for their participation. I requested that R.A. Fisher Ink, the transcription service I used, transcribe the audio data verbatim as a means of capturing as much nuance as possible. Each participant’s interviews took place in a private room on the Silberman School of Social Work at Hunter College campus. Following human subjects protection guidelines, I anonymized all participants’ identifying and demographic information. For reference purposes, I refer to each participant by an alias in the data analyses. Furthermore, only I had access to the encrypted audio and transcribed data. I stored these data on a password-protected external hard drive.

**Demographic questionnaire.** Brief questionnaires have been used in other grounded theory studies on Black MSM (see Hussen et al., 2013). For that reason, I developed a brief questionnaire (Appendix A) in order to capture the demographic characteristics of my sample. I based the development of the questions on questions included in other studies about Black MSM
(see Holtgrave et al., 2014; Hussen et al., 2013; Jones, Wilton, Millett, & Johnson, 2010; Vallabhaneni et al., 2012). From among the questionnaires I reviewed, the HPTN 061 Questionnaire (Koblin et al., 2013) was the most influential because it contained the most comprehensive series of questions purposely developed for this Black MSM population (HPTN 061, 2014). Based on this resource, I used the questionnaire to collect data on the following variables: participants’ age, race, ethnicity, residence, length of residence in NYC, place of birth, sexual orientation, gender identity, sexual history with men, and most recent sexual encounters. I also collected data on variables such as serostatus, sex role(s), HIV testing date, HIV testing frequency, drug and alcohol use, level of education, income, and religious affiliation/belief system. I used the participants’ demographics in the analyses to describe the degree to which there were commonalities and differences across these variables.

**Interviews.** I conducted a series of 25 in-depth individual interviews that allowed me to access Black MSM participants’ unique perspective on and understanding of maintained HIV-seronegativity across the aforementioned age cohorts. I explored each participant’s personal history, perspective, and experience with maintaining seronegativity, partner selection, and sexual practices. Guided by constructivist grounded theory, I selected this data collection method to gather information from their stories, as straightforward questions about their experiences, and learn how they understood their experiences. Moreover, as I created additional theoretical categories based on the data, supplemental data from participants served to augment the development of these categories (Charmaz, 2006, 2014). For instance, during their third round interviews two participants reported that they were going to adopt PrEP. Because they said their decisions were a result of their participation in the study, I considered it important to conduct fourth round, follow up interviews with each one to examine further their motivations and their
preliminary experiences taking PrEP. Although I did not focus on PrEP adoption or use as a method of their HIV-seronegativity maintenance, these Black MSM’s data could contribute to my data analyses and/or provide guidance for future research.

**Process.** I collected foundational data during my initial interviews of the Black MSM participants. I designed the second interviews to follow up on content from their first round interviews. I originally conceived their third round interviews to be supplementary to the second round interviews. I intended their final interviews to be for wrapping up their participation in the study, and as preparation for the member checking focus groups. Since I gathered each participant’s perspective across several interviews, I benefited from being able to conduct contextual analyses of their individual and microsocial behaviors. I anticipated the possibility that their heightened awareness would affect how they responded over time. Nonetheless, with the second and third round interviews, I gathered even more in-depth, unique, and informative data because of their heightened awareness. With each of their subsequent interviews, I was able to go deeper into their experiences. This occurred because the participants were motivated to understand themselves as much as I wanted to understand how they understood themselves. As a result, I was satisfied that the second and third (and fourth) round interviews were more meaningful and substantive.

Although each Black MSM agreed to participate in three in-depth interviews, not everyone completed the interview series. I conducted initial interviews with all 25 participants. For the second and third round interviews, I interviewed 23 of the 25 participants. Isaac, aged 35, and Yusef, aged 45, did not complete the series. Despite making concerted efforts to reach them, I was unable to engage them for follow up. Isaac emailed me to cancel his second interview and was unreachable thereafter. Yusef did not return messages at all. I believe it likely that Yusef
entered into a substance abuse treatment program, which was a goal he expressed in his sole interview. While my follow up attempts to reach him were unsuccessful, my colleague who referred him to the study corroborated my belief that he had entered into substance abuse treatment.

**Interview guide.** As I noted above, after I piloted and validated the initial version of the interview guide, the subsequent second and third round version of the guide I developed through an iterative process. As such, iterations of interview guides contained questions about how participants maintained seronegativity, “How do you think have you been able to remain negative?” or “Why do you think you’re not positive?” I included some questions that asked how did the participants think we could support seronegativity among Black MSM, “How can we help Black men who have sex with men in NYC stay HIV-negative?” and about their sexual practices with partners, “Tell me about what else you do to reduce your risk of getting HIV besides using condoms.” In order to understand how they made sense of their maintained seronegativity, I also included probes and follow up questions for all of the questions in the interview guides. My selected probes focused on explicating and understanding, in depth, sensitizing concepts from my pilot study as possible themes, given that I was advancing the inquiry, which began with my pilot work.

**Data Analysis**

As prescribed by the constructivist grounded theory approach, I conducted the data analysis concurrently with the data collection process (Charmaz, 2006, 2014). Constructivist grounded theory calls for the development and use of codes as tools for narrative and thematic analyses. Charmaz deems coding to link data collection and theory development because through coding, the researcher is able to “define what is happening in the data and begin to grapple with
what it means” (2006, p. 45). After I cleaned and verified all of the narrative data, I began the analytic process of coding segments of each Black MSM’s individual interview data. I coded the data using the NVIVO qualitative data analysis (QDA) and management software program, versions 10 and 11 (NVIVO, 2014, 2015). NVIVO was an essential tool that allowed me to compare and contrast all the individual interview data to establish analytic distinctions. The process I conducted, according to constructivist grounded theory, is known as the constant comparative method. Using the constant comparative method, I conducted a repetitive/cyclical process that lead to further and further refinement of emerging theory. This method helped me make comparisons at each level of my analytic work by finding similarities and differences among the data that support trustworthiness and credibility in the data.

**Memoing.** Memoing was part of my analytic process throughout the study. Charmaz describes memoing as an important step between data collection and manuscript writing (2006, 2014). By memoing, I was able to reflect on the relationship-building processes with the Black MSM in the study. My memos chronicled how my relationships with the participants had an effect on me in my role as the researcher; I used memoing as a means to address my biases throughout the study. Additionally, memoing assisted me with the constant comparative method: I wrote memos about when and how I modified or added specific interview questions and guides. In my memos, I described the evolution of the data collection and analysis processes. Memoing helped me make comparisons and connections among their data. Moreover, by memoing, I provided myself with guidance for further data analysis (Charmaz, 2006, 2014). Specifically in regard to data analysis, I used memoing to increase the abstraction level of my ideas and for examining my codes and coding processes, particularly in the early stages of the analytic process.
Furthermore, memoing allowed me to be reflexive by documenting my ideas, thoughts, and insights about emerging theory.

**Coding.** I analyzed the individual Black MSM’s interview data and the member checking focus group data using a progressive coding process. This progressive process consisted of initial line-by-line open coding followed by focused coding that ultimately lead to theoretical coding (Charmaz, 2014). Through open coding, I scrutinized each line of data to start conceptualizing ideas. With focused coding I separated, sorted, and synthesized large quantities of data for synthesizing and elucidating bigger portions of data (Charmaz, 2006, 2014). Finally, via theoretical coding I coded the array of possible relationships among categories created by focused coding, therefore making my theoretical codes integrative (Charmaz, 2006, 2014), as I progressed toward theory generation. With the assistance of a colleague, a more senior qualitative researcher in the area of HIV prevention in Black MSM populations, I developed the final codebook. To achieve intercoder agreement, we used NVIVO’s intercoder reliability function (NVIVO, 2014, 2015). We coded selected sets of the same data and established and intercoder agreement rate of 92%.

**Trustworthiness and Credibility**

In this study, I applied a “within and between” data analysis process that permitted multilevel data examination (Denzin, 1970, as cited in Bryman, 2004, p. 3). In other words, I triangulated data from within and between individual Black MSM interview data, and within and between their interview and member checking focus group data, to arrive at convergent findings (Bryman, 2004). This multiteried process guided my analysis from the concrete to the abstract by assuring the data’s trustworthiness and credibility (Cho & Trent, 2006; Shenton, 2004). I also ensured trustworthiness and credibility by member checking with Black MSM participants and
by having mentor and peer debriefs. Furthermore, I ensured trustworthiness and credibility by using the constant comparative method for data and theoretical triangulation (Charmaz, 2006, 2014; Krefting, 1991).

Since the nature of qualitative and quantitative research differ ontologically and epistemologically, it is not appropriate for me to evaluate the merit and worthiness of qualitative findings by using the quantitative criteria of reliability and validity. My ability to generalize findings from qualitative data was not a criterion used to describe the trustworthiness and credibility of these data. Trustworthiness of the qualitative data meant that the findings were substantiated based on the research design, from feedback from Black MSM participants, and in the context in which I conducted this research. Credibility rested on the “truth value” of the data. That is, how the Black MSM understood the “truth” of the phenomenon as they lived, perceived, and understood it.

**Member checking.** I shared the preliminary and subsequent findings from the data with select key Black MSM informants and three member checking focus groups of Black MSM participants. This strategy allowed me to confirm or disregard my interpretations and inductions of and conclusions from the data (Charmaz, 2006; Lincoln & Guba, 1985 as cited in Krefting, 1991). The key informants and member checking focus groups participants gave feedback that was affirmative, yet constructive. Their feedback was highly valuable for my interpretive work because it provided me with important insights and justifications for my interpretations. I used member checking as a key strategy for establishing the trustworthiness and credibility of the data and my findings. Through this process, I was able to examine and/or determine if I was “on track” with my analyses. I had a means to gauge if I accurately interpreted their collective, lived
experience. With their feedback, I was able to synthesize further their narratives toward the development of theory about seronegativity maintenance in Black MSM.

Because I relied heavily on memos during the analysis, I was mindful about voicing over what the Black men articulated in their narratives. I mention this because I practiced this same mindfulness when the participants were providing feedback on the findings. Most focus group participants agreed with my interpretations. They supported and embraced the preliminary findings as relative to their own experiences as Black MSM who constantly face seroconversion. There was, however, slight hesitation among some participants about the concept of agency as something that they possessed. Despite this hesitation, they assured me that I had an interpretation that was viable within my theoretical framework.

**Mentor and peer debriefing.** I discussed my analytical processes with my mentors, peers, and colleagues (Krefting, 1991). My colleagues were two highly reputable experts in the field of HIV prevention research on Black MSM. Debriefing enabled me to take a deeper examination of the data.

**Triangulation.** I increased my confidence and trustworthiness in the data by using multiple perspectives to analyze multiple forms of data: interviews, member checking focus groups, and memos. As an outcome, I had a means of analysis that supported the emergence of theory grounded in the data (Charmaz, 2014; Wilson & Hutchinson, 1991). This strategy for ensuring trustworthiness added richness and complexity to my inquiry and analytic processes (Bryman, 2004; Charmaz, 2014). Specifically, I employed theoretical triangulation using multiple theoretical frames, such as Gay Resilience Theory, intersectionality, and critical race theory, when interpreting data (Bryman, 2004). Theoretical triangulation not only promoted reflexivity but reminded me that my construction of theory was influenced by my own unique,
diverse, and credible professional and personal experiences with Black MSM, public health, and HIV prevention (Charmaz, 2014).

Moreover, as an HIV-negative Black gay man with over two decades of personal and professional experience in HIV prevention, public health, and social work practice, I applied my wealth of nuanced insights and understandings about the seronegative Black MSM experience. For me, the professional had personal relevance and vice versa. This professional-personal dynamic influenced my theoretical, analytical, and interpretive frames beneficially rather than problematically. Therefore, I wrote memos in order to prevent and address the influence of this bias as I triangulated the data. Additionally as part of the triangulation process, in order to limit obscuring the Black MSM’s voices with by my own experiences, I applied in vivo codes that came directly from their narratives.

**Focus groups.** I presented the preliminary findings to focus groups of interview participants so that they could provide feedback. I invited all study participants to participate in any one of three focus groups. The three the mixed-age focus groups consisted of 15 men in total. This subsample was a fair representation across the age continuum of the sample. Across all three focus groups, Black MSM aged 50 and older \((n = 6)\) were the majority, followed by 20 and 30 year olds \((n = 4\) each, respectively), and one man in his 40s. I used the focus groups to help determine the quality of my analysis and to validate my emerging theories (Kamberelis & Dimitriadis, 2013) and coding processes. Also, I used it as a form of member checking to explore their collective descriptions and experiences with the HIV epidemic and to capture socially influenced responses within each group. Additionally, I used the focus groups to verify the trustworthiness and credibility of the data and for the explication of theory.

I presented the focus group participants with an overview of the study, demographics,
and an explanation of my analytic processes. Then, I presented each major theme with supportive quotes, three to four examples per theme, and asked for the participants’ general and specific feedback. I solicited their thoughts, feelings, and reactions. I wondered what questions they had about my interpretation of the data. Most importantly, I asked how the themes were/were not aligned with their own awareness about their strengths, resiliencies, and social processes that supported their maintained HIV-seronegativity; I asked if the themes were applicable or transferable to their experiences. At the focus groups, I also collected new data from the men by recording our discussions about my preliminary findings. I analyzed those additional data and theoretically coded them using the constant comparative method. Themes from those data provided additional guidance for the development of theory (Corbin & Strauss, 2014).

**Participant Demographics**

Below, I present a demographic profile of the seronegative Black MSM sample (Table 1). I generated these descriptive variables from the data I collected at each participant’s initial interview. I manually coded each questionnaire and then entered their data into the SPSS statistical analytic software (SPSS, 2014, 2015). Then, I ran frequency distributions and means in order to generate the following demographic profile of the sample. These descriptive variables detail age, race, ethnicity, residence, length of residence in NYC, place of birth, sexual orientation, gender identity, sexual history with men, and serostatus of most recent sexual encounters. In addition, they describe sex role(s), HIV testing date, HIV testing frequency, drug and alcohol use, level of education, income, and religious affiliation/belief system.
Table 1.

Participant Variables from the sample of seronegative Black MSM in NYC aged 21-86

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong> (<em>M</em> = 33 years, <em>SD</em> = 15.3)</td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>11</td>
</tr>
<tr>
<td>30-39</td>
<td>5</td>
</tr>
<tr>
<td>40-49</td>
<td>4</td>
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<td>50-59</td>
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<td>60-80</td>
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<tr>
<td>80 and older</td>
<td>1</td>
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<tr>
<td><strong>Race</strong></td>
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<td>Black/African American</td>
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<tr>
<td>Afro-Caribbean</td>
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</tr>
<tr>
<td>Black Puerto Rican</td>
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</tr>
<tr>
<td>Caribbean</td>
<td>2</td>
</tr>
<tr>
<td><strong>Birthplace</strong></td>
<td></td>
</tr>
<tr>
<td>US-born</td>
<td>20</td>
</tr>
<tr>
<td>Caribbean-born</td>
<td>5</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
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</tr>
<tr>
<td>Manhattan</td>
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<tr>
<td>Brooklyn</td>
<td>7</td>
</tr>
<tr>
<td>Bronx</td>
<td>7</td>
</tr>
<tr>
<td>Queens</td>
<td>1</td>
</tr>
<tr>
<td><strong>Length of Time in NYC</strong></td>
<td></td>
</tr>
<tr>
<td>Lived in NYC ≤ 5 years</td>
<td>4</td>
</tr>
<tr>
<td>Lived in NYC ≥ 5 years</td>
<td>21 (<em>M</em> = 22, <em>SD</em> = 17)</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
</tr>
<tr>
<td>Gay</td>
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<tr>
<td>Bisexual</td>
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<tr>
<td>SGL</td>
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</tr>
<tr>
<td>DL</td>
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<td><strong>Gender Identity</strong></td>
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</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td><strong>Sex roles and sex partners</strong></td>
<td></td>
</tr>
<tr>
<td><em>My sex role is...</em></td>
<td></td>
</tr>
<tr>
<td>Top</td>
<td>8</td>
</tr>
<tr>
<td>Bottom</td>
<td>2</td>
</tr>
<tr>
<td>Versatile</td>
<td>8</td>
</tr>
<tr>
<td>Versatile top</td>
<td>5</td>
</tr>
<tr>
<td>Versatile bottom</td>
<td>2</td>
</tr>
<tr>
<td><em>My partners’ sex roles are...</em></td>
<td></td>
</tr>
<tr>
<td>Top</td>
<td>1</td>
</tr>
<tr>
<td>Versatile top</td>
<td>5</td>
</tr>
<tr>
<td>Versatile</td>
<td>11</td>
</tr>
<tr>
<td>Versatile bottom</td>
<td>1</td>
</tr>
<tr>
<td>Bottom</td>
<td>7</td>
</tr>
<tr>
<td><em>My sex partners are...</em></td>
<td></td>
</tr>
<tr>
<td>Cisgender male partners</td>
<td>21</td>
</tr>
<tr>
<td>Mix of cisgender men, cisgender</td>
<td>4</td>
</tr>
<tr>
<td>women, transgender men,</td>
<td></td>
</tr>
<tr>
<td>and/or transgender women</td>
<td></td>
</tr>
</tbody>
</table>
Table 1. Con’t

*Participant Variables from the sample of seronegative Black MSM in NYC aged 21-86*

<table>
<thead>
<tr>
<th>Descriptive</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual History and Last Sexual Encounter</strong></td>
<td></td>
</tr>
<tr>
<td><em>Number of sex partners in last 3 months</em></td>
<td></td>
</tr>
<tr>
<td>≤ 15</td>
<td>23</td>
</tr>
<tr>
<td>≤ 20</td>
<td>1</td>
</tr>
<tr>
<td>≤ 23</td>
<td>1</td>
</tr>
<tr>
<td><em>Condom use with last partner</em></td>
<td></td>
</tr>
<tr>
<td>Condom</td>
<td>17</td>
</tr>
<tr>
<td>No condom</td>
<td>8</td>
</tr>
<tr>
<td><strong>Relationship with the last partner you had anal sex with</strong></td>
<td>7</td>
</tr>
<tr>
<td>Hookups</td>
<td>2</td>
</tr>
<tr>
<td>Boyfriends</td>
<td>4</td>
</tr>
<tr>
<td>Friends with benefits</td>
<td>3</td>
</tr>
<tr>
<td>Other relationships</td>
<td>2</td>
</tr>
<tr>
<td>Monogamous</td>
<td>2</td>
</tr>
<tr>
<td>Non-monogamous</td>
<td>3</td>
</tr>
<tr>
<td>Partners or husbands</td>
<td></td>
</tr>
<tr>
<td><strong>Last partners’ ages, 23-51 (M = 37, SD = 10)</strong></td>
<td>6</td>
</tr>
<tr>
<td>20-29</td>
<td>8</td>
</tr>
<tr>
<td>30-39</td>
<td>7</td>
</tr>
<tr>
<td>40-49</td>
<td>3</td>
</tr>
<tr>
<td>50+</td>
<td>1</td>
</tr>
<tr>
<td>Did not report</td>
<td></td>
</tr>
<tr>
<td><strong>Last partners’ race</strong></td>
<td>21</td>
</tr>
<tr>
<td>Black</td>
<td>4</td>
</tr>
<tr>
<td>Latino</td>
<td></td>
</tr>
<tr>
<td><strong>Sexual Activities</strong></td>
<td></td>
</tr>
<tr>
<td><em>Oral sex, giving</em></td>
<td>18</td>
</tr>
<tr>
<td>Giving oral sex without a condom</td>
<td>5</td>
</tr>
<tr>
<td>Giving oral sex with a condom</td>
<td>2</td>
</tr>
<tr>
<td>No giving oral sex at all</td>
<td></td>
</tr>
<tr>
<td><em>Oral sex, receiving</em></td>
<td>19</td>
</tr>
<tr>
<td>Receiving oral sex without a condom</td>
<td>3</td>
</tr>
<tr>
<td>Receiving oral sex with a condom</td>
<td>3</td>
</tr>
<tr>
<td>Not to receiving oral sex at all</td>
<td>3</td>
</tr>
<tr>
<td><strong>When I have intercourse, I...</strong></td>
<td></td>
</tr>
<tr>
<td>Top with condoms</td>
<td>15</td>
</tr>
<tr>
<td>Top without condoms</td>
<td>7</td>
</tr>
<tr>
<td>Do not top at all</td>
<td>3</td>
</tr>
<tr>
<td>Bottom with condoms</td>
<td>12</td>
</tr>
<tr>
<td>Bottom without condoms</td>
<td>3</td>
</tr>
<tr>
<td><strong>HIV Status and Testing History</strong></td>
<td></td>
</tr>
<tr>
<td>Last HIV test, 3 to 6 months</td>
<td>14</td>
</tr>
<tr>
<td>Last HIV test, 6 to 12 months</td>
<td>6</td>
</tr>
<tr>
<td>Last HIV test, one year or more</td>
<td>5</td>
</tr>
<tr>
<td><strong>Partners’ HIV status</strong></td>
<td></td>
</tr>
<tr>
<td>HIV-negative</td>
<td>14</td>
</tr>
<tr>
<td>HIV-positive</td>
<td>4</td>
</tr>
<tr>
<td>Unknown</td>
<td>7</td>
</tr>
<tr>
<td><strong>Found out about partners’ HIV status</strong></td>
<td></td>
</tr>
<tr>
<td>Had “the talk”</td>
<td>10</td>
</tr>
<tr>
<td>Tested with partners</td>
<td>6</td>
</tr>
<tr>
<td>Exchanged paperwork</td>
<td>2</td>
</tr>
<tr>
<td>“Trusted him”</td>
<td>7</td>
</tr>
</tbody>
</table>
Table 1. Con’t

*Participant Variables from the sample of seronegative Black MSM in NYC aged 21-86*

<table>
<thead>
<tr>
<th>Descriptive</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and Drug Use</td>
<td></td>
</tr>
<tr>
<td>I use and/or drink</td>
<td>14</td>
</tr>
<tr>
<td>I do not use or drink</td>
<td>11</td>
</tr>
<tr>
<td>In recovery</td>
<td>1</td>
</tr>
<tr>
<td>Socioeconomic Status</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>High school diploma/GED</td>
<td>6</td>
</tr>
<tr>
<td>Some college/associates degree</td>
<td>7</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>9</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>3</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>15</td>
</tr>
<tr>
<td>Unemployed</td>
<td>10</td>
</tr>
<tr>
<td>Public benefits</td>
<td>8</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
</tr>
<tr>
<td>$\leq$ $10K$</td>
<td>9</td>
</tr>
<tr>
<td>$10-29K$</td>
<td>5</td>
</tr>
<tr>
<td>$30-49K$</td>
<td>7</td>
</tr>
<tr>
<td>$50-79K$</td>
<td>3</td>
</tr>
<tr>
<td>Religiosity and Spirituality</td>
<td></td>
</tr>
<tr>
<td>Spiritual</td>
<td>12</td>
</tr>
<tr>
<td>Christian</td>
<td>9</td>
</tr>
<tr>
<td>Agnostic</td>
<td>2</td>
</tr>
<tr>
<td>Muslim</td>
<td>1</td>
</tr>
<tr>
<td>Atheist</td>
<td>1</td>
</tr>
<tr>
<td><em>Importance of your religious affiliation, belief system, or spiritual practice</em></td>
<td></td>
</tr>
<tr>
<td>Somewhat to very important</td>
<td>13</td>
</tr>
<tr>
<td>Not important at all</td>
<td>11</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
</tr>
</tbody>
</table>
Black MSM in this study were aged 21-86, with a mean age of 33 years ($SD = 15.3$). The largest age cohort consisted of men in their 20s ($n = 11$), followed by men in their 30s ($n = 5$), and men aged 50 and older ($n = 5$). Among the 50 and older cohort, four of the men were in their 50s and the fifth man was aged 86. I did not enroll anyone aged 60-85 enrolled in the study. The smallest age cohort consisted of Black MSM in their 40s ($n = 4$).

Although Black racial identity was an inclusion criterion, I found variations among the men’s reported Black identities. The questionnaire asked participants to provide a written response to the question about their race. Most men ($n = 21$) self-identified as Black/African American, one as Afro-Caribbean, another as Black Puerto Rican, and two as Caribbean ($n = 2$). Twenty men were US-born Blacks. The other five men were Caribbean-born: four Jamaican-born and one Trinidadian-born Black MSM.

Concerning residence and length of time in NYC, 10 men in the study resided in Manhattan, and the rest lived in Brooklyn ($n = 7$) and the Bronx ($n = 7$). One man lived in Queens. No one reported living on Staten Island. Four Black MSM had lived in NYC less than 5 years, while most men had resided in NYC at least 18 years or more ($M = 22$, $SD = 17$).

In response to the sexual orientation and gender identity questions, most participants selected gay as their sexual orientation ($n = 17$). Four Black MSM identified as bisexual, two as same gender loving (SGL), one man identified as down low (DL), and another indicated that he was pansexual. Twenty-four men indicated male gender as their identity. One man indicated “other” and defined his gender identity as “androgynous,” even though he self-identified as male when I screened him for study enrollment.

When asked about their sex partners, most Black MSM reported having cisgender male partners ($n = 21$). Four men reported having sex with cisgender men, cisgender women,
transgender men, and/or transgender women. Among MSM, sex role is often synonymous with sexual position with regard to anal penetration (Johns, Pingel, Eisenberg, Santana, & Bauermeister, 2012; Van Tieu et al., 2013). In this study, Black MSM’s anal sex roles were defined as insertive partner (top), receptive partner (bottom), versatile (partner who will top and/or bottom), versatile top (insertive partner who will occasionally bottom), and versatile bottom (receptive partner who will occasionally top). In the sample, eight men were exclusively tops and five were versatile tops. Other men said they were versatile (n = 8), while two said they were versatile bottoms. Two Black MSM were bottoms exclusively. When it came to their partners’ sex roles, one man preferred tops, five men preferred versatile tops, 11 men preferred versatile partners, one man preferred versatile bottoms, and seven Black MSM preferred their partners to be bottoms only.

Consistent with the study inclusion criterion, the participants’ last sexual encounters ranged from the day before to two months before the first interview. In the three months before their initial interviews, two men reported having the greatest number of sex partners. One man reported having 23 sex partners, while the other reported 15 partners. Those two were outliers, because the preponderance of men reported having anal sex with eight or fewer partners. Although not specifically captured by the demographic questionnaire, most men reported being sexually active with men for “a very long time.” In their interviews, most men aged 50 and older reported being sexual active with men since their 20s, which was similarly true for most Black MSM in their 40s and 30s. The participants in their 20s, for the most part, reported being sexually active with men for a minimum of three to four years. In general, most Black MSM reported using condoms consistently with their partners (n = 20) in the last three months, although five had not been as consistent. However, when asked specifically about their most
recent sex partners, 17 men reported condom use and eight reported no condom use. The
participants described their last sex partners in rank order as hookups, boyfriends, friends with
benefits, “other” relationships, monogamous and non-monogamous main sex partners, and
partners or husbands. Their partners were aged 23-51 ($M = 37, SD = 10$). Most of their partners
were aged 33 or younger ($n = 13$) and were Black ($n = 21$) or Latino ($n = 4$). No one reported
having sex with partners of other races or ethnicities during their last sexual encounter.

Pertaining to their sexual activities, most Black MSM preferred giving oral sex without a
condom ($n = 18$). Five men gave oral sex with a condom and two men stated that they did not
give oral sex at all. Nineteen participants preferred receiving oral sex without a condom and
three participants preferred receiving oral sex with a condom. Three men preferred not to receive
oral sex from partners. For the Black MSM who topped their partners (tops, versatile tops, and
versatile men), fifteen preferred to do so with condoms and seven preferred to do so without
condoms. Among the fifteen Black MSM who reported that they bottomed (bottoms, versatile
bottoms, and versatile men), most used condoms ($n = 12$), while three men did not use condoms
for receptive anal sex. Noteworthy is how the participants’ self-identified sex roles did not match
up with their preferred sex role activities.

Most Black MSM tested every three to six months ($n = 14$), which is aligned with the
CDC’s MSM HIV Testing recommendations. Others men tested every six months to a year ($n = 6$) or once a year or more ($n = 5$). Concerning their last sex partners’ HIV status, they reported
that their partners were HIV-negative ($n = 14$), HIV-positive ($n = 4$), and of unknown serostatus
($n = 7$). The participants found out about their partners’ serostatus in the following ways. Ten
had discussed HIV status (had “The Talk”), six tested with their partners, two exchanged HIV
test paperwork with their partners, and the others either had been acquainted with their partners
as friends or “trusted him.”

A little more than half of Black MSM used drugs \( (n = 14) \) and/or alcohol. Eleven reported no alcohol and/or drug use; one man had been sober for nine years. Among those men who used, alcohol and marijuana were their common substances of choice. Although participants reported more alcohol and marijuana use, they did report that they used cocaine, GHB, and crystal meth. A participant reported some unspecified pill consumption.

The socioeconomic profile of the sample is as follows. Six participants had a GED/high school diploma or fewer years of education. Seven men had some college education and/or associates degrees. Nine Black MSM had college degrees (BAs) and three men had some graduate education and/or a master’s degree. More than half of the men were employed \( (n = 15) \). Some men received public benefits or SSI \( (n = 8) \). Regarding annual income, the participants were in the following income brackets: less than $10K \( (n = 9) \), $10-29K \( (n = 5) \), $30-49K \( (n = 7) \), and $50-79K \( (n = 3) \).

The majority of Black MSM had a spiritual and/or religious affiliation. Most described themselves as spiritual \( (n = 12) \), followed by Christian \( (n = 9) \). Two men were agnostic. One man was Muslim and the other one was an atheist. When they were asked about the importance of their religious affiliation, belief system, or spiritual practice was, 13 Black MSM reported it as important and 11 reported it as not important. One participant did not answer this question.

**Participant Demographics Summary**

This sample of seronegative Black MSM can be described as follows. The majority were long-time NYC residents, American-born, gay-identified men who preferred cisgender male sex partners. Their ages ranged from 21-86, and they reported having had recent sex partners who were close in age or age peers. Although most Black MSM described themselves as tops, the
majority of them preferred versatile- and bottom-identified sex partners. Many of the participants had eight or fewer sex partners at the time of the first interview, with the exception of two outliers who had 15 and 23. Black MSM reported being condom users, particularly with their last sex partners. Intraracial sexual partnering was common among the sample, and very few had partners who were not Black. The men described their most recent sexual relationships as predominately casual and monogamous, with a few having had non-monogamous primary relationships. Concerning the sample’s sexual activities, giving and receiving condomless oral sex was popular, and regardless of sex role, condom use for anal sex was a reported practice for most men. Although some Black MSM reported condomless anal intercourse (CAI) with their most recent partners. This sample of men tested routinely for HIV and reported having HIV-negative partners. Fewer Black MSM had sex with seropositive men, and almost a third of the sample reported sex with someone of unknown serostatus. Most participants had “The Talk” by discussing HIV status with their partners, and some even reported having taken HIV tests with their partners. Because many men had preexisting relationships with their partners, they were more likely to believe their partners when they reported being HIV-negative. The men in the sample were mainly college educated and employed, although some were working class to low income. Finally, spirituality and religiosity were important to these men.

**Summary**

This chapter presented the study design. This study’s design offered an alternative to public health’s traditional approaches to the exploration of HIV prevention in Black MSM populations. Its design, methodology, and methods centered on the examination of Black MSM’s maintained seronegativity by using constructivist ground theory methods and sensitizing concepts from Gay Resilience Theory. By investigating sensitizing concepts from Gay
Resilience Theory, via a constructivist grounded theory approach, I qualitatively collected data and used a rigorous, multistep data analysis process to interpret the findings. As a result, I altered Gay Resilience Theory through my constructivist grounded theory approach. Therefore, applying several of Gay Resilience Theory’s sensitizing concepts to my constructivist grounded theory approach facilitated my ability to identify the seronegative Black MSM’s strengths and resiliencies. Specifically, I identified several protective and preventative factors that have helped them in their efforts to maintain their seronegativity.

I used a purposive sampling strategy to recruit a diverse cohort of Black MSM participants that could provide varying experiences of seronegativity maintenance across the life course. I enrolled 25 Black MSM in the study and collected their demographic data that gave some demographic context and insight for to my analysis of their narrative data. I collected the Black MSM’s narrative data via a series of in-depth interviews with each participant over a period of several months. Using the constant comparison method, I conducted data analysis concurrently with data collection. I coded the data using a progressive data process that lead to higher levels of abstraction and theory emergence. I assured trustworthiness and credibility of the data and my interpretations by memoing and documenting my methods iteration process. I conducted member checking with select participants and debriefed with my mentor and peers. Finally, I triangulated the data and conducted member checking focus groups to test my nascent theory and interpretations.

The next chapter begins my presentation and discussion of the study’s findings. Included in this dissertation are three findings chapters. These chapters discuss the majors themes that emerged from the study: agency, social supports, and constructed HIV risk. The order in which I present these findings is intentional. Conventional public health empirical reporting places a
great emphasis on the examination of Black MSM’s sexual practices and behaviors. Black
MSM’s seronegativity maintenance practices and behaviors are important, but I approach this
presentation differently. I begin by contextualizing the findings by presenting those things that
support their ability to make actionable their sexual practices and behaviors. In other words, why
Black MSM are able to maintain seronegativity, and then how they do it. In the next chapter, I
discuss agency as a strength that enabled the Black MSM to maintain HIV-seronegativity.
CHAPTER 4: AGENCY

Seronegative Black MSM possess identifiable strengths and resiliencies that have been understudied in HIV prevention research. In this chapter, I introduce thematic findings related to my research questions about their seronegativity maintenance:

1) What are the strengths and resiliencies that contribute to the maintenance of seronegativity in Black MSM?

2) What are the strategies and tactics, besides condom use, that Black MSM employ to maintain their seronegative status?

This chapter discusses the men’s agency as represented by three types: exemplified, equivocal, and transformative agency (Figure 2). I use the participants’ narrated experiences to describe how this theme enhanced their ability to maintain HIV-seronegativity. Additionally, the findings in this chapter discuss how they recognized their HIV risks, and how they actively took measures to mitigate those risks (Millett, 2015). I include the participants’ descriptions as quotes from their narratives to highlight this theme using participants’ pseudonyms.

Social work’s strength-based approach emphasizes the importance of one’s personal power, competence, and self-efficacy (National Association of Social Workers [NASW], 2017). Examples of these attributes are found in research furthering the development of empowerment theory and include social work’s value of self-determination. In the context of their sexual relationships and other encounters, these seronegative men spoke about their ability to influence others by exercising their own personal power. I operationalized their personal power as the construct, agency, which I defined as synonymous with authority. According to Bandura, personal agency is the mechanism through which, “[p]eople make casual contributions to their own psychosocial functioning” (1989, p. 118). Cole furthers Banduras definition of agency by
adding it is “how people think for themselves and act in ways that shape their experiences and life trajectories” (2007, para. 2). One of strengths the men described was their ability to exercise agency in their sexual relationships and casual encounters as a means of facilitating their seronegative maintenance.

I found that the Black MSM exercised three discrete types of agency. Some men were able to exercise their agency because of their level of self-awareness based on self-identified attributes and positive self-conceptualizations. These men exercised exemplified agency. The second type, equivocal agency, was drawn from exposure to risk reduction education common to public health HIV prevention interventions and messaging. Others exercised transformative agency, which meant they underwent a process of becoming aware and learning how to exercise their agency due to a “close call” or “slip up.” Moreover, I discovered that their near misses with HIV served as catalysts for growth, which allowed them to progress forward towards developing resilience (Marston & Marston, 2018). For all men, their agency types included combinations of the following components: self-efficacy, positive self-regard, positive self-esteem, and resilience. I identified the participants’ agency in their attitudes, behaviors, beliefs, and actions.
Figure 2. Types of Agency. The seronegative Black MSM’s three discrete types of agency. The men who exercised exemplified agency did so because of their level of self-awareness based on self-identified attributes and positive self-conceptualizations. Those men with equivocal agency drew from exposure to risk reduction education common to public health HIV prevention interventions and messaging. Others who exercised transformative agency underwent a process of becoming aware and learning how to exercise their agency due to a “close call” or “slip up.”
Leveraging Attractiveness as Currency

Researchers have examined the role of attractiveness in the sex roles, partner selection, and dating preferences of gay men (Reed & Miller, 2016; Sergios & Cody, 1986; Swami & Tovée, 2008). Some studies have described attractiveness, regardless of the degree of subjectivity, as a key component of one’s positive sexual health (Robinson, Bockting, Simon Rosser, Miner, & Coleman, 2002; Robinson, Galbraith, Swinburne Romine, Zhang, & Herbst, 2013). Some participants, whose positive self-conceptualizations included attractiveness, recognized how their attractiveness enabled them to be more discerning in their sexual encounters.

And so some people, sometimes, when that opportunity [for sex] comes along, even if they know it might be unsafe, they accept it because they don’t know when it’s going to come along [again] and I think I have been spared that [lack of opportunities to have sex]. You know besides the fact that I’ve been prepared [for sex] and so on, I think there’s a certain currency I have based on what society thinks is good-looking. (Samuel)

Samuel, aged 47, recognized how “[some] people have low self-esteem, they think they’re ugly, they think people don’t like them, they don’t know how to do it [socially engage], they’re, you know, like misfits socially and so on” and are less likely to negotiate their sexual practices with partners. He acknowledged that men told him he had physical attributes they found “very physically attractive.” This meant that “at some point somebody’s going to want to have sex with me that I’m going to want to have sex with [or not], so I don’t—at least I could call the shots at some level because I have the cache [physical attributes] that they want.”
Because Samuel was aware of his attractiveness as “currency” or “cache,” he was emboldened to exercise agency in his sexual encounters. He exercised agency by being selective about with whom he would or would not have sex. More importantly, he determined how he had sex with his partners, which was “safe only” after a discussion about serostatus (Bird et al., 2017). Because Samuel was accustomed to receiving compliments about his attractiveness, stating “people compliment me all the time,” he had a positive self-regard that empowered to take up his authority and demonstrate a high degree of agency by being direct and assertive (Leaper, 1987) in sexual situations.

Samuel also recognized that not everyone was like him, able to exercise the agency that he had, “which ultimately puts people in trouble.” According to him, those with low agency were more passive and nonassertive (Leaper, 1987) and more willing to have indiscriminate sex with partners. Therefore, when an opportunity presented itself, those with low agency, according to Samuel, made sexual decisions from a place of insecurity and were more likely to engage in risky sexual activities such as condomless anal intercourse (CAI). Although Samuel’s statements may sound vain, he was proud in his ability to maintain HIV-seronegativity, since he understood his agency. I experienced him as a humble man who poignantly spoke to his ability to be self-reflective as one of the older and spiritually oriented men in the study.

**Being Picky**

In contrast, Donté at 29 years old operated from a place of high self-regard. He boastfully embraced his agency. He described several situations in which he declined sex because “he [potential sex partner] wasn’t cute enough for me.” He viewed “pickiness” as a protective factor that fueled his agency:

Because I’m picky. I think that’s the main reason [why I’m HIV-]. Because it’s
like, if I wasn’t picky, I would have sex with *any* guy, and I’m sure I would have contracted something [an STI]. I am positive I would have contracted something, because, I mean, the amount of guys that ask to have sex with me, and I don’t have sex with all of them, that’s a reason. That’s a reason, because if I wanted to, I could get sex every night, every night, if I wanted to. I know I can.

Other studies have examined MSM’s explicit partner selection criteria and their selection processes similar to Donté’s (Bird et al., 2017; Dworkin et al., 2017; Kelly, DiFranceisco, St. Lawrence, Amirkhanian, & Anderson-Lamb, 2014). He attributed his positive self-regard and high self-esteem to this attractiveness currency and arguably his ego inflation. Based on Leapers agency typology (1987), Donté exercised high agency in his interactions with other gay men. An example was when he told a story about how he set strong boundaries when a partner wanted to have “risky sex.”

‘Do you want to use poppers [alkyl nitrate]?’ And I know what those are but I don’t know how to use them, so I was like, ‘No.’ He’s like, ‘Well we can use them.’ So, you want to use poppers and I don’t, I’m not using them, I’m not having sex with you. *Boom!* [oral exclamation mark].

In that situation, Donté’s partner wanted them to use poppers, a popular chemical inhalant used to enhance sexual intercourse. As a “strict bottom (exclusive receptive partner),” Donté knew how poppers relaxed the anal sphincters making anal penetration easier. If he did poppers his concern was whether he would be unable to determine if his partner “takes off the condom or not.” Because he was not willing to take that chance, he remained committed to excluding partners who insisted using any drugs for sex.
I’m very picky, like, I listen to how you talk to me, and I listen—because I want to know exactly what’s going on with them. Because if you say you want to chill, I want to know what does that relationship mean, you know? So guys who smoke [marijuana], I probably won’t go meet, because I don’t smoke . . . . I won’t go meet any guys who use any kind of sexual stimulants, like poppers. I won’t meet a guy who uses those, or Viagra, or any of those. I’m not meeting the guy.

Because Donté understood his increased sexual risk as a bottom, he exercised his agency to reduce his risk. Particularly in relation to sex and drug use, his statements spoke to what previous research has indicated about how Black MSM are less likely to mix sex and drugs as a harm reduction approach (Millett et al., 2012; Millett, Flores, et al., 2007). Donté also shared how his agency empowered him in his sexual encounters because “[tops (insertive partners)] believe bottoms have no power.” He attributed his HIV-seronegativity to how he approached sex with an attitude of high regard for his own sexual health, “because I know who I’m having sex with, and I know who I’m not [emphasized] having sex with.” Donté wanted to be certain that no one could ever say to him, “You gave me something.” Although he did not express himself with Samuel’s humility, he felt able to negotiate in his sexual encounters at any given time.

Equivocal Agency

“Doing what I’m supposed to do”

Nate was an astute 21 year old and one of the youngest men in the study. One of Nate’s strengths was a combination of his positive self-regard and awareness of his agency. He presented as an exemplar or a poster boy for the positive affect of MSM-focused public health HIV prevention campaigns and messaging (French, Bonell, Wellings, & Weatherburn, 2014). When asked about condom use in his first sexual encounter, he replied matter-of-factly,
Yes, because that’s what you’re supposed to do. I know what I need to do and I know I have to do it. Even though I’m young, I am persuasive…and I know that I’m cute and that dudes want me, so I work it [laughs].

He elaborated on these comments by explaining how he exercised his agency because he did not want to have a reputation for being sexually promiscuous, because he possessed positive self-regard,

I think just because, just being safe, you know, to a large degree, and caring about myself and having some fear of [HIV], you know, you know, doing something and, you know, possible results or repercussions of that [getting HIV]. [pause] And not being like, you know, a total hoe [sexually promiscuous], and just you know, going around and fucking everybody or letting everyone fuck me, you know? [pause] But there’s people with like the most ridiculous body counts [number of sex partners] that are still HIV-negative. That’s never going to be me [someone with a high body count].

Although Nate stated that here are “people with like the most ridiculous body counts [number of sex partners] that are still HIV-negative,” he implied that “being a total hoe” superseded the significance of HIV-seronegativity maintenance. Subtler in his statement was an undertone of how having a large number of sex partners increased HIV risk that was about having a low self-regard, which implied lower agency. However, Nate pointed out how difficult it was for him and his peers to dissociate having “large body counts” from assumed CAI. Nate’s dissonance resulted in his ambivalence about how sexual behaviors were more important than the number of sex partners were. His description aligned with a recent study by McDavitt and Mutchler (2014) that suggested for young gay men, sexual judgmentalism (“slut”/“hoe”
shaming) can obstruct communication of sexual health risks.

When I asked Nate how someone his age became self-assured and confident enough to negotiate his sexual encounters, he told me that beginning in high school, he was educated on the risks of contracting HIV. Also as a young Black man living in NYC, he was part of the “targeted populations,” that is, the focus of several HIV prevention campaigns. From his perspective as a young Black man having gay sex in the third decade of the epidemic, “But I’ve just always, I think just because, you know, just seeing safer sex messages, whether they was heterosexual or homosexual, just always about being safe….and I was always like, I know I need to be safe.” His exposure to risk reduction education mitigated his desire to rack up “larger body counts.” Nate admitted “people make assumptions” about men his age concerning their ability to negotiate safer sex and implement risk reduction practices.

When Nate began the study, he was dating an HIV-positive Black man. His relationship ended during the course of the study. When he learned his partner’s HIV status, it was “clear that we was going to be using condoms from the get go.” Nate admitted finding comfort in knowing that his partner was undetectable (virally suppressed). Having a seropositive partner did not dissuade him from pursuing the relationship. Instead, it provided him with a degree of assuredness, resolution, and commitment to practicing safer sex. He felt empowered knowing that he was with someone who was seropositive. He said,

I can’t take no chances, no slip ups . . . [Y]ou know, people I’ve known from the past, and I’ve taken them at their word [that they were HIV-negative].…with someone positive, I know I can and must insist on using protection.

Similar to Samuel and Donté, Nate was aware of how his physical attractiveness was currency that he could leverage via his agency. For instance, Nate shared how he had been with HIV-
positive men who were not amenable to using condoms until he “pulled the ‘I know I’m cute and can get someone else who will use protection with me’ card.”

**Setting Boundaries**

Most participants who were in their twenties reported consistent use of their agency. Perhaps, their ability to exercise their agency was an artifact of being Millennials, which is a generation typified as “entitled” and more apt to exercise their sense of entitlement (Stein, 2013). I highlight the young men in the study’s consistency, since young Black MSM are the ones most affected by HIV among all MSM (CDC, 2017; KFF, 2017; NYCDOHMH, 2017). Victor, aged 23, stated that typically young men are believed to be more vulnerable to persuasion especially in intergenerational relationships with older male partners (Chamberlain, Mena, Geter, & Crosby, 2017; Millett et al., 2006), which is supported in studies that compare intergenerational risk among Black MSM (Garcia et al., 2016; Hussen et al., 2013). In contrast to the findings from prior studies, I found the opposite generally true among participants in their 20s who represented the largest age cohort. Victor’s recount of a “typical” situation in which he was with a partner 20 years his senior is an example. During the encounter, Victor was steadfast to his preferred practices of condom use for oral and anal sex. Even though he knew his partner was HIV-negative and Victor was taking preexposure prophylaxis (PrEP), he was unwavering in his insistence on condom use. He described how he exercised his agency during the encounter:

No. No. There was one time that one of my partners—or friend with benefits [casual partner], I’ll say—wanted me to give him a blow job, and you know, he wanted me to perform something that I wanted to do [give him a blow job], and I told him “No,” because he wanted me to do something like that without a
condom, and it’s not the same feeling with a condom, without a condom, and he got very upset and mad, but I told him that’s the way it was…

Victor specified his commitment to maintaining HIV-seronegativity: (a) he was adherent to his daily PrEP regimen, (b) he required condoms for both oral and anal sex, and (c) he was more likely to have sex with partners who recently tested HIV-negative and in most cases would ask to see recent test results. Similar to Nate, he attributed his commitment to public health HIV prevention recommendations for MSM. This made his risk reduction practices intentional and purposeful. Similar to others in the study, Victor’s agency was buttressed by the knowledge that his physical attractiveness was currency that he could leverage. He explained how “easy it was” for him to kept his stance. He knew his partner was “frustrated to the point that he wanted me to leave . . . [but would] come back later…coz he liked me since I’m young and cute.” Victor wanted to please his partner and clearly articulated that if his partner wanted his “hot, young mouth and ass” that “you gotta be protected, it has to [be]. And any given moment, something like this, you can slip, and it could go chaotic. Coz I know he wants me, I’ll work the situation to my advantage, you know?”

Victor had a strong commitment to stringent prevention practices, even though he had been taking PrEP for two and a half years prior to being in the study. Contrary to predictions about PrEP-related sexual risk compensation increasing sexual risk taking (Calabrese, Underhill, & Mayer, 2017), Victor followed the public health recommendation about PrEP being used in conjunction with condoms. Probed further, Victor explained how he came to exercise his agency in his sexual relationships.

When I started up, you know, when I started being sexually active, yes. When I started being sexually active, yes, but I was going— you know, I was actually
going into that world [gay world], you know? Experimenting sexually and everything and then it came to a point that I got scared one time, and I said, ‘This is who I am. It’s scary, I know, but I know I got to keep [myself] protected.’ I have to protect myself, because there’s a lot of people that find me attractive, and I have to protect myself—and since that day, I made a commitment to myself, not anybody [else]. I told them [my partners] this rule towards the way I am, and it’s protected [sex], yes; ‘not protected,’ I don’t want to hear it, about anything [unprotected].

This description was typical among others who felt empowered to reduce their risks when they began to accept their sexuality. Gay resilience theory describes this process as demonstrative of the individual-level resilience factor related to self-monitoring, regulation of behavior, and limit setting (Herrick et al., 2014). Victor demonstrated his resilience and agency through consistent limit setting with his sex partners.

**Being Diligent**

Regardless of their age, men in the study expressed real and inherent challenges to consistently practicing safer sex and/or risk reduction. They described having condom fatigue, desiring closeness and intimacy through CAI, and lamenting how “nobody uses condoms anymore.” However, they maintained a general attitude of “I can get what I want…and I want to be safe” (Earl, aged 50). How they exercised their agency in sexual situations bolstered this attitude. This finding was consistent across all age cohorts. Among the men aged 50 and older, Willie, aged 86, and the oldest man in the study, purported how he could still “work it [attract partners for sex]” and still felt confident enough to exercise his agency despite his age. He
reported a robust and active sex life and exhibited few of the sex and intimacy issues found in older gay men (Pope & Schulz, 1991; Pope, Wierzalis, Barret, & Rankins, 2007).

Similar to many gay, bisexual, and other MSM during the mid-1980s AIDS era (Hammack, Frost, Meyer, & Pletta, 2017), Willie honed his practices of negotiating safer sex: “…I was very diligent. Very diligent, and if a person didn’t want to use them [condoms], then it was, okay, that’s it, you know? We’re not gonna do this [have sex at all].” Similar to other men’s narratives, Willie recognized that his physical attractiveness and desirability fueled his ability to exercise his agency in sexual situations. More specifically, “for decades,” he shared how his attractiveness, charm, and charisma were currency in potential sexual situations: “…I meet men all the time, so…. And from the first time I used condoms…and it was like a novelty then [in the 1980s], but the more people that were dying, I said, ‘No, no, no, this is what I’m gonna do [use condoms].’” Willie shared how, even at 86, his agency is still strong: “…and I still tell my partners, ‘This is what I’m gonna do’…if not, then I’ll go find someone else in the park [laughs].” Willie’s sexual encounters typically occurred in public parks, and he spoke about his ability to negotiate his risk reduction practices in that context by making sure his partners understood, “I told him that I’m going to be making sure that I’m safe and I want you to be safe too [by using condoms].” Research has shown that sex in public spaces can be challenging, because sex can be rushed, there may be no risk reduction discussion at all, and alcohol and drug consumption may be present (Parker et al., 2017).

Transformative Agency

Having a “Close Call”

A younger participant, 25-year-old Fred, described how he exercised his agency. He confided that he had been insecure and had a less positive self-regard until he realized,
'I am only as attractive as other people perceive me to be attractive,’ was what my logic was. And since other men were willing to see me as attractive, I conditioned myself into thinking, like, ‘Okay, you actually are [attractive] because these men are lined up wanting to fuck you.’

Fred’s attitudinal shift was a result of coming to terms with himself as a Black gay man. By addressing his internalized homophobia, he began embracing himself as a gay man. According to Gay Resilience Theory (Herrick, Stall, et al., 2013), his reconciliation process helped him develop both a higher self- and a higher sexual self-regard. Prompted by a negative sexual experience with a down low (DL) (non-gay identified MSM) partner, he described how his attitudinal and behavioral shifts happened after he received an STI diagnosis. Fred realized how having an STI put him at greater risk for HIV infection, and that he could have contracted HIV. This realization, which he described as a “scare” and a “close call,” motivated him to evaluate his sexual practices and to take stock of his sexual health.

Fred admitted to having had condomless sex more often than not with casual partners, even though he reported a low number of recent sex partners. Many of Fred’s sexual encounters occurred in the context of serononcordance (Bird et al., 2017). He did not know his partners’ serostatus, and he exercised a broader interpretation of his HIV risk. That is, what he would do under the assumption of being with some who was HIV-negative vs. HIV-positive.

After he received treatment for the STI, Fred committed to more frequent condom use and sexual boundary setting. He understood that he had agency and needed to negotiate sex more safely than he had previously. Fred shared the maxim that reminded him to take up his agency: “Look, you’ve had unprotected sex in several moments, and it only takes one time…and you never want that to happen.” He proudly recalled the first time he exercised his agency by
intentionally setting limits and holding boundaries with partners. It happened at a sex party where CAI was the norm, even though condoms were available.

But since most of them were DL and probably didn’t—I highly, highly doubt, particularly for the older men, that they weren’t getting tested regularly and what their motivations were behind getting tested…I would anticipate that if a man’s having sex with me, he’s probably having sex with other men as [well] . . . . So, I remember going to a sex party and having sex but it was protected. And I think between the sex party—so between the diagnosis, between the treatments, or I guess, between the treatments and then meeting [former partner]—I only remember maybe like two or three sexual partners and they were protected. They were anal protected, I didn’t have oral sex at the sex party, I was like, ‘Okay, I have limits.’

At the sex party, Fred successfully negotiated condom use, because having CAI was not a risky behavior he wanted to continue. Fred recounted how his close friends and supportive family members were happy to hear how he was changing his sexual practices to maintain HIV-seronegativity. They encouraged him to do so, and he felt confident that he could with their support. Essentially, his agency was bolstered by his social support network, which has be shown to have a positive effect on Black MSM’s ability to maintain HIV-seronegativity (Dacus et al., 2017; Reed & Miller, 2016). He realized how much he was at risk given his sexual history. He thought it was pure luck that he had “dodged the bullet” because of his inconsistent condom use and felt God had been watching over him. His sentiments were similar to what several Black MSM in my pilot study expressed about having “close calls” or having HIV “scares.” They considered themselves “lucky” to not have contracted HIV, and their luck was due to divine
intervention (Dacus et al., 2017). Subsequently, they are more apt to exercise their agency in order to reduce their HIV risks.

**Avoiding Bodily Fluids**

There were participants who, under certain circumstances, did not believe they had much agency or chose not to exercise it. Sometimes when they feared rejection from sex partners, felt lonely, or craved intimacy; they made sexual decisions from a self-described “place of insecurity,” because of “low self-esteem,” and/or “low self-worth” (Lorenzo, aged 26). Under those same circumstances, they also were more likely engage in high-risk sexual activities, “even though I shouldn’t” such as receptive CAI with a seronoconcordant partner. Similarly, the current study indicated factors associated with low agency similar to those identified in other studies about Black MSM and MSM in general and their increased HIV risk (Kelly et al., 2013, 2014; Kelly, St Lawrence, Tarima, DiFranceisco, & Amirkhanian, 2016). However, several men in the study related how they had performed more of their agency once they realized the need to take ownership of their sexual health by reducing their HIV risk.

Twenty-six year old Lorenzo described a time when his self-esteem was “pretty nonexistent” following a difficult breakup. He admitted to feeling as if he had little concern about his sexual well-being post-breakup. He admitted to “putting myself at risk…. [when s]ome of them, you know, shown, have either shown interest in me, and I—it just took me off guard because I wasn’t feeling cute and I know I’m cute [laughs].” Frequently, due to his low self-esteem and desire to be “wanted by any man,” he bottomed without a condom; in fact, he was the study participant who reported the highest number of sex partners. “[T]hat’s when I started doing the little hoe thing, and say ‘fuck niggas, niggas ain’t shit.’ That’s how I was going through the whole mental process, like, niggas ain’t shit, and stuff like that.” When his main support, non-
kinship “[big] brother,” an HIV-positive Black gay man, confronted him about his self-destructive behaviors, he began to realize, “I’m better than that—it’s not attractive no more [being a hoe], is my personal opinion, it’s not attractive no more to be, just, to be getting slayed [fucked] all through New York City.”

From that moment forward, he began the process of recovering from the breakup and exercising more of his agency “because I be scared, sometimes, to catch it [HIV]. And to catch other things too.” His big brother confronted him in a manner that was “brutal and fierce…and about tough love.” That confrontation helped Lorenzo recognize why he needed to change his behavior and how fortunate he was not to have contracted HIV. “I would say, I would say I had a lucky streak that I ain’t got infected, as much as harmful things I was doing, I didn’t get infected. I must have had a lucky streak.” Lorenzo acknowledged putting himself at risk by having CAI and felt that he did not exercise any agency in those situations. However, when probed more in-depth, he reported he had exercised agency during those condomless encounters. He did not negotiate or insist on condom use; however, he explicitly told his partners “not to cum in me.” Avoiding contact with bodily fluids such as semen, a common harm reduction practice, likely contributed to his ability to maintain HIV-seronegativity. Lorenzo’s harm reduction practice has been debated and considered a controversial seroadaptive strategy with mixed results (Grace et al., 2014; Napper, Fisher, & Reynolds, 2012). Yet, Ober and colleagues (2017) have found support for how HIV-negative Black MSM in their study of positive deviance have used this same strategy. Lorenzo’s rationale was, “I don’t need some random nigga’s cum all up in me like that.” If he were in a relationship or dating the man, he might have considered, otherwise he did not allow casual partners (“hookups”) to ejaculate inside him.
Summary

These findings add to the growing body of behavioral science knowledge about the psychosocial processes of HIV-negative Black MSM. Specifically, this chapter discussed one of the strengths participants had for maintaining their seronegative status, *agency*. I categorized agency as exercised in one of three ways: *exemplified*, *equivocal*, or *transformative* agency. Exemplified agency centered on positive self-conceptualizations that allowed participants to leverage their attractiveness to be discerning in their partner selection and sexual activity processes. Those who exercised equivocal agency were exposed to HIV prevention intervention messages and enacted those messages consistently and diligently in the sexual encounters. Last, several participants who had “near misses” of HIV exposure underwent a reevaluation process with the support of their social networks in order to exercise transformative agency. The role of social supports and supportive networks continues to be an area of investigation in HIV prevention research. The next chapter elucidates the role of these Black men’s social supports and their expectations of the participants’ maintained seronegativity.
CHAPTER 5: SOCIAL SUPPORTS

In this chapter, I discuss the role of supportive networks that helped participants maintain agency. The men described how most partners, kin, extended family, close friends, and peers provided them with invaluable support for their maintained seronegativity. My pilot study also provided evidence of the significance of supportive networks in these men’s lives (Dacus et al., 2017). I labeled their supportive networks broadly as social supports. These social supports were highly influential and often key to their ability to exercise their agency. Social supports provided mental, emotional, behavioral, and spiritual sustenance and communicated clear expectations that the men maintain HIV-seronegativity. Analysis of their narratives also revealed a relationship between how out they were and their supports’ expectations of them maintain HIV-seronegativity. Being “out” referred to the degree of the men’s sexual orientation disclosure (SOD) (Soler, Caldwell, Córdova, Harper, & Bauermeister, 2017) to their supports. As a sensitizing concept from gay resilience theory, “being out” or “outness” was operationalized as the degree to which the men had reconciled with their internalized homophobia and embraced their sexual orientation identities as gay, bisexual, and other men who have sex with men. The findings in this chapter suggest that the more out the men were about their sexual orientation identities, the more their families and friends expressed expectations that the men maintain a seronegative status. The social support theme encompassed the following categories: familial and non-familial supports. Familial supports consisted of the men’s families of origin and non-familial supports consisted of their chosen families and peers (Figure 3). In this chapter, I use the participants’ narrated experiences to describe how this theme illuminated their ability to maintain HIV-seronegativity.

Each participant had unique experiences with his family of origin. Broadly, the men
described their familial relationships as being positive, negative, or mixed. However, several men cited the pivotal role their families of origin played in their ability to maintain seronegativity. Rovers (2004) defined *family of origin* as the living unit in which a person develops physiologically, psychically, and emotionally. Nugent (2013, para. 1) defined one’s family of origin as, “the family, or parents an individual was either raised by or born into.” One’s family of origin experience has been characterized as an environment that includes interpersonal relationship dynamics, rules, and expectations about a person’s behavior (Rovers, 2004). *Family of choice*, on the other hand, has been defined as a significant person or persons in an LGBTQ person’s life who may be a partner or friend (Joint Commission, 2011).

In this study, I reframed the term family of choice with *chosen families*. Chosen family has been used by to describe how gays and lesbians have constructed their own family ties by drawing upon symbolic representations of love, friendship, and biology (Weston, 2005). More appropriate to this study, the term reflected more descriptive studies of fictive families among Black Americans (Chatters, Taylor, & Jayakody, 1994; Stewart, 2007). More recently, several scholars applied the term in place of fictive families in their examination of family typologies and support among young gay and bisexual men of color (Soler et al., 2017). Based on previous studies and guided by how the Black MSM described their chosen families are purposefully constructed, based on their definitions of chosen families (“my friend…I call her my sister,” “they have totally showed me the love I need for me to call them my family”), I expanded this definition to include the Black men’s select members of their families of origin, self-described non-kinship family, close friends, and non-kinship persons with whom they lived. Finally, for persons not considered chosen family, *peers* included platonic, intimate, and/or casual relationships with persons of the same or other genders. For social beings navigating the
precarious sexual landscape of New York City (NYC), the social supports theme described seronegative Black MSM’s beliefs and experiences of being cared for and cared about by various important people in their lives.
Figure 3. Social Supports. The HIV-negative Black MSM’s social supports were highly influential and often key to their ability to exercise their agency. Their social supports provided mental, emotional, behavioral, and spiritual sustenance and communicated clear expectations that the men maintain HIV-seronegativity. Social supports consisted of the following categories: familial and non-familial supports. Familial supports consisted of the men’s families of origin and non-familial supports consisted of their chosen families and peers.
Family of Origin

Being “A Huge Influence in My Life”

Studies have examined the phenomenon of social undermining in the lives of lesbian, gay, and bisexuals (LGB) persons. Social undermining has been characterized as manifestations of social strain, social conflict, and negative social support often expressed in the forms of intimidation, aggression, and criticism often linked to psychological distress (Soler et al., 2017; Vinokur & Van Ryn, 1993). Researchers have found that when young Black MSM do not perceive their parents as being accepting or supportive of their homosexuality, they often turn to other kinship supports as confidants such as aunts, uncles, and siblings (Dickson-Gomez et al., 2014).

Billy (aged 26) described his aunt as his “best friend,” who had been a “huge influence in my life… [as] the first person I came out to when I was 13. I still tell her everything that’s going on with me.” When Billy described how influential and supportive his aunt had been after he came out to her as a teenager, he described the first time they had the “birds and the bees talk.” During that talk, Billy said his aunt was frank, open, and honest about sex and sexuality with him “in a very real and palatable way.” She spoke to him from a position of sex positivity and never made him feel ashamed about being gay. According to Billy, her approach with him was the opposite from that of his mother, from whom he speculated had difficulty with his sexuality, because she lost a brother to AIDS in the 1980s: “…she has all these stigmas of what gayness is.” Billy attributed his aunt’s influence partly to how he had developed a positive self-concept as a Black gay man, since she made a strong effort to establish a rapport with him built on openness, honestly, and with an emphasis on sexual self-care. Billy proudly described his aunt as, “a woman who is more than a second mother to me.” He added how she regularly stated,
“Under no circumstance will you ever call me up and tell me that you have HIV, because if you do I’ll kill you myself.”

He understood that this was not an idle threat. Seeing that his aunt was someone who cared deeply for him, Billy reiterated how he “never wants to have that conversation with her [about getting HIV].” Imitating her voice he stated, “Because that means that you did not listen to what I told you, in that you did not follow the instructions that I’d given you all these years.”

Moreover, because of the closeness of their relationship, Billy stated,

And that kind of just resonated with me [her expectation that I remain HIV-negative] and it kind of just became more of a mantra for me that it was like, ‘I’m not going to disappoint my aunt by making a decision such as that [putting myself at risk], that I have control over, in that fashion.’

Although Billy’s aunt passionately described what she would do if he ever said he was living with HIV, he understood her terse statement originated from a place of deep love and concern about his well-being because one of her gay brothers had died from AIDS-related causes.

Therefore, Billy’s maintained seronegativity was of paramount importance; she did not want to lose him to HIV. Billy appreciated her toughness, because it supported his ability to exercise his exemplified agency in sexual situations. He knew he could candidly confide in his aunt about any challenges to reducing his risk because “staying HIV-negative is very important in my lifetime.”

Because of his aunt’s influence, Billy would contemplate the “what ifs”: “…Oh, so I had a one night stand with this person and never heard from them again. Oh shit, what if. Like what if they put the condom on wrong? What if there was a micro-tear?” In order to avoid the “what ifs,” he talked about how he would consult his aunt when he would become anxious, “[I]ike all
these different things start coming [to mind].” He described how he developed a practice, based on conversations he had with his aunt about intimacy, desire, and emotional and sexual fulfillment.

It’s like, you know what I’d much rather not have sex with somebody and just wait until I meet somebody who I know is going to be around for a while. And then we can go—if we think we’re at that point, we’ll get tested together [for HIV and other STIs] and we can go and start having sex and then that’s fine.

He came to the following resolution: “I’ve learned very early on in my life, that it’s just easier for me not to engage in the behaviors [that will put me at risk], to avoid the anxiety that’s going to come after the fact.” What supported his resolution was a commitment not to subject himself to “obsessive testing” in order to have “peace of mind” about is HIV status. Ultimately, any of his ruminating he would tie to his relationship with his aunt:

She’s kind of the litmus test of I ask myself, ‘What would she think if she knew?’ insert whatever it is. And if I feel like her opinion of it would not be the highest than it makes me reconsider, ‘Do I actually want to do this or do I want to go in a different direction?’ if that makes sense?

As a young man who exemplified agency bolstered by his aunt’s support, Billy took steps to further his knowledge about sex and sexuality to empowering himself more by becoming a sexual health educator in college. Because his aunt positively modeled how to express openness about sex and sexualities, he decided he would become a model for his peers how not to have any “qualms about asking [sex-related] questions.” By practicing as an educator, he felt more empowered to inquire about his partners’ statuses, the last time they tested for HIV, and their sexual history. He said, “I tend to air on the side of if I’m going to be engaging in anything
sexual with you I want to have a background on what’s going with you before I do that.”

**Having a “Very Close Relationship”**

The men aged 50 and older with sustained seronegativity identified members of their families of origin as health promoters in their lives. James’s (aged 59) case served as an example. A proud native New Yorker and “boy from Harlem,” James was “very sexually active” and in his late 20s at the onset of the epidemic. He stressed how old he was at the time, as he waxed nostalgic about the pre-AIDS era sexual freedom that existed in NYC. Reminiscing about the “happy gay days” prompted him to describe emotionally his experiences of heavy losses in the NYC’s Black gay community. Given what he “managed to live through,” his narrative served as a testament of how supportive a Black MSM’s family of origin could be. His story was one of many that countered the narrative that families of origin disavowed Black gay men. James described having a “very close relationship” with his mother and sisters who encouraged him to protect himself by using condoms and avoiding sex with HIV-positive men. The type of support James described aligns with findings from a recent study by Jeffries, Marks, Lauby, Murrill, and Millett (2013). In their study, they suggested that for Black MSM, connectedness to three or more family members lowered the odds of condomless anal intercourse (CAI).

James further spoke about how familial closeness helped him maintain HIV-seronegativity through the ‘80s and ‘90s, “while losing friends and lovers.” He adopted condom use when having relationships with HIV-positive partners decades before the introduction of viral suppressing drugs. He was “so open” about his sexuality and his relationships with men, to the extent that his mother and sisters developed close relationships with some of his partners.

I’ve been out to my family for over thirty years. It’s not been a problem. I’ve had long term lovers that they knew, and had lovers that lived with me, and I’ve lived
with them. They knew my parents, and siblings, and all of that stuff. So, that’s not been an issue.

Because his mother and sisters knew about the intricate details of his life as a Black gay man, he reported that if he were to seroconvert, they would be “devastated.”

 Seriously. [long pause] The level of, ‘You went through all of this, you didn’t—you were vocal about being negative, and dating positive men, and now, 25 years later, you become positive. What’s wrong with you?’ They would lose their minds. It would be, it would be hurtful to my family and my friends….My family would kill me.

James’s statements mirrored the voices of other men who asserted the importance of remaining “HIV-free” so as not to disappoint their families. He stated, “my family would kill me,” in a matter-of-fact way, which emphasized how serious his family was about him maintaining HIV-seronegativity. Similar to his younger peer, Billy, James did not take the seriousness of their expectations of him and his sexual health for granted.

As the oldest and only male child in his family of origin, his family had other expectations of James in addition to him maintaining seronegativity. Because of his role in the family as a “mama’s boy” and the supportive and stabilizing force that “everyone goes to for help,” he emphasized that telling his mother that he had seroconverted would be extremely difficult. Arguably, this would be the most difficult conversation he would ever have; he did not want to disappoint his mother. Concerning his sexual health, he therefore exercised his agency by insisting on condom use. James’s agency was more equivocal than exemplified. He recalled enjoying condomless sex with men before the “AIDS thing happened.” He responded to the “massive losses” and being exposed to public health prevention campaigns, along with his
family’s expressed expectation that he commit to “taking care of myself while I’m out there.” James summed it up as an expectation: “…I just can’t…I can’t go home and tell my mama that…I’m HIV-positive. It would kill her. She would kill me. She’d be so hurt. Disappointing her would be worse than actually getting HIV [tears up].”

James’s understanding of his mother’s concern parallels Black mothers’ protectiveness of their male children. The expectation that James would maintain HIV-seronegativity is similar to “The Talk” that many Black mothers have with their Black sons. The Talk concerned the inherent difficulties that James would face growing up as Black man in America. Others in the study noted how their supports expressed concern because the participants already had to contend with having multiplicatively oppressed identities (Gopaldas, 2013) as Black people and as men. Adding homosexuality to the mix of their oppressed identities further augmented their supports concerns about the men’s vulnerability. Conceivably their mothers and other supports’ concerns were magnified once the devastating effects of the HIV/AIDS epidemic became visible in NYC’s Black and Black gay communities. Therefore, HIV infection became one of their mothers’ expressed concerns when the men came out to them.

In my pilot study, the participants also described how their mothers expressed their concerns about their sons’ vulnerability to HIV and provided them with guidance and support around maintaining seronegativity (Dacus et al., 2017). Similar to the experiences of his age peers, James witnessed firsthand the devastating impact that AIDS had in his Black and Black gay communities. As a result, he knew how much his family of origin wanted him “[to be] takin’ care of yourself when you’re out there doin’ your thang with men.” In essence, protecting himself was of the utmost importance because, “I just don’t ever want to have to have that conversation with my mother.”
Committing to “Not Losing Family”

Many men considered “disavowal” or loss of their family and supports as a “fate worse than receiving an HIV-positive diagnosis.” At age 21, Paul shared what motivated him to exercise his exemplified agency to engage in consistent safer sex practices with an HIV-positive partner:

I could have lost her [my mother] as a support system, if I had [gotten it] HIV [from my ex-boyfriend]. But I mean I’m just saying that out of the fear. I don’t think she would have ever disowned me, but it would have crushed her.

Paul elaborated by explaining how his mother explicitly discussed HIV as the topic of a family talk once, which was a continuation of “The Talk” he often had with his mother. He summarized what he took away from their discussion.

And if they, you know, know that I [pause] carelessly did not take the proper precautions in sex, they would be very disappointed, you know. But I mean if I got it, I don’t think they would disown me. But definitely, though, they would be very disappointed if, you know, I revealed to them like, ‘Yeah, I did this [consciously put myself at risk] because I wanted somebody to love me.’ They wouldn’t— they would not go for that. They would still love me, but it’s just like, [imitating his mother] ‘Paul, no. Like, how could you [put yourself at risk like that]?”

Paul had to deal with stressors due to his multiplicatively oppressed identity as a “femme and petite” Black gay man. Consequently, it made sense how strongly he wanted to hold onto to his family of origin’s support. He was committed to not “losing his family” like other Black gay men he knew had. Paul was “going to not get it [HIV] no matter what.”
Chosen Families

During the first decade of the AIDS epidemic, behavioral science researchers examined HIV-positive gay men’s social support networks such as their chosen families (Hays, Chauncey, & Tobey, 1990). Their studies demonstrated how the men’s chosen families, primarily other gay men living with AIDS, provided them with invaluable psychological and emotional support as they contended with the impact of being HIV-infected or living with AIDS. The interest in gay men’s social support networks is still of particular interest to HIV researchers. One study investigated a theoretical framework for describing the degrees to which lesbian, gay, and bisexual persons’ chosen families have compensated for the lack of support of their families of origin (Dewaele, Cox, Van den Berghe, & Vincke, 2011). More recently, the family of choice hypothesis has been examined in relation to the gay youth’s online/virtual social networks (Etengoff & Daiute, 2015). Both studies have furthered the concept of chosen families as sites of resilience that are intentionally constructed (Oswald, 2002; Weston, 2005).

Most participants indicated having established a chosen family. They were labeled as social “families” that provided support for coping with familial social undermining and social rejection and homophobia (Soler et al., 2017). HIV prevention-focused research studies also have examined Black MSM’s chosen families. Specifically, researchers examined chosen families structures within NYC’s legendary House and Ball Scene/Community that has existed since the Harlem Renaissance (Arnold & Bailey, 2009; Kubicek et al., 2013). Men in the study selected their own “kin.” They described how they developed and maintained supportive relationships with persons that were similar to and/or substitutes for those relationships with members of their families of origin. The participants that constructed chosen families demonstrated a need for support and sought it. The men’s ability to construct chosen families
was not only a strength; it was also an indicator of their resilience.

**Having a “Gay Family”**

Lorenzo (aged 25) described his relationship with his “gay family” with whom he shared an apartment. His chosen family included one member of his family of origin and close friends. The family consisted of a male cousin and two “extended brothers,” who he met “at a ball” where he grew up. He described his family as,

We’re very cool, we hang out all the time. We are very friendly, we hang out, we chill, we’ll fight for each other, we’ll laugh with each other. Sometimes we have our disagreements. Basically, what regular siblings do. We have our disagreements, sometimes we have our agreements, sometimes we won’t have our disagreements. Sometimes we—sometimes we can talk on a personal level as deep as to who’s our current partner, or what we think about in our lives, or how do we feel this way. Stuff like that. We family.

Lorenzo went on to describe how his chosen family kept him “clothed, feed, nurtured,” and “loved me” after he was rejected by members of his family of origin for being gay. He described his strong bonds with the members of his chosen family, which had powerful implications such as the development of his transformative agency and resilience after having experienced severe social undermining from his family of origin for choosing to be out and “embrace that [gay] lifestyle.” His chosen family, on the other hand, supplanted the role his family of origin had in his life. He relied on his chosen family for much needed support and guidance as he explored the NYC sexual landscape. For example, when it came to the topic of HIV, “tough love is what they give me.” Lorenzo described how his chosen family expressed concern about him maintaining seronegativity,
I would say, I would say it’s very important to them. They probably was always talking in my ear, like, they always saying, ‘Well, you always having sex with these boys, these men,’ and I just be, like, airballing [letting it pass by, not taking it in]. Sometimes, they be getting on my nerves about it, because they’ll say all the time. So, I think, I think it’s very important, from their perspective, as it is very important that I remain negative. They always airballing [nagging] me, they’re always blowing my head off.

His chosen family nagged him because he admitted that it took a while for their advice to “sink in slowly.” They also stated things “a little too bluntly” for him. Rather than ask, they would confront him with questions such as, “Did you have unprotected sex recently, do you think you’re exposed?” Lorenzo knew they did “…not intended to be shady” or malicious, rather “that’s how they be.” Lorenzo elaborated on what happened when his brother and male cousin “tag teamed” him,

Lorenzo: Like, these little pep tests [sic] they give to me. Like, they’ll ask me, well, they’ll be shady [rude] about it. They said, ‘Well, what men have you had sex with this time?’ I’m like, ‘whoa.’ And I get to talking about them, they said, ‘Well, did you take your time to know their HIV status?’

Interviewer: They ask you that?

Lorenzo: Yeah, very bluntly. They’re straight to the point because they care.

Although Lorenzo did not always appreciate the “shady” approach his family members used, he understood that they wanted him to maintain HIV-seronegativity. This was especially true concerning his older brother who had been living with HIV for a number of years. Lorenzo’s brother was the most diligent and consistent about making sure Lorenzo was reducing his risk.
Further, his brother’s “tough love” supported Lorenzo’s transformative agency. Before his big brother confronted him about his HIV risk-taking behaviors, Lorenzo had exercised low agency. Yet, he did cite his big brother’s “airballing” or nagging as one of the reasons why he never let his partner ejaculate in him as the receptive partner or bottom. He “didn’t want to hear it,” meaning having to feel the verbal wrath of his big brother’s disappointment that he was, “letting niggas cum all up in me.” Although their relationship might appear abusive or even hostile, Lorenzo did not think this was the case. Their mode of communication was culturally normative, and it was natural for them to be loud and boisterous with each other, “that’s just how we is.”

**Helping Uplift “Their Fellow Brothas”**

In contrast to Lorenzo’s chosen family, Isaac’s (aged 35) chosen family took a gentler and more generous approach in supporting him. He identified their support as a main reason why he had been able to maintain HIV-seronegativity.

You know, my friends always kept me, ‘Go to school, go to work’ and, you know, when I would say stuff like, ‘Oh, I don’t want to do this anymore,’ they would be like, ‘Okay, here, I’m gonna give you money, you don’t have to do that. You don’t have to do this, you know, you don’t have to do that.’ And I think that a lot of gay Black men, because, you know, when they do come out they’re ostracized, they’re, you know—they, you know, their parents kick them out their home, they do whatever they need to do to survive, and I’m grateful that I never had to be in that position. You know, and I think that that’s also one reason that kept me HIV-negative.”

His statements provided evidence of the commitment of Black MSM’s social supports to their care. His descriptions were similar to those of young Black MSM in the House Ball and Kiki
Scene whose “gay families” took care of them in their roles as “mothers,” “fathers,” “sisters,” and “brothers” of each House (Arnold & Bailey, 2009; Kubicek et al., 2013). In Isaac’s case, his “brothers” were well-established Black gay male professionals who “come from the old school” belief that they needed to “help uplift their fellow brothas.” Isaac’s descriptions of his chosen family illustrated how some HIV-negative Black MSM’s social networks have helped them contend with social inequities in positive and meaningful ways by promoting greater sexual self-care and health (Matthews, Smith, et al., 2016). Because of their generous support, Isaac never had to resort to “doing this and that” to survive and to take care of himself. Unlike others he knew, he never had to engage in sex work or survival sex, or in his words, “turn tricks,” to feed, clothe, or “find a place to lay my head.” He implied that Black MSM who “do whatever they need to do to survive” might have done so at the risk of their sexual health. Isaac felt fortunate that he did not have to engage in survival sex or sex work, risk behaviors that one study found to be more prevalent among Black MSM that their non-Black counterparts (Millett et al., 2012).

Isaac also did not want to disappoint the people who supported him and endeavored to meet their expectations. Isaac stated with conviction how often they told him how he “wasn’t gonna get into any of that messiness,” meaning high risk sexual behavior, as long as they were “friends, close and intimate friends.” Because of their emotional, spiritual, and financial support, Isaac felt able to exercise his exemplified agency by making sexual decisions that did not involve placing himself at risk for HIV infection (i.e., condom use). He admitted he had sexual encounters in which he considered having condomless sex. However, he did not have CAI, because he acknowledged that even in those fleeting moments, he would hear his “brother’s voice speak to me.” Isaac recounted what his brother, a close friend of 14 years, always told him, “...so you know, he was basically telling me, use a condom with everyone, so that [hearing his
brother’s voice] has helped me along my way…to stay negative and use condoms.”

**Being Affirmed, Validated, and Understood**

Other participants spoke about the influence of the “brothers” from their chosen families. When Carl (aged 27) described his chosen family, he talked about being closest to his “brothers.” He compared their relationships to the degree of closeness he had with two members of his family of origin, his mother, and his twin sister. Concerning his chosen family, he spoke highly about his brothers who not only provided him with social support, but also affirmed, validated, and understood his “often complicated” co-occurring identities.

And then [there are], my buddies, my guy friends, several of them, the three that are here in New York City, are people that I’ve known for a long time, so it’s like [we can always talk about] relationships, guys, you know, [and] what it’s like to be blay [sic]—blay. [laughter] I’m trying to say Black and gay at the same time.

Carl emphasized how crucial his Black gay male friends were in his life. They were the people with whom he could talk about the “gay stuff.” His Black gay brothers were empathetic as opposed to sympathetic about his experiences as a twenty-something Black gay man in NYC “trying to figure it all out.” He stressed how paramount it was for him to have those men in his life; they were multifaceted peers, who “I would call my best friends, best male friends, [friend 1] and [friend 2]. And they—they’re African American. They’re successful [Black gay men] like me.” Black gay public health HIV prevention researchers have emphasized the significance and positive value of Black MSM’s peers and their supportive peer networks (“families”) as vectors of culturally competent and well-received prevention strategies and messages (Jones et al., 2008; Matthews, Smith, et al., 2016; Wilton et al., 2009).
Being Held Accountable

As the men described their experiences of co-occurring and multiplicatively oppressed identities (Cole, 2009; Collins, 2002; Gopaldas, 2013) as Black gay, bisexual, and other MSM, it became evident how invaluable their supports were. Just as others who drew on familial supports as psychosocial/influencing factors, they did not want to disappoint their supports. They relied on their chosen families more than they did on their families of origin. Some felt compelled or even “obligated” to exercise their agency in order to maintain their chosen family members’ expectations that they maintain seronegativity. Theo (aged 33) spoke passionately about the “sole conversation” with his “gay mother,” an older transgender woman. Their conversation focused on how important it was for her that he maintained HIV-seronegativity.

I think it’s very important, ’cause they—I think particularly my, my [gay] mother, who is—she’s positive. She will tell me, you know, ‘If you were to tell me you were positive, I would punch you in the face [emphasized]…I would. You know you can get any man you want, so you don’t have to be with just any man with a dick.’

Theo was certain that his gay mother would keep her promise of “punching him the face” if he ever told her he had seroconverted. His gay mother vehemently described how she would react if he were ever to seroconvert. She meant this as a threat and to strongly conveying how concerned she was about his sexual health. Theo knew that she “would never want me to go through what she’s had to go through” as a person who had contracted HIV. More so, her strong words to him were part of a collective set of expectations from nearly all of his HIV-positive family of friends. Theo also attributed their collective voices as a poignant reminder to exercise his exemplified agency in order to his maintain HIV-seronegativity:
I think the fact that I’m doing all these things [to remain negative], I think, and the fact that there’s people that are invested in me being negative—again, my [gay] mother being one of them, but a lotta my [HIV-positive] friends. Even the ones who are positive don’t want me to become positive. And if they know that I work in HIV prevention, they feel, they probably hold me to the same amount of accountability that she does and I hold myself to, that, you know, I know too much to not act like I don't know [how to prevent seroconverting].

Theo’s supports, particularly those who were HIV-positive, held him accountable for doing everything within his power to maintain HIV-seronegativity. Rather than relegating their influence to simple peer pressure, it was evident that his chosen family and members of his broader social network were personally “invested” in him maintaining seronegativity. Theo’s case was similar to others in the study. They illustrated a more nuanced and culturally rooted approach that Black MSM’s social supports have taken to empower and support one another as a promoter of positive health outcomes (Matthews, Smith, et al., 2016).

**Peers**

In addition to their families of origin and chosen families, many participants attributed their ability to maintain HIV-seronegativity to the influence of their peers. Their relationships consisted of platonic, intimate, casual, and mentor relationships with age, gender, and sexual orientation peers. Their peers not only included other Black MSM but also people of other ages, genders, and sexual orientations. The men valued “anybody” who “would be there from me, no matter what,” rather than exclusively seeking relationships with other Black MSM. Studies have examined Black-Black MSM intraracial sexual relationships, as one possible explanation for high seroprevalence in young Black MSM’s sexual networks in NYC (Kapadia et al., 2013) and
among Black MSM’s sexual networks more broadly (Matthews et al., 2016; Millett et al., 2012; Young et al., 2017). However, few studies have examined Black-Black MSM non-sexual relationships as promoters positive health outcomes as suggested by Matthews and colleagues (2016). The Black MSM in this study described how important their Black-Black non-sexual relationships with their peers were to supporting their agency and other methods they used to maintain their seronegativity.

**Sharing a Similar Life Trajectory**

One of the younger men, 25-year-old Fred, talked about how “my [Black] roommate is another person. She is the same age as I am, same situation I’m in, meaning recent college graduate, we’re still trying to navigate our professional lives, etcetera. Dating lives too.” For Fred, it was important to have friendships with Black people whose life trajectories were similar to his, but not necessarily with people of the same gender or sexual orientation. His Black female roommate was someone he met when he moved to NYC. They became “very close” once they became roommates. Fred appreciated having a roommate with whom he could talk about “the boys” he was dating and his sex life. He considered her a confidant and valued her opinion. She often encouraged him to exercise his transformative agency by not “letting them boys fuck me whatever way [condomless]” because he had already had a “slip up” that resulting in contracting an STI.

**Sharing the Lived Experience**

James at age 59 was one of the older men in the study. He described his supportive peer group as “mentors.” His peers were “the larger network of [Black] people I know socially, I see them out at a bar on occasion, or at parties, or through activities that I participate in.” Fred’s close friendship developed because he and his peer lived together as roommates. However,
James recounted how he and his group of peers became close as they “lived together” through the early days of the epidemic. “I was in an HIV-negative support group in the late ‘90s, because—it was a group of us who all worked in HIV, and it was six or seven of us, and three of us had partners who were positive.” James and his HIV-negative peers provided each other support, especially those who were also in serodiscordant relationships, a pairing that was “highly looked down upon.” They would discuss the challenges of being with HIV-positive partners, the social stigma that came with disclosure (“Are you fucking crazy?” “You must want to die!”), and how important it was to exercise their transformative agency as to maintain HIV-seronegativity while still enjoying rich, emotional, and passionate sex lives.

**Having Seropositive Supports**

Gay resilience theorists have stressed the importance of dyadic relationships in MSM’s lives that support positive sexual health outcomes (Herrick, Stall, et al., 2013; Herrick et al., 2014). Further, gay resilience theorists and others have described seronegative MSM’s HIV-positive peers’ vested interest in them maintaining HIV-seronegativity (Hammack et al., 2017; Herrick et al., 2014). Many of the men’s seropositive peers have been their educators and mentors about how to maintain seronegativity. Isaac (aged 35) described how an HIV-positive peer, who later became a member of his chosen family, mentored him on an approach to safer sex practice,

And so, you know, he’s the one that really taught me how to stay negative, is because he always—he had one phrase he said, well, a mantra he said was, ‘Treat them all as if they have HIV, then you never have to worry about contracting it, because you’ve treated everyone as if they had it.’ So you know, he was basically telling me, use a condom with everyone, so that has helped me along my way.
Isaac’s HIV-positive peer imparted an approach to HIV prevention that harkened back to the early days of epidemic: the assumption that everyone potentially has HIV, because “you can’t be certain who has it.” Carefully heeding his peer’s advice and wanting to meet his peer’s expectation that he maintained HIV-seronegativity, Isaac began to approach each sexual encounter as if he were with someone who had HIV. “The Talk” happened when Isaac and his peer began to unearth some of Isaac’s challenges to consistently using condoms for anal sex with his partners.

…I[t was hard for me to use condoms, but the reason why it was hard for me, because I didn’t have any self-esteem or self-worth. So you know, condom negotiation, I should say—condom negotiation was difficult for me until he [HIV-positive peer] started drilling into me that he needed me to remain negative. The more I began to value myself, the more I knew I had to protect myself.

A result of Isaac’s mentoring by his HIV-positive peer in HIV prevention was that Isaac’s self-esteem and positive self-regard increased. The HIV-positive peer not only had the expectation that Isaac maintain seronegativity; he also facilitated Isaac’s awareness of his sexual risks, thereby encouraging Isaac to exercise his transformative agency in his sexual encounters.

**Needing HIV-Negative Supports**

Since the beginning of the HIV/AIDS epidemic, seropositive Black MSM have played an important role in their seronegative counterparts’ lives (GMAD, 2014). Historically, seropositive Black MSM were the ones who initially crossed the serodivide, the social division between seropositives and seronegatives, by providing primary HIV prevention support to their HIV-negative friends, families, and lovers (Persson & Eliard, 2012; Persson & Ellard, 2014; Persson, Newman, & Ellard, 2017; Young, Flowers, & McDaid, 2016). As much as the study participants
valued their seropositive peers’ support, support from seronegative peers was also necessary. Many stated how difficult and challenging it was to meet other seronegative Black MSM because “everyone’s positive.” The belief that “everyone’s positive” was a commonly held belief or truism, even among some men who had other seronegative Black MSM friends. Perhaps because of that belief, Earl (aged 50) a man with seroconcordant friendships passionately stressed why they were important, and why he needed them with other seronegative Black gay men in his life.

I think [HIV-negative] supports in your life help you navigate that stuff [remaining negative], and folks need help around it. But I think it’s like, again, it’s standing up and saying, ‘I’m such and such, I’m an alcoholic.’ It really starts with the self-admittance, right? Like, ‘I’m such and such, I need help with this stuff [remaining negative].’ And I said that to them [my HIV-negative peers] and I got it.

Earl also underscored how important it was to have supports “who are also Black, gay, and HIV-negative” because of the challenges to maintaining HIV-seronegativity and exercising his exemplified agency in his sexual encounters.

…[C]orrect, it’s very stressful [remaining negative]. So just to have that—because I think it’s very interesting how we start off the conversation and the support that we have. Imagine someone who doesn’t, like [have support], and they’re struggling with this stuff and they don’t have someone to go to and talk about, you know, if they were to seroconvert or, you know, ‘what’s in place for me not to,’ and I just don’t think—it would be sad to tell, and I just don’t think there’s enough in place for you not to.
As a self-identified Black gay man, Earl benefited from having seroconcordant friendships with other Black gay men. His statement, “brothas have helped me, and we need to help each other out,” expressed a personal commitment to reciprocity in extending his agency and supporting other Black MSM who endeavored to maintain HIV-seronegativity.

Yeah, that’s sort of sad as I think about it, as I say [laughs]. Yeah. So yeah. But that’s my commitment to this [helping others], is to stay in the forefront and sort of push buttons, because I just think what I’m seeing is a travesty [lack of support for HIV-negatives], and I’m not standing for it.

Earl’s statements were typical of the common belief that there was a dearth of support for HIV-negatives because “prevention programs are more geared towards HIV-positives than negatives.” He explained how important it was for him to meet and develop peer relationships with other HIV-negative Black gay men, since he could not count on support from social service organizations. Earl spoke for other men in the study when he shared how these peer relationships lessened his thoughts and feelings about “being the only one” or “one of a few” HIV-negative Black gay men in NYC. Most importantly, his seroconcordant peer relationships buffered his experiences of isolation, marginalization, and “HIV-negative stigma” within NYC’s Black gay communities as one of the “negative outsiders.” Earl proclaimed if had not been able to establish his own collective of “brothas who are still negative,” he would “probably be positive by now.”

Summary

This chapter discussed the role of supportive networks that bolstered participants’ agency. I labeled their supportive networks broadly as social supports. I categorized their supports as familial and non-familial, with the latter composed of their chosen families and peer supports. The men described how their families of origin, chosen families, and peers provided
them with support for their maintained seronegativity. The men’s degree of outness related to their supports’ cogent expectations of them maintaining HIV-seronegativity. The more out the men were, the more likely their supports were to expect the participants to exercise their agency in order to maintain HIV-seronegativity. Most seronegative Black MSM in this study possessed an ingrained commitment to meeting their social supports’ expectations. Moreover, they cited their relationships with their families of origin, chosen families, and peers as affirming and validating. Their HIV-positive and HIV-negative peers served as mentors and were empathetic to their experiences as men with multiplicatively oppressed co-occurring identities. The following chapter elucidates how the Black MSM conceptualized their HIV risk and employed risk and harm reduction strategies, besides condom use, to maintain their seronegative status.
CHAPTER 6: CONSTRUCTED HIV RISK

In this chapter, I build upon the themes of agency and social supports and provide answers to my second research question: What are the strategies and tactics, besides condom use, that Black MSM employ to maintain their seronegative status? Based on findings from my pilot study, I argued that many Black MSM intentionally maintained their seronegativity for reasons rooted in their spiritual, emotional, cognitive processes, and social interactions (Dacus et al., 2017). In this chapter, I discuss how the men constructed their HIV risk and provide examples of how they implemented risk reduction strategies for maintaining HIV-seronegativity.

HIV surveillance data indicates that Black MSM continue to carry the greatest HIV burden in the US. This is especially true for those aged 13-29 (CDC, 2017; Fields et al., 2015; Hall & Applewhite, 2013; NASTAD, 2009; NYCDOHMH, 2017). The primary mode of HIV transmission for Black MSM continues to be condomless anal intercourse (CAI) followed by injection drug use (IDU) (CDC, 2017a, 2017b). However, researchers have shown that Black MSM do not engage in higher risk behaviors than their non-Black MSM counterparts and peers (Millett, 2015; Millett et al., 2012; Millett, Peterson, Wolitski, & Stall, 2006). On the contrary, they are more likely to use condoms, report less CAI, and test for HIV regularly as per the federal HIV testing guidelines (Hussen et al., 2013; Millett, 2015). Although the connection between higher HIV acquisition and transmission rates among Black MSM remains unclear, this chapter offers insight into the strategies HIV-negative Black MSM have employed to reduce their 50% lifetime probability of seroconversion (CDC, 2017a).

In the early 2000s, public health HIV prevention researchers conceptualized disease acquisition by explaining how bio-social-cultural factors, syndemics, contributed to greater seroprevalence in sexual minority men (Singer et al., 2006; Singer & Clair, 2003; Singer, 2009).
According to the CDC (2010), syndemics occurs when multiple afflictions interact synergistically and contribute to the excess burden of HIV infection within a population. Syndemics such as depression, drug abuse, and violence victimization have been studied to understand their contribution to the HIV burden among sexual minority men (Safren, Reisner, Herrick, Mimiaga, & Stall, 2010). As a result, the preponderance of HIV prevention research shifted to a focus on syndemic phenomena in Black MSM (Mustanski, Newcomb, Du Bois, Garcia, & Grov, 2011; Safren et al., 2010; Stall et al., 2003).

The public health conceptualization of HIV risk in Black MSM populations is different from how Black MSM understand their own HIV risk. Few participants spoke about syndemic factors when they described the ways in which they constructed their HIV risk. However, everyone spoke about their multiplicatively oppressed and co-occurring identities as confounding factors (Gopaldas, 2013). In this study, I utilize the term constructed HIV risk to describe how the participants formed theories about their level of HIV risk. They developed “logical” constructs that informed their conceived HIV risk based on knowledge and/or assumptions about their sex partners’ serostatus as seroconcordant (HIV-negative), serodiscordant (HIV-positive), or serononconcordant (unknown) (Bird et al., 2017). Their constructed HIV risk was critical to understanding the subtheme regarding how they exercised agency via their risk reduction strategies for seronegative maintenance. Furthermore, there was another subtheme about how the HIV-negative men evaluated their risk with certain sex partners. Some had more control than others did over their ability to assess that risk. The ones with less control were more likely to be the ones who discussed syndemic factors in their lives such as homelessness and drug dependence.
The ways in which they constructed their risk led to protocols for vetting partners and making determinations about what they would do sexually with them. For example, participants said they were more likely to initiate discussions with potential sex partners about HIV status and testing history, as in “having ‘The Talk’” as found in other studies (Bird et al., 2017; Bird & Voisin, 2011). Moreover, the men implemented a variety of harm reduction and seroadaptive strategies. Other strategies included sex with partners with undetectable viral loads (i.e., virally suppressed), limiting the exchange and exposure to bodily fluids (especially semen), using condoms with non-primary partners, and serosorting. Serosorting involved purposely selecting HIV-negative partners, so that there was seroconcordance (Carter, 2009). Seroadaptation included strategic positioning by being the “top” or insertive partner. In this way, they adopted the sexual role that reduced their risk of HIV acquisition, (Carter, 2009; Parsons et al., 2005; Vallabhaneni et al., 2012). Finally, their approach to harm reduction included managing alcohol and drug use before and during sexual engagement.

** Constructed HIV Risk

**Being “Loose”**

HIV prevention research has emphasized understanding, determining, and predicting Black MSM’s perceptions of HIV risk. Studies have found that participants make decisions about their conceived HIV risk based on their past sexual behaviors (Napper et al., 2012). The adage, “perception is reality,” also applied to HIV risk for Black MSM in this study. Each was asked about his perception, conception, and understanding of his HIV risk. This process of inquiry resulted in a shared interpretation of how they had developed specific constructed HIV risks. These informed sexual decision-building and sexual decision-making processes that enabled them to act on their risk reduction strategies.
In this study, the individual narratives converged into shared explanations about how they made sense of being HIV-negative in a socio-sexual environment that perpetually challenged their ability to remain so. Based on their experiences of being men confronted by the prospect of HIV exposure during sex, they developed a process of reasoning related to their constructed HIV risk. Their thinking was based on the reality that they lived in a city with high HIV seroprevalence (NYCDOHMH, 2017). Their familiarity with HIV seroprevalence in New York City encouraged them to exercise their agency in their sexual encounters. Their logic was heavily informed by (a) their conceived HIV risk and (b) assumptions about their sex partners based on perceptions about their partners’ behaviors. Gary (aged 28) explained,

I sometimes would just start the discussion there, you know, ‘What are you really looking for? Are you looking for, you know, sex without protection, sex with protection?’ So we start that conversation, and then I get a feel of what people are thinking and I know that, you know—and then sometimes I also risk it by deciding, you know—which, you know, is weird, but I judge—I wouldn’t say judge, but I look at somebody and know if I want to make that risk [to have sex] with them, so if I want to take that risk for myself with that person.

Here Gary described how he sometimes initiated his “interviews” to discern whether his sex partners wanted to have sex with condoms or preferred CAI. He preferred having CAI after establishing a monogamous relationship with a partner and being tested for HIV together. He was born, raised, and lived in Jamaica until his early 20s. Now as an NYC resident, Gary explained how he had to learn to be more mindful about his sexual health,

It’s weird. Believe me, it is. It’s weird. It’s, it’s weird in every sense, that, you know—in Jamaica, when I was dealing with guys, there was only two things you
had to worry about: jealousy and, you know, the location of where you have sex, because Jamaica is so homophobic.

Similar to other men from the Caribbean, Gary considered his HIV risk as “of significant concern” once he moved to the US. In his relationships with HIV-positive partners in Jamaica, he had been more concerned about homophobia than HIV in his home country. This is consistent with earlier research on Black Caribbean MSM that suggested due to homophobia coupled with HIV stigma, Black Caribbean MSM faced greater structural inequities that catalyzed the HIV epidemic (Caceres, 2002). Recently, researchers examined how Caribbean HIV stigma played a significant role among Black MSM (Best, 2016). Pervasive homophobia increased their HIV vulnerability, because it slowed a national public response to the epidemic (Beck et al., 2017; Worrell, 2016). Given Jamaica’s homophobic culture (Allyn, 2012; Cowell, 2011), the Jamaican-born and American-born Jamaicans described homophobia as more significant than HIV acquisition. Gary had to reexamine his HIV risk when he moved to “a place [NYC] with less homophobia” and HIV-related stigma. White and Carr (2005) found that homophobia was associated with low levels of HIV testing in Jamaica among MSM, which suggests why Gary tested for HIV infrequently before moving to NYC. Following the recommended public health HIV testing guidelines, Gary and most of the other participants tested regularly, “every three months like clockwork.”

In order to understand how Gary conceived of his HIV risk, I asked how he determined who he would “make that risk [have sex] with.”

Interviewer: How do you make that decision?
Gary: …. [I]’s weird, but—mmm, how should I word this? [pause] The fact that when we have sex, you know, I [can] tell [when] somebody when somebody’s
kind of not heavily [very sexual]—if somebody is, you know, not running around
that, that much [having a lot of sex]. You know, when I came here [to NYC], guys
here are a little bit, we’ll call it ‘loose [sexually promiscuous],’ you know. And
so, you know, I’ve met, I’ve dealt with a couple of guys who were, you know, I
knew were always around the place [bars, clubs] because they were absolutely,
you know, ‘looking [for sex].’

Gary reported the logic he used to determine risk; men who were highly social (‘running
around”) were likely to be sexually promiscuous (“loose”). He said that it had less to do with the
openness and social liberties that gay men in the US had, which he appreciated. Instead, he had
to be cautious about dealing with the “loose” ones.

Gary’s definition of “loose” was two-fold. First, it applied to men that he saw regularly at
social gatherings and in social venues. Specifically, he described “bottoms” (receptive partners)
that actively looked for tops to “hook up with…because they be thirsty [desperate, needy,
horny].” Although he reported having a “healthy and positive” attitude toward sex and sexuality,
he thought that “loose bottoms” were more promiscuous and more likely to expose him to HIV
because, “if they’re always thirsty [desperate, needy, horny], they must have a lot of random
[casual] sex.” Therefore, if he saw a man he was interested in behaving in “loose ways,” then he
was unlikely to engage. Even if he did engage the man, then he was unlikely to want to have sex
with him. His experience of coming out and being sexually involved with men in the Caribbean
helped him develop exemplified agency. Because of the pervasiveness of homophobia and risk
of HIV infection in Jamaica, he committed to condom use with casual partners in order to avoid
being outed as gay. If he “got something, especially HIV,” he would experience both HIV
stigma and homophobia. Therefore, he exercised exemplified agency by having a non-negotiable condom use practice with his partners.

Gary’s second definition of “loose” was his belief that if his partner’s anal sphincters were not physically “tight” it meant that “the bottom was having a lot of sex.” Gary’s protocol for vetting new partners included “inspecting the goods.” He would examine his partners’ anal sphincters both physically and visually. If he “easily got two or three fingers up there,” he assumed that his partner “had had a lot of sex with multiple partners.” The logic behind this inspection process led to his construct of the risk, “[S]o, and—so, you know, especially I look at the age [of the sex partner], I’m saying if you are such and such age and you’re loose, that means you’ve been a little bit around the block.”

When questioned about the logic behind his perception of “loose,” Gary believed that if a partner was “tight,” he was having less sex and therefore less likely to expose Gary to HIV or STIs. “So if they aren’t loose, haven’t had as many sexual partners…that means that they have not been exposed as much [to HIV, STIs] and I won’t be exposed.” Although not well reasoned, Gary’s logic was predicated on public health advice about how MSM can reduce their HIV risk by reducing their number of sex partners. Recommended since the early days of the epidemic (Reiss & Leik, 1989), limiting the number of sex partners limited the lifetime risk of exposure to HIV (CDC, 2018). Extending this reasoning, by avoiding loose partners Gary determined he was reducing his chances of HIV exposure by culling out men he reasoned frequently had anal intercourse. His logic was so powerful that if he found a “loose booty [anus]” it was “a turn off”; he would “go soft” and not be able to penetrate his partner. He would not have intercourse with men who were “not tight enough,” particularly because he preferred CAI with a monogamous
partner. Since moving to NYC, he had very few sex partners and even fewer monogamous relationships.

At the time of the study, Gary reported recent CAI with only one partner and reported using condoms with all other partners. His current partner, “someone I tested with and plus I trust him,” had been his most consistent casual sex partner (“friend with benefits”) for the last couple of years. Gary explained how and why he felt that his friend with benefits was not placing him at risk as an example of his constructed risk:

Gary: So because he is a little bit kind of hard to [penetrate]—you know, I have to take my time…

Interviewer: He’s tight?

Gary: Yeah. So I know that he doesn’t really do that much, you know, get around [have a lot of sex], so. So I use that sometimes to, you know, test, you know, what’s going on with people who I have sex with.

In the end, Gary clarified what being loose signified on a deeper level, which provided more depth to the logical argument of his constructed risk. He described how he wanted to experience intimacy and comfort in his sexual encounters, which has been described in other studies on HIV-negative MSM’s risk reduction motivators (Gamarel & Golub, 2015; Underhill, 2015):

It’s—I’m not too much concerned [about someone being loose]. It’s just that I’m concerned for my well-being if—because I don’t want to be just the next dude being with you when, you know—you know, I consider my, my sex to be very important and very, you know, very important, when it comes down to making
sure that I’m comfortable, you’re comfortable, it—it feels special. That’s what I want my sex to be.

For Gary and others, constructed HIV risk drew on public health HIV prevention recommendations and knowledge about high seroprevalence among Black MSM in NYC. The combination of these two factors informed the development of his logic or if-then thinking. Gary represented many men in the study who believed if they limited their number of sex partners and vetted those partners who they conceived as promiscuous, then they would “logically” reduce their HIV risk. Other studies have explored MSM’s various processes for understanding and making decisions about their actual, conceived, or assumed HIV risk. Many of these studies have focused on the relationship of their partner selection processes, sexual risk taking behaviors, and ages (Kelly et al., 2013, 2014, 2016; Maksut, Eaton, Siembida, Driffin, & Baldwin, 2016). Gary also asserted that non-promiscuous partners took better care of themselves: “Some people are very health conscious. Some people really are. Everybody’s not loose [promiscuous] and willing to take that risk like me.” Although Gary’s reasoning was weak, he insisted that it was a key component of his protocol for maintaining HIV-seronegativity.

**Being “Loose and Hunting”**

Similar to Gary, other study participants shared their constructions of HIV risk as the reasons why they avoided loose men, which meant sidestepping seemingly promiscuous men and/or evading penetrative sex with partners whose anal sphincters were not “tight enough.” Omari (aged 48) and Paul (aged 21) described avoiding partners assumed to be promiscuous as part of their risk reduction protocols. For Paul, if potential partners were reluctant to discuss their HIV status and when they last tested, he categorized them as loose and frequently jettisoned them. He explained why,
Paul: About [HIV] status? Oh me. Oh me, yeah me. Yeah, me. Yeah I’m big on that [asking about HIV status].

Interviewer: All right. So, you say that very confidently. So—

Paul: Yeah. Oh yeah, I don’t, I don’t, I don’t—no, I ask questions. I don’t—some men get intimidated by that, but I don’t care, because at the end of the day, there’s only one of me. And even after I die there will only be one of me, so no, I am all for asking of the questions. Mm-hmm [yes].

Omari’s litmus test for vetting loose partners was whether “we can chill, hang out, smoke some weed, have some beers.” He opined that loose men were not willing to “just chill…because they are busy chasing the nut [ejaculate].” Establishing a connection was paramount to engaging sexually for Omari because, “you hung out with them the first time, they’re not really new to you, so you can be a little bit more open and talking.”

Among the other men that conceived of promiscuous partners as vectors of HIV transmission, Yusef’s exemplified his age cohort’s resilience. Aged 45, he was the only participant who reported chronic housing instability and drug dependence and recognized he was at increased risk for HIV infection because of his circumstances. Because of this awareness, he spoke about syndemics more commonly found among Black MSM than non-Black MSM (Millett et al., 2012): his practices of survival sex for food, shelter, and drugs. He developed a logic similar to the others premised on the avoidance of loose sex partners, especially those partners that were “hunting.” He described how he was able to exercise equivocal agency, because he acknowledged the vulnerable space he occupied because of his drug dependence and homelessness.
Yusef: I guess it’s just gut instincts. If I see a person, I’m looking at that person, how they approach me, are they loose [emphasized] like that, then I might be, I probably be, ‘Yeah, I’ll use a condom.’

Interviewer: What do you mean, ‘Are they loose like that?’

Yusef: Partly you can tell with a kind of person that this is what they do—they come out searching every night, trying to have a sexual partner and offer them money and things like that, or if this is just a situation that just happened to occur for this person, too. And I guess that’s what it was, too, and then the people that I dealt with [had sex with], it didn’t seem like that they was out on the streets hunting [actively seeking sex].

Nonetheless, Yusef described himself as a “survivor.” A humble and thoughtful man, he candidly described his transition from being a Wall Street executive to a “homeless drug user…for three or four years now,” he was attracted to “trangenders [transgender women].” Further, he reported a sexual history with cisgender men and identified his sexual orientation as “other.” Yusef did not have a term to describe his orientation other than, “I really start questioning my sexuality and stuff like that.” Although he had no term to describe his sexual identity, he embraced his sexual orientation, which gay resilience theory would argue was an indicator of his resilience (Herrick, Lim, et al., 2013). Given the instability and chaotic nature of his life, he was able to enact his equivocal agency in his protocol for vetting his sex partners. Yusef reported being reluctant to have sex with partners who were loose and hunting because he automatically conceived them as “risky.” He did not report having “a ton of sex” or partners, because of being unstably housed: “It’s [sex] not that often because I don’t have a place [to have sex].” He also had limited access to condoms. Even when he did have condoms, he lacked safe
places to store them among his belongings. Although survival sex was sometimes a means to an end, he reported avoiding anyone who seemed to be overtly active about having sex with him or hunting. “Those who are hunting” were “mostly gay men” that approached him for sex when they did drugs together, which was “the majority of the time.”

Similar to others in his age cohort, Yusef recognized that his attractiveness was currency that he used to his advantage, but that it also “gets me a lot of attention from those who are hunting.” He said that he was not homophobic at all, and that sex with gay cisgender men no longer interested him because “I’m all into—[pause] more, how do you say, like excited or interested in like transsexuals or she-males [transgender women].” Interestingly, his construction of risk did not preclude sex with transgender women, a population with high HIV seroprevalence (CDC, 2018b) that has also been attributed to syndemics (Brennan et al., 2012; Operario, Yang, Reisner, Iwamoto, & Nemoto, 2014).

Yusef felt “constantly at risk” for exposure to HIV because of his homelessness and drug use. The first time he had sex with another cisgender man was while he was high. Yusef believed he was able to maintain his seronegative status due to his avoidance of promiscuous partners. Also, he also did not report any injection drug use, which has been associated with elevated HIV risk among men, Black men, and Black MSM (CDC, 2017c, 2017b, 2017d; NYCDOHMH, 2017). However, there was more to his risk reduction approach than he recognized, because he lived day to day, which gave him little time to “think about my life when I’m not chasing a high.” Yet, he realized some advantages to having a “limited” sex life that was, circumstantially, beyond his control.

Because I have, I have, I have no—I’m not highly sexual, and I’m not, kind of like, my whole day wouldn’t even be around nothing where is that, is dealing with
sex. So the less you have sex, the less you contract something, and the less I, you know, when it happens unexpectedly, then you have a quick moment to think of doing something productive as far as protecting yourself or not protecting yourself. Or when it’s like, you know, it’s not something that’s average or all the time, you wouldn’t know how decisions occur if you want to be protected. I guess they’re gut instincts. I guess it’s just gut instincts.

Yusef’s decisions were a result of his limited opportunities for sex, limited spaces in which to have sex, and vetting partners who were hunting. Yusef had CAI with cisgender men and Black and Latina transgender women more often than not. An HIV prevention counselor from an AIDS service organization (ASO) referred Yusef to the study because of his ability to maintain HIV-seronegativity as a homeless Black MSM with drug dependence. He also revealed he met most of his sex partners at ASOs.

Another unstably housed participant, Usher (aged 43), who “never used condoms” with his cisgender male and mostly Black and Latina transgender female partners, also met his sex partners in social services settings. Both Yusef and Usher reported they did not meet loose or hunting sex partners in settings that provided health and wellness services. They had more opportunities to develop connections based on the shared experience of being recipients of social services. The most important insight for both of them was that they were having CAI with partners who were undetectable. When Yusef made the connection between where he had met his recent sex partners and why they were receiving services, he realized that he could begin asking an important question as part of his protocol: “Now I know, that’s something new for me, now. Because now I’ll first say, ‘Are you undetected [undetectable]?’ [laughs].” Then, he
recalled overhearing snippets of a conversation about one of his past sex partner’s undetectable status in a health clinic.

Something like that, because the, this person, named [Woman 1] asked somebody was they [past sex partner] detected, undetected [undetectable], and I was just on the sideline hearing a little bit of conversation, but actually knowing fully what they was meaning. But I know he’s positive, but it’s undetected [undetectable].

Yusef and Usher were not aware that the places where they met their partners were significant elements of their risk reduction strategies. At the time of data collection, clinical research and other studies on HIV viral suppression in MSM indicated that there was negligible risk of HIV transmission in serodiscordant relationships (Grace et al., 2015; Mitchell, 2013; Rodger et al., 2014; Wilson et al., 2016). As fallible and unreliable as Yusef’s logic was, it increased his awareness of his HIV risk, his ability to be more conscious about how he met his partners, and his ability to exercise agency by vetting his partners.

**Knowing “from the Jump”**

Participants in this study freely discussed their fears about seroconverting. Anxiety and fear about contracting HIV have motivated Black MSM to become engaged in their sexual health and well-being (Hojilla et al., 2016; Khosropour et al., 2017; Nanín et al., 2008). Public health HIV prevention research, programs, and interventions have equipped Black MSM with the knowledge and skills and to increase their self-efficacy, so they can protect themselves from acquiring HIV (BAI, 2012; Dyer et al., 2012; Gamarel & Golub, 2015; NASTAD, 2009; Peterson & Jones, 2009).

Although participants feared contracting HIV, they normalized the likelihood of meeting an HIV-positive Black male partner in NYC. In general, they believed they were more likely to
find HIV-positive partners, because they preferred to be with Black men. This is interesting in light of studies that have explored whether intraracial sex has contributed to high seroprevalence in Black MSM populations (Millett, 2015; Millett, Flores, Peterson, & Bakeman, 2007). They feared HIV but did not express concerns about being with seropositive Black male partners even though they understood about high HIV prevalence among Black MSM in NYC. Very few shirked at the idea of meeting and having sex with an HIV-positive partner given the availability of preexposure prophylaxis (PrEP) and increased commonality of HIV viral suppression (Calabrese et al., 2017; Gallagher et al., 2014; Gamarel & Golub, 2015; Underhill, 2015). Many Black MSM’s conceptions of HIV risk shifted because of the emergence of biomedical interventions for seronegatives to maintain their HIV-seronegativity and the benefits of viral suppression among seropositives. They no longer conceived of HIV infection “as a death sentence” or “that bad.” Rather, they maintained healthier attitudes about relationships with seropositive people and were less likely to stigmatize HIV-positive Black MSM.

Several participants, such as 21-year-old Paul, were open at the prospect of being with a positive partner: “Just looking at it from an HIV standpoint, I mean [pause] life is all about taking risk. I mean if you happen to fall in love with someone who’s HIV-positive, I mean, definitely take the proper precautions.” Paul’s first same-gender relationship was with an HIV-positive Latino partner who was undetectable. Paul was open with his social support network of family and friends about their “magnetic” (serodiscordant) relationship. Paul asserted, “…at least I knew. I knew from the jump [the beginning] that he was positive and I was ok with it. My mom wasn’t happy, but I knew he was safe because he took his meds and was undetectable.” With the (reluctant) support from his family of origin and knowledge about his partner’s HIV-positive and undetectable serostatus, Paul was able to exercise his exemplified agency by insisting on
consistent condom use as the bottom. Researchers have dubbed the emergence of undetectable serostatus as the new “safer sex” because as Paul stated, the likelihood of HIV transmission is extremely low. At the time of this study, the Partners Study found a less than 1% transmission rate among serodiscordant couples was attributed to infection by a non-main partner (Rodger et al., 2014). Paul’s level of comfort with being with an HIV-positive partner spoke to how most participants contended with the prospect of having a positive partner: “...the fear of HIV is there and then it isn’t.”

    Most men held liberal attitudes about engaging with seropositive partners. However, some expressed ambivalence about being with undetectable partners even though they exercised agency by employing their risk reduction strategies such as condom use. Twenty-three year old Kenyatta offered an excellent example of his ambivalence about being in a “mixed status” relationship,

        No, I—no. No, no, no, no, no, no. I do feel safe, but I’m gonna, I’m gonna—I’m gonna tell you the truth is that I don’t—I’m not gonna say—I tell you I don’t—I’m sure I don’t fear—because I’ve said to him already, ‘If you want both of us to be positive and that’s the end of it, that’s fine.’ But because he wants me to be—he wants me to be negative, I’m fine being negative.... Maybe I have a fear I don’t know about. Maybe I need to discuss it, but maybe I have an inside fear you know [of getting HIV from my partner].

One might have assumed that a key strategy that men such as Kenyatta employed to maintain seronegativity was not to have sex with HIV-positive men, especially as the receptive partner. Contrary to this assumption, both Paul and Kenyatta who were “strict bottoms,” expressed comfort in having serodiscordant partners. Their constructed level of HIV risk was based on their
partners’ viral suppression, and they knew that the coupling of consistent condom use with an undetectable partner nearly eliminated their HIV risk: “Being with a positive man isn’t intimidating at all...he [partner] made sure we were safe by wearing a condom” (Paul).

**Knowing vs. Not Knowing**

Rather than stigmatizing and discriminating against seropositive men, participants’ willingness to and comfort with crossing the serodivide debunked the assumption that seronegative MSM will exclude seropositive MSM in order to remain seronegative (Courtenay–Quirk, Wolitski, Parsons, Gomez, & Seropositive Urban Men’s Study Team, 2006; Dowshen, Binns, & Garofalo, 2009; Gamarel & Golub, 2015; Khosropour et al., 2017; Smit et al., 2012). Numerous times, participants voiced how they were more fearful of being with partners who did not know their HIV status or with those who assumed to be HIV-negative. With HIV-positive partners, HIV was undeniably part of the equation. They felt more assured by HIV-negative partners that had recently tested because they were very likely ask for documentation of their last test and/or would test together as Billy (aged 26) described,

> I’m going to say that four out of the five [men] I’ve dated consistently, I’ve gotten tested with or insisted that they at least go get tested so I can see the results before we actually start having sex. Just because like that’s important to me, to make sure that me and my partner are being safe in that capacity.

In contrast, their experiences with partners who assumed themselves to be seronegative or did not know their status was that they were more likely to result in CAI and other high-risk sexual acts such as sex with multiple concurrent partners (“threesomes,” “foursomes,” “orgies”) and sharing bodily fluids (“he was trying to nut [ejaculate] in my mouth”). Hassan, aged 54, was one of the few participants that had initiated PrEP before participating in the study. He recalled
an experience with a “fuckbuddy” (casual sex partner) who had “always been shady [vague]” about his HIV testing history. “So when we started to fuck [at a sex party], when he brought in—he’s comfortable enough he brought in the first guy for a threesome, I don’t think all those times I—our condom use was consistent, I don’t think.” Because Hassan was taking PrEP, he was comfortable having CAI as the top in the threesome. Even though he consented to CAI in the threesome, he exercised agency by following up further about his fuckbuddy’s testing history. He stated, “Yeah, dude said that because he was neg [HIV-negative] we could bareback [have CAI] but couldn’t tell me when he last tested…or thought he had tested recently.” Hassan recognized that his conceptions of HIV risk had shifted once he adopted PrEP as part of his risk reduction strategy. Early studies on PrEP uptake suggested that many MSM would forgo condom use as a form of sexual risk compensation, increased risky sexual behavior(s) prompted by a decreased perception of HIV risk (Calabrese, Earnshaw, Underhill, Hansen, & Dovidio, 2014; Calabrese et al., 2017). Shortly after initiating PrEP, Hassan consciously decided to forgo condom use “because I don’t like to [use condoms]…. I don’t unless you ask me to.” Yet, he explained how his understanding of risk played out before PrEP, when he was in a relationship with an HIV-positive partner.

Yeah. So he was afraid that I would become infected—even though he was undetectable—so we were 100% condom use, even though I wasn’t afraid…. No rational—there was no rational thought behind it at all. Absolutely no rational thought, purely an emotional basis—‘I didn’t care. I didn’t care. I love you, I don’t care, I’m not willing to take that chance,’ he [partner] would say.

Hassan understood there was low risk with an undetectable partner, and his partner supported Hassan’s equivocal agency by encouraging consistent condom use. He felt “safer,”
and it was easier for him to exercise his agency because his partner was virally suppressed. Like others in the study, Hassan explained that his conceptions of risk were based on public health messaging that strongly implied, “having sex with an undetectable guy is ‘safe’ whether you’re using condoms or not….they can’t give you HIV. It’s been proven.”

**Topping Theory**

Men in the study conceived their HIV risk in various ways. Their constructions of HIV risk informed the development of a logic or if-then thinking about how to reduce their risks. Their logic consequently informed their risk reduction strategies, which in turn became their sexual practices. More than half of the participants proclaimed their sex role as something that had prevented them from acquiring HIV. Repeatedly, participants made statements denoting a “topping theory.”

Topping theory is the belief that “not getting penetrated at all…it also prevented me from contracting HIV” (James). This was a strongly held belief particularly among men who had CAI as the top and continued to test HIV-negative, “…every time I’ve taken these tests, they’ve come back negative (Omari).” Among the sample, most reported their sex role preference as top and versatile top. Public health has given credence to *reduced* HIV risk and sexual positioning as the insertive partner (CDC, 2018a). Recent studies have debated topping theory as a controversial seroadaptive strategy with inconclusive efficacy (Khosropour et al., 2017; Vallabhaneni et al., 2012). However, participants either read about or heard evidence of how “topping is not as risky as bottoming.” Therefore, men who researched sexual positioning and HIV risk constructed their risk as “less risky” because “receptive anal sex is much riskier for HIV” (CDC, 2018a, para. 5). For others, “perception is reality” played out in their lives as Omari stated, “And it seemed like everybody who was getting sick were the ones who were bottoms, who were letting somebody
fuck them and ejaculate in them, you know?” James offered more about his topping theory,

There’s a school of thought that, if all the bottoms were just bottoms and all the
tops were just tops, that it would be harder to pass HIV because if it has to be
penetrated [done via penetration]—if you have to get it through the act of
dissemination [insemination], if I’m a top and no one disseminated [inseminated]
into me, I can’t disseminate [inseminate] it [HIV] into somebody else.

On the surface, James’ theory seemed logical. If tops only topped and bottoms only bottomed,
then HIV would not be spread because “it’s harder for tops to get HIV.” Gary made several
detailed statements that corroborated James’s logical thinking and topping theory,

Interviewer: So how do you think your sex role has played out in your ability to
remain HIV-negative?

Gary: I think that’s why. I think because I’m a top, it’s, you know, understanding
that, you know—understanding how the system works, you know, the, you
know—because we know that there’s tearing or ripping caused, you know, blood,
you know, tissue to be tearing and blood can be, you know, passed on. And I just
think that, you know, because most times I use condoms and the few people I
don’t use condoms with I know their status, and just remaining a, a straight top
since all those years, and which I also learned that that can also reduce your
chance of being infected with HIV.

James’s topping theory was consistent with his preferred sexual position and his sex role. He
described how he exercised agency during his sexual encounters based on his exclusive sex role
as a top,

Part of it is age, part of it is because of a power dynamic, because they don’t want
to see me as—they see me as aggressive, and as a top, and taking charge, so they wait for me to do x, y and z. Part of it is about attitude. How you present yourself, not only in the bedroom, but before [being in] the bedroom.

Since he was seen as the “aggressive” person who was “taking charge” as the top, rarely did his partners refuse to use condoms. In his sex role, he felt a responsibility for his own sexual well-being as well for his partners’. He also admitted, “if I don’t bring up condoms, I don’t think these boys will either.” For that reason, the onus was on him to be the sexually responsible partner. All the exclusive tops in the study felt that same responsibility.

In a qualitative examination of circuits of power and pleasure among HIV-negative gay men, Hoppe (2011, p. 194) described how gay men understood and give meaning to their “positional identities.” Although the study examined bottoms’ positional identities, the study elucidated how sexual positioning played out in the participants’ socio-sexual worlds. A complimentary study about sexual positioning, sexual decision making, and gender roles among young gay men, expanded similar concepts and notions from Hoppe by contextualizing both top and bottom positional identities in HIV prevention (Johns et al., 2012). The study’s findings suggested that because being a top was associated with heteronormative ideals of masculinity, the responsibility for sexual safety was often relegated to and dependent on the insertive partner.

Unlike in heterosexual relationships, sex roles based on positional identities played a significant role in the men’s risk reduction strategies. James offered more logic to support his topping theory by offering a commonly held critique about versatile men as possible vectors of HIV transmission,

And that all the vers [versatile] guys of the world were the ones passing HIV.

And, people get—some of the vers guys get offended by that conversation, but I
say, ‘If I fuck you, and you fuck him, then HIV can go back and forth…. But if
I’m always doing the fucking [because I’m the top], and I’m not passing anything,
then you can’t get it.’

As many participants self-identified as versatile men as they did “total tops,” or exclusively the
insertive partner, in the study. Yet, many versatile men, such as Omari, believed that topping had
mitigated their HIV risk. He explained: “[S]o I do believe that I’m HIV-negative today, after
always being gay and having sex unsafely, but never [penetrated] unsafely [condomless] anally.”

Some men at the other end of the positional identity spectrum had their own version of
topping theory. Theo, aged 33, who self-identified as a “total bottom,” expressed his topping
theory,

I feel that the person who’s supposedly the top partner is more—more likely to be
negative. I mean I—I—I definitely see results [HIV test documentation], I don’t
go into it just like assuming it, but I—I—I guess in terms of risk I believe, because
what’s—you know the CDC or whatever information I’m finding is saying that
because the person who’s the inserter [top] is less risky than the person who’s
receptive [the bottom]. And then I go into that and I say, ‘Well okay, well maybe
if I—if I—more likelihood if I meet total tops [exclusive tops], if they’re not
already infected, they’re going to stay that way even if they do fuck around. As
opposed to someone who is a bottom who may be more at risk or so on.’

Theo offered a lot to be unpacked, argued, and disputed. He would only bottom for men he
believed were total tops. However, because he could only take “their [tops’] words at face
value,” he exercised exemplified agency by “making sure—I always watch to make sure—the
top always uses condoms when I get fucked.”
Summary

This chapter discussed the participants’ *constructed HIV risk*. In doing so, I discussed how they employed a seemingly abductive *if-then* reasoning process to develop their theories and logic that informed their risk reduction strategies for maintaining HIV-seronegativity in either seroconcordant, serodiscordant, or serononconcordant sexual encounters with cisgender Black and Latino MSM and/or with Black and Latina transgender women. Black MSM avoided potential partners they deemed to be “loose” and/or “loose and hunting,” because they conceived of loose partners as promiscuous and likely to engage in CAI, therefore, posing an HIV risk. Additionally, they would physically check to see if their anal receptive partners (bottoms) were “loose” by digitally inspecting their partners’ anal sphincters. If their partners’ anal sphincters were “loose,” then the Black MSM would either not have sex with them or engage in other non-penetrative sexual activities. Again, the men associated looseness with a bottom’s promiscuity and a higher likelihood that he had engaged in CAI.

Notably, this chapter highlighted some of the cultural and circumstantial nuance that affected their constructions and evaluations of HIV risk such as homophobia and syndemics. Some of this nuance pertained to the Black MSM’s acculturation experiences as immigrants. As a demonstration of their resilience, some Black MSM were able to maintain seronegativity amidst their syndemic conditions. Further, the men normalized the likelihood of encountering seropositive partners, and they were able to exercise agency with support from their HIV-positive partners, but also due to either their knowledge or adoption of PrEP or by being with partners with suppressed viral loads. The Black MSM held a topping theory, a ubiquitous abductive reasoning process that they considered a seroadaptive approach to risk reduction that aided them in maintaining seronegativity.
CHAPTER 7: DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

In this chapter, I summarize theoretical material that emerged from this study of Black MSM in New York City who maintain HIV-seronegativity. Earlier chapters in this dissertation proposed theories that served as sensitizing concepts for the research, a common practice in grounded theory-based research (Bowen, 2006). Because of the in-depth exploration of the experiences these participants, I was able to both build on and shape existing theoretical propositions. This enabled me to alter these extant theories so they can apply to the contemporary experiences of Black MSM. They illustrate how historical events have shaped the ways in which Black MSM experience themselves as members of the African diaspora and as racialized sexual minorities, because the co-occurrence of their racial and sexual identities is key to identifying and understanding their resiliencies. The chapter also includes strengths, limitations, implications of the study, and recommendations for future research.

Little empirical research has considered how Black MSM maintain seronegativity. Consequently, in this dissertation I strove to understand the phenomenon of maintained seronegativity among a cohort of Black MSM in NYC by answering specific research questions. What were the strengths and resiliencies that contributed to the maintenance of seronegativity in Black MSM? What were the strategies and tactics, besides condom use, that Black MSM employed to maintain their seronegative status? Guided by a strengths-based approach, I employed constructivist grounded theory (Charmaz, 2014), building on sensitizing concepts from Gay Resilience Theory (Herrick et al., 2014), to explicate how Black MSM demonstrated resilience amidst high seroprevalence in NYC. Hence, using a qualitative approach, I explored the strengths and resiliencies in this group of seronegative Black MSM. This led to refined theoretical propositions specific to this population. Although Black men think of their lives as a
daily struggle, for these men their struggle was compounded by their co-occurring identities as both Black men and Black MSM. My findings suggest that their unique strategies, strengths, and resiliencies are indubitably interconnected with their co-occurring identities as Black men.

Participants for this study included 25 Black MSM aged 21-86 that I recruited using a purposive sampling strategy. I used a questionnaire to collect their demographic data, and I gathered their narratives through three individual in-depth interviews with each participant over a three to eight month period. By following the constructivist grounded theory approach, I employed an analytic strategy that involved coding the data using a three-tiered approach. I began with line-by-line open coding followed by more focused coding and ending with thematic coding. As a means of assuring coding rigor, I developed a codebook based on the major domains of the interview guide and emerging themes from the first round of participant interviews. Additionally, I included memos as part of my analytic process in order to increase the abstraction level of my ideas and for examining my codes and coding processes.

I developed the final codebook with the assistance of a more senior qualitative researcher in the area of HIV prevention in Black MSM populations. Using NVIVO 10/11 qualitative software (NVIVO, 2014, 2015), we coded selected sets of the same data with an intercoder agreement rate of 92%. Further, I also ensured trustworthiness and credibility of my findings by member checking and having mentor and peer debriefings. I shared the preliminary and subsequent findings from the data with select key participants and three focus groups of participants. I increased my confidence and trustworthiness in the data by triangulating multiple forms of data: interviews, focus groups, and memos.

The constructivist grounded theory approach suggests the methodological practice of theoretical agnosticism (Charmaz, 2014), which is setting aside or bracketing any knowledge of
extant theories. I used sensitizing concepts from Gay Resilience Theory and critical and interpretive frames as part of my investigative approach. Therefore, I did not practice theoretical agnosticism. However, I took a critical stance towards them and concentrated my explication of the Black MSM’s maintained seronegativity on their own interpretations and insights. Now I present the components of Black MSM Resilience Theory (Figure 4) in relation to extant theories I discussed in the review of the literature in Chapter 2. Specifically, I discuss Black MSM Resilience Theory in relation to the following theoretical framework: Gay Resilience Theory and its components of social support and agency.
Figure 4. Components of Black MSM Resilience Theory. Black MSM Resilience Theory focuses on resiliencies found at the intersection of the multiplicatively oppressed identities of Black men who are MSM. One component is a theory of agency located in their coexisting identities as Black MSM. Another component is their social supports that bolstered their ability to exercise their agency in order to maintain seronegativity. Lastly, the third component, constructed HIV risk, informs how they take steps to avoid seroconversion, even if they are not consciously engaging in safer sex, risk reduction, and/or harm reduction practices.
Discussion

The three previous chapters presented findings analyzed from the Black MSM’s narratives that illustrated the emerging theories. In each chapter, I included content that offered interpretations of their perspectives, insights, conceptions, constructs, and understandings about how and why they were able to maintain HIV-seronegativity in the face of ominous seroprevalence as Black MSM living in NYC. The major themes I presented were about their agency, social supports, and construction of HIV risk. Moreover, in each chapter I presented each major theme as an emerging grounded theory that proposed answers to the research questions and complimented and refined the sensitizing concepts I took from Gay Resilience Theory. In the next section, I provide context for the development of Black MSM Resilience Theory.

Black MSM Resilience Theory

In their seminal article about resilience as a framework for HIV prevention research for gay and bisexual men, Herrick and colleagues (2014) provided compelling support for strengths-based approaches to address health disparities among gay and bisexual men. With encouragement from Stall, one of the lead researchers, I endeavored to further their theory in order to propose plausible explanations for not just how, but for also why many Black MSM are able to maintain HIV-seronegativity given their high seroprevalence rates in NYC (NYCDOHMH, 2017). As part of my methodological process, I took constructs from Gay Resilience Theory and used them as sensitizing concepts through my employment of the constructivist grounded theory approach (Bowen, 2006; Charmaz, 2014). These constructs included resiliencies on the individual, dyadic, familial, and community levels. Subcomponents of these constructs included factors such as homophobia management and HIV risk behaviors.
Black MSM Resilience Theory purposefully takes an intersectional and more nuanced critical race theory approach (Gopaldas, 2013; Graham, Brown-Jeffy, Aronson, & Stephens, 2011; Harris, 2012), because I located myself in the research as a Black gay man with considerable HIV prevention-focused social work practice with Black MSM. My practice also included capacity building with the health departments, CBOs, and other public health agencies that prioritize HIV prevention for Black MSM populations. Unlike Gay Resilience Theory, Black MSM Resilience Theory focuses on resiliencies found at the co-occurrence of the multiplicatively oppressed identities of persons who are Black men and who are men sex with men have sex with men (Gopaldas, 2013).

Traditional public health HIV prevention intervention development has infrequently attended to this critical co-occurrence as a starting point (Bowleg, 2013; Bowleg et al., 2017; Matthews, Smith, et al., 2016). Bowleg and colleagues (2017) argue that Black MSM’s social locations cannot be extracted from the intersection of their sexual locations and that behavioral and social science has inadequately acknowledged their social locations as intersectional. The CDC’s d-up!: Defend Yourself HIV prevention behavioral intervention serves as an example of how an intervention for Black MSM was developed as a “cultural adaptation” of another community-level intervention that was originally developed for the broader MSM population (Jones et al., 2008; Stall, 2007). Often, I have heard from colleagues and social services providers that the “one size fits all” approach to intervention development is missing the mark (Matthews, Smith, et al., 2016) when it comes to Black MSM. Black MSM Resilience Theory rests on the co-occurring multifaceted identities and social locations that seronegative Black MSM occupy. With my presentation of Black MSM Resilience Theory, I offer an opportunity for
public health to capitalize on a theoretical framework that is more congruent with Black MSM’s life experiences and HIV prevention needs.

Because of the phenomenon of “less risk, more effect” in Black MSM (Millett et al., 2006), I considered it important to develop theory from qualitative data collected explicitly from self-identified Black men. Moreover, in order to further extant theories, it was equally important to identify new variables through an iterative process as suggested by my mentors. Herrick and colleagues also recommend qualitative approaches to build theory, even though their quantitative data from a multicity study of a racially and ethnically diverse cohort of gay and bisexual men informed the development of Gay Resilience Theory (Herrick, Lim, et al., 2013; Herrick, Stall, et al., 2013). Significantly, among their cohort (N = 1,541), only a fifth (19.5%, n = 300) were Black men. This is not to detract from the relevance and applicability of Gay Resilience Theory. Rather, I distinguish how Black MSM Resilience Theory is more applicable to understanding maintained seronegativity among Black MSM populations, because it was developed specifically with Black men. Given the HIV burden that Black MSM experience (CDC, 2015, 2017a; NYCDOHMH, 2017), this degree of intentionality is warranted and critical to strengths-based theoretical approaches for future research and intervention development with these populations.

From a critical race theory perspective (Graham et al., 2011; Harris, 2012), Black MSM Resilience Theory builds on the historical resiliencies found in Black MSM populations because they are Black people. Prior to DuBois’s examination and explication of the racialization of Blacks in the 1890s (Burghardt Dubois, 1898), Black people in the US had been and continue to be resilient in the face of unceasing American anti-Blackness. In the previous chapters, I describe how Black MSM Resilience Theory centers on the indigenous protection found in the ways that Black people in the US have historically helped each other. This help has taken various forms
such as the promotion of positive racial socialization and racial identity in Black adolescents, positive character development of Black children in a hostile environment that influences high academic achievement, Black parental participation in early childhood intervention, and imparted coping mechanisms to deal with systemic and institutional racism, sexism, and other forms of discrimination and oppression (Hill, 1998; Miller, 1999; Miller & MacIntosh, 1999; Reynolds, 1998). The Black MSM’s agency, for example, is bolstered by their social supports, other Black people in their lives, whose influence ties into their constructions of HIV risk. Although I have presented the major themes separately, they were invariably interconnected and worked in concert with each other in the Black MSM’s lives. Further, whereas Black MSM were excluded from the historic 1981 HIV/AIDS report (CDC, 1981; Villarosa, 2017), they now experience an intense public health focus because they are MSM first before they are seen as Black. Rather than pathologizing Black MSM, Black MSM Resilience Theory validates and supports the ways that Black MSM have taken care of themselves individually and with community support as Black people (Cross Jr, 1995; Cross Jr, Parham, & Helms, 1991; Cross, Parham, & Helms, 1998). This has ranged from “schooling” each other on how to survive in the streets when “walking,” “driving,” “standing,” and/or “breathing” as Black to advocating for themselves when public health has taken colorblind and pathologizing approaches to HIV prevention intervention implementation and programming. As a consequence of living within social systems that do not provide them with support, Black MSM have had to figure out as many means as possible to survive as both Black men and Black MSM. This is perhaps why Black gay men were involved and had prominent roles in Black social movements as early as The Civil Right Movement and as recently as the Black Lives Matter movement.

In addition to a critical race lens, Black MSM Resilience Theory adopts the common
public health behavioral descriptor *men who have sex with men* or MSM as an umbrella term. I chose to be as inclusive as possible while focusing on their sexual behaviors and by recognizing that because Black men who have sex with other men have other sexual identities in addition to the gay and bisexual orientations in Gay Resilience Theory. For instance, most Black men in the study selected gay as their sexual orientation. A smaller number of men self-identified as bisexual. However, there were Black men who self-identified as same gender loving (SGL), down low (DL), and pansexual. Although the MSM descriptor has been debated as being limited in breadth (Khan & Khan, 2006; Young & Meyer, 2005), in the development of Black MSM Resilience Theory, I opined that it was important to use a descriptor that would allow for the inclusion of other sexual identities common to Black men found in other studies (Matthews, Smith, et al., 2016). I acknowledge culturally-related identities such as SGL (Black Men’s Xchange National, 2012) and socio-sexual identities such as DL in a spectrum of sexual orientations in Black MSM Resilience Theory. Therefore, Black MSM Resilience Theory offers application to Black men who embrace various sexual orientation identities and/or sexual behavioral identities. Consequently, this theory offers a unique perspective for public health HIV prevention because not only is it inclusive of Black men’s sexual behaviors, it also considers their sexual orientations and socio-sexual identities, which are important factors for future work with this population. In this regard, I argue that public health scholarship and intervention needs to define Black MSM according to how these Black men define themselves, or it will continue to miss the mark. What follows is discussion of the emerging theories that comprise Black MSM Resilience Theory.
The Dimensions of Agency

I began the discussion of my findings with the first of the three major themes, Agency, as an emerging theory of one of the strengths the Black MSM possessed. Participants reported exercising their agency in their relationships and in sexual encounters as a means of facilitating their seronegative maintenance. For example, when Fred talked about having “the agency and control” to maintain HIV-seronegativity, he meant that it was important for him as a young man moving through adulthood to be consistent and to stick to his risk reduction practices. Similar to Fred, the majority of the participants exercised their agency. Even if they did not explicitly identify it as or call it “agency,” they demonstrated agency through their actions, practices, beliefs, and HIV risk determinations that move beyond Bandura’s (1990) description of individual agency. Among the cohort of Black MSM, I identified three types of agency: exemplified, equivocal, and transformative.

I began by describing Black MSM who exercised Exemplified Agency. This type of agency was commonly rooted in self-awareness based on self-identified attributes and positive self-conceptions. I discovered that this theme contained two subthemes that were both interconnected and independent of each other. In one subtheme, the seronegative men leveraged their physical attractiveness as currency in sexual encounters, so that they could employ their risk reduction strategies. They understood that other men found them physically attractive, which gave them the upper hand in determining what they would allow to occur in sexual encounters. This type of limit setting to reduce risk was a sensitizing concept from Gay Resilience Theory that the Black MSM employed beyond self-monitoring of their own behaviors. They could leverage their physical attributes so that they could control or manipulate the kind of sexual experiences they wanted to have with their partners. They based these experiences on what they
understood would protect them from seroconversion as a form of intentional agency (Bandura, 1990).

Some of the men were very expressive when they described how attractive other men found them, while others were more reserved. However, as long as they recognized the power they had based on their desirability to other men, they could restrict their partners to specific prevention activities. For example, some participants used their attractiveness to assure that their partners wore condoms when they penetrated them anally.

In the second subtheme of exemplified agency, some men were picky, and this “pickiness” derived from their desirability to others that was not limited to their physical attributes. Beyond their physical attractiveness, their personalities and comportment exuded sexiness. Being sexy and desired gave them power in negotiating sexual relationships. They also believed that their selectivity of partners helped them avoid acquiring HIV. Because these men could afford to be discerning about whom they did and did not have sex with, they were able to reduce their HIV risks.

I found this subtheme of agency particularly interesting, because among MSM attractiveness is a privileged physical attribute (Hatala & Prehodka, 1996; Kaminski, Chapman, Haynes, & Own, 2005; Sánchez, Greenberg, Liu, & Vilain, 2009). The men with exemplified agency knew “how to work it” as a means of getting their sexual needs met in a positive way. Herrick and colleagues (2014) describe healthy sexuality as a kind of resilience on the dyadic level. I found that participants understood that their attractiveness made them desirable, and the more attractive they were, the more desirable they were to others, and the more this enabled them exercise their agency with a high level of confidence. This echoed what participants from member checking focus groups reported.
Some men drew *Equivocal Agency* from what they had learned from public health messages about HIV transmission. They reported extensive exposure to HIV prevention interventions, messages, and risk reduction education common to public health and specific to Black MSM. Given my own exposure to these same messages as a Black gay man in NYC, I understood why the participants reported a lot of experience receiving public health messages. The men felt “targeted” by public health HIV prevention messages and described specific social media campaigns that implied the inevitability of them, as Black MSM, becoming HIV-infected because of who they were. None of the participants, regardless of his sexual practices, was unaware of his HIV risks.

Everyone, regardless of how they preferred to enjoy sex, knew how to reduce their risks even if they were not consciously employing risk reduction or harm reduction strategies. This theme also had several subthemes. For example, participants implemented their public health-aligned risk reduction practices by following public health messages. I found this to be more often expressed by the younger Black MSM, whose age demographic (29 years and younger) was a public health focus at the time of the study. Even the younger Black MSM understood why there was a public health shift to “targeting” their age demographic, “because it’s been all over the news about how young Black gay men in NYC are getting infected.” Their knowledge about their demographic-specific risk was an interesting contrast to how often HIV prevention education is the first line of approach to addressing HIV risk in Black MSM.

More often than not, non-Black social service providers treated them as if they were ignorant to “all the craziness that’s going on.” Their statements implied experiences of racism, homophobia, and other biases from non-Black social services providers in pathologizing ways. However, when they spoke with Black and Latino male social service providers, “especially the
gay ones…they know I know what’s up.” When they discussed HIV prevention, not focused on their risks, the Black MSM reported fewer experiences of feeling shamed and stigmatized because of their co-occurring identities. Part of their demonstrated agency was how they educated themselves about their socio-sexual environment. Many relied on social media posts and news feeds, whereas others actively researched mainstream and scholarly articles about HIV. They also tended to seek and share more facts-based knowledge with their Black MSM peers. Frequently, they relied on each other more than on social services providers. The participants’ responses and actions affirmed how I typically tend reply to assertions that Black MSM need more (or lack) HIV education: they already possess a lot of knowledge and are doing a fair job at educating themselves. If they are not educating themselves, they tend to seek information from their trusted social supports that tend to be other Black people in their lives.

I quickly established that members of the cohort possessed considerable knowledge about HIV and their HIV risk, and they spoke about the realities and real limitations of safer sex practice. Frequently, participants commented on how they were “targeted” because they were Black MSM. They could recite the common verbiage about public health HIV prevention guidelines and recommendations such as testing regularly and using condoms for anal sex. The only limited area of knowledge that I found pertained to preexposure prophylaxis (PrEP). At the start of the study, the Food and Drug Administration (FDA) and the CDC had just released expanded PrEP guidance (CDC, 2014). Most knew about post-exposure prophylaxis (PEP), a couple of men had taken it, but most had little to no information about PrEP. The exceptions were the two men who were already taking PrEP before they started the study.

Other subthemes of equivocal agency also emerged from the Black MSM’s narratives. One pertained to the men’s ability to set boundaries by having non-negotiable risk reduction
practices and the other was about how diligently they implemented their risk reduction practices. The Black MSM’s powerful expressions of their agency were impressive and spoke to their resilience. Two participants among the cohort contended with acute syndemics (CDC, 2010; Dyer et al., 2012; Wilson et al., 2014) such as drug dependence and chronic homelessness. Nevertheless, because of their ability to exercise equivocal agency, they managed to set boundaries and diligently employ their risk and harm reduction strategies such as “no risky behavior [condomless anal intercourse (CAI)].” An important finding was that Black MSM in the study with syndemics were eager to further their knowledge and self-efficacy to reduce their HIV risks. Another important observation among the equivocal agency group was their ability to enact their prevention knowledge as practices by planning, strategizing, and having forethought (Bandura, 1989, 1990) about situations that might compromise their ability to maintain seronegativity. Paraphrasing the men, they knew what they were supposed to do, and they did it because they needed to do it.

Lastly, Black MSM who exercised Transformative Agency learned how to exercise their agency after having sexual encounters in which they either had a “slip up” by having condomless anal intercourse (CAI) and/or had a “close call,” possible exposure to HIV. The transformative aspect of their agency meant that they not only rebounded from the experience, but they were able to transform their brushes with HIV infection into fodder for their reexamination of risk. Borrowing from Marston and Marston (2018), I argue that the elevation of their agency from low to high was an indicator of their transformative resilience that produced their agency. Regardless of their transformative process, slip-ups and close calls were interlinked subthemes of transformative agency.
Some of the Black MSM had close calls by having CAI with a seropositive partner. In some cases, they were not aware that their partners were HIV-positive until after the fact and panicked once they found out. After having a “wake up call,” they committed to “no more raw butt sex” unless they were in committed monogamous relationships. Slipping up and having a close call had greater implications for the Black MSM concerning what they wanted to offer a future partner or “hubs [husband].” They felt a need to be HIV-negative to attract a “hubs.” They believed that potential partners would think of their seronegative status as an indicator of their sexual health and sexual well-being. If they were in seroconcordant relationships, they could offer themselves as “HIV-free” to potential partners.

Not everyone in the study was consistent with his sexual risk reduction practices; however, they all implemented harm reduction practices. Harm reduction was a subtheme among the men who reported having multiple close calls. Some men in the cohort were having frequent high-risk sexual encounters. Straddling the fine line between clinician and researcher, I consciously made certain to take an overwhelmingly sex positive approach while interrogating them about the specifics of their sexual encounters. Initially, they appeared to exercise low agency and had little concern about their sexual health. For them, HIV “wasn’t that bad” and they could “get on medication” if they ever got it. Intrigued by their responses, I probed them deeper and uncovered that they were exercising a higher level of agency than what they reported. A key element to their transformative agency was their social supports. Their supports facilitated a shift in their self-regard, whereas they began to actively avoid contact and/or exposure to bodily fluids that carry HIV as a harm reduction practice that likely contributed to their seronegative maintenance (Ober et al., 2017). Further, many frequently engaged in receptive CAI
with serononconcordant partners (of unknown HIV status), but they did not let their partners ejaculate inside of them.

**Social Support Theory**

The second major theme, the emerging theory of *Social Supports*, describes what helped the Black MSM maintain agency. I discovered a relationship between how “out” (the degree of the men’s sexual orientation disclosure (SOD) (Soler, Caldwell, Córdova, Harper, & Bauermeister, 2017) the men were and the expectation their supports had that they would maintain HIV-seronegativity. Being out or outness was another sensitizing concept I took from Gay Resilience Theory that described the degree to which the Black MSM had reconciled with their internalized homophobia and embraced a socio-sexual orientation identity. Interestingly, I noticed a pattern in the way that the Black MSM consistently commented that the more out they were to their supports, the more they experienced their supports as invested in their sexual health and well-being. Their descriptions of their experiences departed from those that typically describe Black families and communities as inherently homophobic. Additionally, their supports stressed how important it was to them that the Black MSM maintain their seronegativity because of how HIV has particularly affected Black communities. The men’s supports did not only view the men solely as MSM, they saw and treated them as Black men first. Since their social supports tended to attend to the Black MSM holistically, the men received emotional (love, empathy, trust), instrumental (tangible), informational (advice, information), and appraisal support (self-evaluative) (Barrera, 1986; Langford, Bowsher, Maloney, & Lillis, 1997; Wills, 1991). The Black MSM’s types of social supports varied; they primarily encompassed two types, familial and non-familial. Their familial supports consisted of members of the men’s families of origin; non-familial supports included their chosen families and peers.
As the Black MSM cited the pivotal role their families played in their ability to maintain seronegativity, I could explore their unique experiences with their families of origin. I operationalized *Family of Origin* as the family in which the men were either raised or born. This theme, similar to agency, contained several subthemes. One subtheme illustrated how their families of origin were “huge” influences in their lives. I found that the closeness and intimacy in their familial relationships positively supported their agency. When I asked the Black MSM what people in their families meant to them, they characterized their family members as their “best friends,” “confidants,” “second parents,” and “mentors.” In these various roles, their family members advised them on how to protect themselves while embracing their sexual identities as Black men.

Many men in the study offered narratives that countered common notions about Black families being more homophobic than non-Black families (Arnold, Rebchook, & Kegeles, 2014; Jeffries et al., 2013; Loiacano, 1989). Rather than experiencing familial rejection, judgment, or discrimination, they told me about their familial experiences of tolerance at the very least, acceptance, and celebration of their sexualities. Given the important role of the Black family as a source of social strength and a buffer for anti-Black racism and other forms of discrimination that Black men face, I found their positive narrations to be refreshing and important to highlight in this study as a source of their strength and resiliencies (Black & Lobo, 2008).

Another subtheme of family of origin described how the Black MSM had “a very close relationship” with members of their families of origin. In some of the men’s cases, this closeness was so strong that their family members had also developed relationships with their partners. For the men who were “very out” to their families, their family members knew about their long-term partners, how many they had lived with, and treated them like “part of the family, because you
know how Black people do.” In some cases, the Black men’s families described their partners as “husbands” and “spouses” long before marriage equity became a reality in the US. The closeness that the men described speaks to the ways in which Black families and Black communities have a history of embracing (heterosexual) domestic partnerships and non-sanctioned or legally recognized relationships. Given the degree of closeness the participants described, I must emphasize the most important aspect about this subtheme: their families of origin explicitly expected them to do everything they could to maintain HIV-seronegativity. These Black MSM did not want to disappoint them by ever having to say that they had seroconverted. I refer to this as the, “I can’t ever go home and tell my momma I have HIV” talk they avidly wanted to avoid.

The last subtheme of family of origin concerned the men’s commitment to not losing their families. For these Black men, disavowal from their families would be worse than contracting HIV. Their Black families provided them with the affirmation and intrinsic support that they need to combat their daily experiences of both racism and homophobia. The Black MSM repeatedly told me that their sexual health often was the topic of “The Talk” that many Black mothers have with their Black sons; therefore, they committed to safer sex and risk reduction practices so that seroconversion would never be a topic of “The Talk.” The Talk was indubitable about how to survive as Black boys and young Black men. It included subtopics such as strategies for contending with and addressing racism, not acting “too Black,” “correct comportment” in the presence of the police, how to preempt criminal accusations, and how to “not get killed.” The Talk also included their mothers concerns about how the Black men had to contend with an additional layer of hardship for being MSM. This is not to say that no one had close relationships with their fathers or other male guardians in their lives. I anticipated that the Black MSM would speak more about having close relationships with mothers as some studies
have shown (LaSala, 2010, 2011). As if by default, the Black MSM were inclined to discuss their mothers’ roles in their lives as their primary sources of familial support. I speculate that this was indeed an artifact of The Talk and their Black mothers’ influential roles. Yet, The Talk was not limited to their mothers or to members of their families of origin.

In my review of the literature, I encountered what scholars often describe as “family of choice” when they refer to LGBTQ constructed families (McCarthy & Edwards, 2011). Instead, I used the term Chosen Families to describe the deliberateness of the Black MSM’s constructed families (Joint Commission, 2011; Oswald, 2002; Weston, 2005). I also encountered some scholars who referred to their constructed families as Fictive Families (Chatters et al., 1994; Herrick et al., 2014). I chose the more LGBTQ-affirming term, chosen families, because it was more aligned with how Black MSM described their constructed familial relationships as embodying more intimacy, closeness, and affiliation than what can be imagined or expected between non-kinship persons.

Examples of these types of close and intimate non-kinship relationships have been discussed in studies of young Black MSM in the NYC House and Ballroom scene (Arnold & Bailey, 2009; Kubicek et al., 2013; Soler et al., 2017). Therefore, I expanded the concept of chosen families to include members of the participants’ families of origin (e.g., extended family members such as cousins, aunts, uncles, and grandparents), self-described non-kinship family, close friends, and non-kinship persons with whom they lived. Sometimes, their chosen families developed from social “families” that provided support for coping with familial social undermining and social rejection and homophobia (Soler et al., 2017).

The chosen families theme had several subthemes. For example, I found that having chosen “gay” families that clothed, feed, nurtured, and provided love was important to the Black
MSM whose families of origin rejected them because they were MSM. In general, gay families consisted of close social friends and sometimes included an extended family member such as a cousin. When the Black MSM spoke about their chosen families, they described how those relationships developed out of friendships (“we bonded over the years”) and became intimate, loving, and supportive. Chosen family members gave the Black MSM “what I wasn’t getting from home,” which was respect, validation, and affirmation of their sexual identities. Frequently, I heard how some of the Black MSM’s gay families could be harshly critical of them. Yet, the men cogently described how their families’ tough love as culturally rooted, and how the tough love approach helped them become aware of their high-risk sexual behaviors. In other cases, the men constructed chosen families made up of like-minded Black gay men committed to helping and uplifting their fellow “brothas.” The fact that they called each other “brotha” implied their need for constructed family and/or family-like relationships for survival, although “brotha” is a polysemic term that also indicates how Black men “see” and honor each other as Black men.

Their brothas consistently said, “I love you” and were often substitutes for members of their families of origin that they preferred to confide in. In general, the Black MSM’s’ chosen families provided emotional, material, and economic resources, so that the Black MSM could focus on their life goals without having to “hustle” in order to survive.

Another subtheme spoke to how their chosen families provided them with social support by affirming, validating, and understanding the complexities of their intersecting identities as Black gay men. I heard the men stress not only the importance of having “brothas” they could talk to about the “gay stuff,” but also the necessity for supports that were empathetic to their experiences as Black MSM in NYC. Because their chosen family members were like brothers to them, I found an interrelated subtheme that described how the Black MSM’s chosen families
held them accountable for doing everything within their power to maintain HIV-seronegativity. By being held accountable by their chosen families, they “made up my mind” not to seroconvert. The Black MSM still aimed to enjoy their sexual activities (“I’m a freak”) while exercising agency to reduce their HIV risk. Participants felt highly committed to exercising their agency to maintain seronegativity because their chosen families “has my back” and would do everything possible to help them maintain seronegativity. In this regard, their experiences with their “families” were real. Their chosen families co-created real and meaningful experiences with the Black MSM that made them feel “just like family,” and in some cases, “better” than how they felt about their families of origin.

Among their chosen families, their HIV-positive chosen family members tended to express the strongest expectations that the men maintain seronegativity. Frankly, their seropositive chosen family members wanted to assure that the participants would never undergo what they had gone through themselves. By not only expressing their expectations, but by also providing the support, nurturance, and spiritual sustenance that the men in the study needed, their HIV-positive chosen family members acted as preventionists and/or interventionist. Research has shown the negative effects of lack of social support for Black MSM that experience social discrimination and economic hardship as associated with CAI with serodiscordant or serononconcordant sex partners (Ayala, Bingham, Kim, Wheeler, & Millett, 2012). With their chosen family members’ support, the Black MSM were able to avoid, if not curb, many syndemics that might have led to their seroconversion. I understood how their chosen families’ support was integral to the Black MSM’s well-being beyond sexual health; it was integral to their social, emotional, spiritual, and mental health as well. Being held accountable was a powerful influencing factor to the Black MSM’s HIV-seronegativity maintenance.
Finally, I used the term, *Peers*, to describe persons in the Black MSM’s lives not considered chosen family. The Black MSM spoke about their peer relationships that included platonic, intimate, and/or casual relationships with age, gender, and sexual orientation peers. In some cases, I found that peer support concerned sharing a similar life trajectory. Through my dialectical engagement with the men, I understood how important it was for them to have friendships with other Black people whose life trajectories were similar to theirs, but not necessarily limited to people of the same gender or sexual orientation. We discussed how and why they considered their peers with similar life trajectories to be confidants and valuable social assets that encouraged them to exercise their agency as a means of reducing their HIV risk. They valued this type of peer relationship because they needed to be able to talk to “someone [who] kinda knows exactly what I’m going through.”

Some participants needed to have other Black MSM peers who shared “the lived” experience of being HIV-negative in an environment that challenged their ability to maintain an HIV-negative status. Having peers who possessed this lived experience was important for the Black MSM who had “lived through” the early days and experienced the devastation of the epidemic.

Two subthemes under peers were interconnected for most of the Black MSM: The men had peers with whom they “lived together” not just through the early impact of the epidemic, but also those peers that had been in serodiscordant relationships long before viral load sorting (i.e., selecting partners with undetectable viral loads) (Card et al., 2018) was an option. Particularly, the Black MSM aged 50 and older were likely to have been in serodiscordant relationships, and they refused to let a partner’s seropositive status be an exclusion criterion. As some scholars have argued, these Black MSM viewed their intraracial sexual networks as sources of strength
and not as sources of viral pathology (Matthews, Smith, et al., 2016). They preferred to be with other Black MSM and AIDS was not a deterrent. At a time when their fellow Black gay men were dying, they pledged to show how powerful, to paraphrase the late poet Lloyd Vega, brothers loving brothers was a revolutionary act (Hemphill & Beam, 1991). Distinctly, the Black MSM valued the support they received from other seronegative men who had also been in serodiscordant relationships and strove to maintain HIV-seronegativity.

A further subtheme was about seropositive supports. Nearly every Black man in the study discussed how his seropositive peers were his primary educators and mentors about how to maintain HIV-seronegativity, which other researchers have noted (Hammack et al., 2017; Herrick et al., 2014). The men spoke reverently and deferentially about the Black gay men and Black transgender women who “schooled them” on HIV prevention strategies and approaches that would allow them to still enjoy their sexual activities.

Finally, I described a subtheme concerning the Black MSM’s need for seronegative supports. The men’s need for seronegative peers differed from their need for their “lived together” peers. This subtheme illustrated how much all the men felt it necessary to have general support from other seronegative Black men. Specifically, they needed Black MSM peers whose experiences paralleled their own challenges to seronegativity maintenance. They professed how they needed a lot of help and support, and support from “the few” other seronegative Black MSM was of paramount importance.

Similar to what Black MSM in my pilot study expressed, the men in this study talked about being unattended to by social services agencies, because there were hardly any supportive programs, support groups, or services for HIV-negative Black MSM. One participant was so passionate about the lack of resources for men like himself that he started his own support group
at the conclusion of his interviews. “Back in the day” there were “negative support groups” in which many Black MSM learned a lot about “how to stay safe.” By committing to take care of each other, the Black MSM took their agency beyond their individual levels of experience by taking the “for us, by us” (FUBU) approach with the larger community of Black gay, bisexual, and other MSM. Their actions indicated an individual-community dynamic that was reciprocally supportive. It was not the first time that I had heard participants speak about the lack of seronegative peer support. Older men in the pilot study cohort spoke similarly. They too started up their own support groups, running them out of their homes, and gave them culturally relevant names such as “New Attitude,” a 1984 song by Patti LaBelle who was known for her AIDS activism and support of Black gay men. They did for themselves what White gay men at the time refused to do for them.

Before the establishment of Black gay AIDS service organizations such as Black Men’s Xchange (BMX), Us Helping Us, My Brother’s Keeper, and NAESM, Black gay men sought out and established their own peer support networks. While groups lead by White gay men, such as ACT-UP and Gay Men’s Health Crisis (GMHC) were mobilizing and advocating for AIDS research, treatment, and prevention programs, they largely excluded Black MSM. Whereas White gay men mobilizing in response to the epidemic was seen as them acting on behalf of “the gay community,” it is important to note that racism was at play. In GMHC’s early days, it did not provide services for injection drug users as a means to discourage Black gay men from seeking its services. The irony was that there was considerable drug injection among White gay men too. This exclusion only changed once Ryan White funding was established and indicated that funded organizations could not exclude Black people. In response to Black gay men’s experience of exclusion and disregard lead to the establishment of their own organizations such as Gay Men of
African Descent (GMAD) in 1986 (GMAD, 2014). Then as now, Black MSM knew how to love and support each other in order to survive. By establishing their own supportive networks with other Black gay, bisexual, and other MSM, they have networks that capitalize on their shared coping mechanisms as Black men that lend to their ability to cope, thrive, and survive as Black MSM.

**Theory of Constructed HIV Risk**

I found the theory of *Constructed HIV Risk* that emerged novel. I called this major theme constructed HIV risk to describe how the participants formed theories founded on “logical” constructs of their HIV risk. I found that their risks were “constructed” because the Black MSM formed ideas (“if…”) based on conceptual elements, and “logical,” because their constructs made sense to them (“then…”). It was as if they had an abductive reasoning process for their construction of HIV risk.

I unearthed from their narratives how their constructions rested on their perceptions and conceptions about their sex partners’ serostatus as seroconcordant (HIV-negative), serodiscordant (HIV-positive), or serononconcordant (unknown) (Bird et al., 2017). Furthermore, as this theme emerged, I recognized that their constructed HIV risk was important for understanding how they exercised agency in relation to their risk reduction strategies and practices, which included harm reduction. Scrutinizing this theme revealed an embedded subtheme about how the Black MSM evaluated their HIV risk with certain sex partners. Some had or perceived more control over their ability to assess their risk, while others experiencing syndemics, such as homelessness and drug dependence, had less control.

Over the course of the study, I examined how the participants developed their constructs based on their conceived HIV risk and assumptions they made about their partners’ behaviors. I
observed that their constructions centered on abductive *if-then* reasoning. My examination of this theme, as compared to the others, entailed more application of constant comparative method (i.e., among and between the participants narratives) (Charmaz, 2014), so that I could accurately substantiate what emerged from their narratives and avoid making the data fit my public health heuristics. Concerning this emerging theory I needed to be especially reflexive (Hall & Callery, 2001; Mruck & Mey, 2007) and judicious with my use of memos (Charmaz, 2011). These subthemes I found particularly interesting and should be of interest to others conducting similar research with Black MSM populations.

One subtheme concerned the Black MSM’s beliefs about partners being “loose.” Being loose was a polysemic term because it carried multiple meanings. Unfortunately, the participants use of this term reinforced negative sexual stereotypes that research has found are frequently ascribed to Black men and Black MSM by the general US population (Calabrese et al., 2018; Lichtenstein, Kay, Klinger, & Mutchler, 2018). Some Black MSM defined loose as it pertained to the tightness, or lack thereof, of a receptive partner’s anal sphincters. According to the men who topped (insertive partner), if they were able to penetrate digitally a bottom’s (receptive partner) anus with multiple fingers easily, then they concluded that the bottom was having a lot of sex. Following their *if-then* thinking, *if* the bottom was having a lot of sex, *then* the assumption was the bottom had multiple sex partners and posed an HIV risk. It was easy to follow this logic about how they were able to test their partners’ “looseness,” since digital anal stimulation could be part of their sexual play. Paraphrasing the men, they were “just checking the goods,” which is a recommended sexual harm reduction strategy about the importance of visual inspection of partners’ genitals for signs of STIs.
Several of the Black MSM took the inspection process one step further: Their other definition of loose described how bottoms, in social venues such as bars and clubs, actively looked for tops to have sex. Black MSM with this definition said “loose bottoms” were “thirsty [desperate, needy, horny].” Similar to their use of loose above, the participants use of the vernacular expression thirsty also reinforced negative sexual attributes that have characterized Black men and Black MSM as hypersexual, promiscuous, and sexually deviant (Bowleg, 2013; Ghavami & Peplau, 2013; Hequembourg & Brallier, 2009). This was, yet, another example of their if-then thinking. They considered thirsty, loose bottoms to be sexually promiscuous (“if…” and, therefore, vectors of HIV transmission, because they were (“then…” having “a lot of casual sex” and likely to be having CAI. Again, I was able to understand their construction of this association because public health has recommended limiting the number of one’s sex partners as a risk reduction strategy (CDC, 2018).

The last definition of loose expanded the implication of partners as promiscuous by adding that they were also “hunting” for sex, phrased as “loose and hunting.” Their application of these labels was also an indicator of how sexual scripts have been racialized and applied to Black men and Black MSM (Calabrese, Rosenberger, Schick, & Novak, 2015; Dangerfield et al., 2017; Dangerfield, Ober, Smith, Shoptaw, & Bluthenthal, 2018; Lichtenstein et al., 2018). Men with syndemics recognized their HIV vulnerability and actively avoided partners they determined were hunting. I learned that some Black MSM tried to “avoid” men described as “hunters,” but it was not entirely possible or feasible for them to do so. If sex did occur, they did their best to reduce their sexual risks by exercising as much agency as possible. For example, the Black MSM who engaged in survival sex with the hunters made certain to use condoms regardless of their sex role. For those men who had limited control over their ability to assess
their risk and/or use condoms, unknowingly, they were more likely to have sex with partners whose viral loads were undetectable (virally suppressed).

Black MSM experiencing syndemics explained that because they were involved with numerous social services agencies most of which provided comprehensive HIV treatment services, they were likely to meet their sex partners in those spaces. They knew they would likely meet a partner living with HIV as a reality their life situation. Unbeknownst to them, they were viral load sorting (Card et al., 2018), because they were likely to meet their sex partners in social services organizations that provided antiretroviral treatment as prevention services to facilitate viral suppression among persons living with HIV (CDC, 2017).

Consequently, another subtheme was how participants normalized the likelihood of meeting an HIV-positive Black male partner, although they still feared contracting HIV. At first, I considered that they were simply ambivalent about being in serodiscordant relationships. However, as I sought a deeper understanding of their experiences, I discovered Black MSM knew a great deal about the high seroprevalence in NYC, and they were receptive to meeting and having sex with an HIV-positive partner given the availability of PrEP and increased commonality of HIV viral suppression. In fact, two participants had been taking PrEP prior to the study and two others initiated PrEP as result of being in the study. The deeper meaning I uncovered was that they preferred knowing that a partner was HIV-positive “from the jump.” When men gave examples of their openness to engaging with a seropositive partner, they said they were “poz-friendly (HIV-positive-friendly)” and felt safer with and had more trust in those partners because of their partners’ disclosure. Some men even expressed “relief” knowing that they were engaging with some who was seropositive because there was no guesswork about their HIV serostatus.
A related subtheme was Black MSM’s willingness to cross the serodivide, which challenged assumptions that they excluded seropositive MSM as a risk reduction strategy (Courtenay–Quirk et al., 2006; Dowshen et al., 2009; Gamarel & Golub, 2015; Khosropour et al., 2017; Smit et al., 2012). The Black MSM with more dating and sexual experiences confirmed my belief about their stance that a partner’s seropositivity would not be a “deal breaker.” According to them, the deal breaker was if a partner lied about his serostatus. It was not an issue of non-disclosure. Since they were likely to initiate discussion about HIV status, they gave their partners the opportunity to disclose and “get it out of the way first.” In this regard, they made informed evaluations and choices based on the knowledge of their partners’ seropositivity. Most important, the Black MSM stated their preference for knowing versus not knowing their partners’ serostatus.

Unequivocally, none of the Black MSM acted as if HIV did not exist in their worlds. HIV had affected everyone in some capacity. The Black MSM in this cohort lost brothers, sisters, parents, partners, lovers, and large segments of their communities to the epidemic. I regarded them as “HIV realists.” They were acutely aware of high seroconversion rates for Black MSM in NYC (NYCDOHMH, 2017). Given that and being HIV realists, the men talked about their concerns about being with serononconcordant partners: those who did not know their HIV status or believed they were HIV-negative. Even the few Black MSM taking PrEP worried about meeting serononconcordant partners, so they inquired about their partners’ serostatus and insisted on condom use with most partners. They discussed the importance of the “know your HIV status” campaigns and how there is still a significant number of persons (15%, 162,500) who are living with undiagnosed and untreated HIV infection (Bird et al., 2017; CDC, 2017a).
Some participants’ vetting protocols consisted of a mental checklist of dos and don’ts. For instance, the dos included having a phone conversation to verify information that was on an online profile, dating app, or shared textually. Another “do” was to share a partner’s phone number and other information if it was a “hookup” (casual encounter) for safety purposes with a trusted social support. Moreover, several Black MSM took their inquiries about HIV status and testing history further by requesting documentation. Several men in the pilot study also asked for proof of recent HIV test, because they were equally willing to share their test documentation. Black MSM who requested documentation used that request as a route to having “the HIV talk” and gave their partners the opportunity to disclose their serostatus.

What I gleaned from those who maintained a record of their testing history in order to share with their partners was that, as Black men, they were not trying to prove they were HIV-negative. Rather, they were more likely trying to disprove the assumption that they were HIV-positive. Further, nearly a third of the Black MSM took HIV tests with their partners before they had sex for the first time. Many reported that few of their partners had refused to test together. Some recounted how it “just happened” on their first dates given the presence of many mobile rapid testing units in the “gayborhoods” of NYC.

The final subtheme of constructed HIV risk explained how the Black MSM asserted that their sex roles facilitated their maintained HIV-seronegativity. I described this specific type of abductive reasoning as “topping theory.” Topping theory has several interconnected subthemes. The Black men who topped asserted that as long as they were not anally penetrated they were reducing their HIV risk. Their assertion is grounded in some truth: HIV risk is lower for the insertive partner (CDC, 2018a).

Another subtheme of topping theory had to do with the men’s positional identities or how
their sex roles played out in their socio-sexual interactions with other MSM (Hoppe, 2011; Johns et al., 2012). For example, several tops believed the onus was on them to be sexually responsible for both themselves and their partners since their role was associated with heteronormative ideals of masculinity. They felt burdened at times because if they did not insist on or provide “protection,” their receptive partners would not. Yet, some tops embraced the responsibility. They needed to be protective of their partners, which meant not exposing them to HIV or STIs, or harming them sexually.

Overall, topping theory was the mostly commonly held construction of HIV risk that I found among the cohort. The men’s articulations of topping theory aligns with studies on seroadaptive behaviors in which MSM purposely selected sex roles and sexual positions to reduce their HIV risk based on knowledge of, or lack thereof, their partner’s serostatus (Grace et al., 2014; Khosropour et al., 2017; Ober et al., 2017). Their intentionality about topping to reduce their HIV risk, for some participants, was likely compensatory. It was a means to decrease their sexual risk behaviors based on their increased perception of HIV risk. In this regard, the Black MSM’s topping behavior should not to be mistaken with sexual risk compensation, which describes increased sexual risk taking based on a decreased perception of HIV risk. Hence, the consensus was that “total tops” (exclusively insertive partners) were less likely to put bottoms at risk since topping has a lower risk of HIV acquisition. In most encounters, this construction of risk did not result in CAI for tops or bottoms. On the contrary, it activated their ability to exercise more agency, particularly for the bottoms: “I’m not letting anybody fuck me without a condom.”
Conclusions

The aim of this study was to identify the strengths and resilience factors among Black MSM in New York City who maintain HIV-seronegativity. With this study, my intent was to explicate how so many were able to maintain seronegativity in contrast to the odds that indicate a 50% lifetime chance of seroconversion (CDC, 2017; NYCDOHMH, 2017). Through my investigation about how and why they maintain seronegativity, I found that Black MSM possessed a variety of biopsychosocial strengths (Hatala, 2013) that enabled them to be resilient in an environment with high seroprevalence. I found that their strengths and resilience factors were intrinsically interconnected to their multiplicative and co-occurring identities (Bowleg et al., 2017; Gopaldas, 2013) simultaneously as Black people, as Black men, and as Black men who have sex with men. One of the findings to emerge was a theory of agency located in their coexisting identities as Black MSM. Another finding emerged as social supports that bolstered their ability to exercise their agency in order to maintain seronegativity. Finally, the ways in which the Black MSM constructed HIV risk emerged as a theory that informed how they took steps to avoid seroconversion, even if they were not consciously engaging in safer sex, risk reduction, and/or harm reduction practices. These findings constitute the components of Black MSM Resilience Theory, which proposes how and why these men maintain their HIV-negative status. Black MSM Resilience Theory also evinces how as Black people, their strengths and resiliencies were not solely located on the individual level. They originated from their Black dyadic, family, and community level supports. Moreover, Black MSM Resilience Theory built on and furthered constructs from Gay Resilience Theory (Herrick et al., 2014) and other extant theories that are not premised on the co-occurring realities of Black MSM.
Strengths

This study’s findings align with other theoretical frameworks applied to public health HIV prevention with MSM, in general (Carter, 2009; Herrick et al., 2014; Ober et al., 2017) and to a greater extent with Black MSM in particular (Bowleg et al., 2017; Hussen et al., 2013; Matthews, Smith, et al., 2016; Millett, 2015). Although the findings are generally congruous with extant theories and other researchers’ findings, they differ in several ways. This research took a strengths-based departure from traditional deficit-based approaches by qualitatively explicating the phenomenon as a means of identifying indigenous strengths and resiliencies in HIV-negative Black MSM. The findings alter extant theories so they can be applied to the experiences of Black MSM from an intersectional perspective with phenomenological undertones (Giorgi, 2010)—that is, from the perspective of the lived experience instead of being solely based on theoretical notions. For instance, the Black MSM’s agency is multifaceted. Agency is generally conceived of as personal and intrinsic in nature (Bandura, 1990). Black MSM Resilience Theory augments Bandura’s definitions of agency and furthers Gay Resilience Theory’s implications of agency by positing that Black MSM’s agency is intrinsic and connected to a communal exercise of agency for their survival as Black people and Black men (Bell, 1982). Similar to other MSM, the Black MSM had exposure to public health messaging. But what is unique among them is how the systems they inhabit enable them to apply those messages to protect themselves. Additionally, the Black MSM’s social support relationships offer counter-narratives about Black families as inherently homophobic, substantiate their chosen families as substantive, and validate the strengths of their racial, age, gender, and seronegative peer relationships. Furthermore, their constructions of HIV risk, albeit sometimes unreliable, stemmed from their heightened awareness of their risk because they are Black MSM living in NYC. Black
MSM engaged in abductive reasoning processes that enabled them to exercise agency by vetting partners who they perceive as “risky,” prompting discussion about HIV status with partners that often lead to testing together before their initial sexual encounters, and they normalize the likelihood of meeting HIV-positive partners.

Lastly, Black MSM Resilience Theory empirically demonstrates how historical events have shaped the ways in which HIV-negative Black MSM experience themselves as Black people, Black men, and as Black sexual minorities. Because of their co-occurring identities as Black men and Black MSM, they contend with compounded experiences of racialization and racialized sexuality (Barot & Bird, 2001; Fassin, 2011; Omi & Winant, 2014; Schaefer, 2008). As Black men, they struggle with being stereotyped as hypersexual and/or hypermasculine. As Black MSM they grapple with being stereotyped as hypersexual and sexually promiscuous. However, research has shown that Black children and youth who receive support ranging from the concrete to emotional, advice, and information from their families and other caring adults are more apt to demonstrate resilience as adults (Brown, 2008; Brown & Tylka, 2011; McHale et al., 2006). Essentially, the strengths and resiliencies that aided these Black men with co-occurring, multiplicatively oppressed identities in maintaining seronegativity were derived from how they learned to survive in the world as Black boys and Black young men. Many of them stressed the importance of “The Talk,” which historically has been about the cultural transmission of methods for survival and skills for coping with/while “being Black.” They received “The Talk” that emphasized how they should socialize in ways not to draw unnecessary attention to themselves, how they ought to present themselves as “respectable” Black men, and how to interact with and placate Whites in order to counter being preconceived as or assumed to be “thuggish,” intimidating, or threatening. Their mothers, fathers, extended family members, and
other caring adults in their lives acknowledged how unjust it was that as Black MSM they had to go the extra mile to survive in a world that will be hostile towards them for already being Black men. However, the Black men knew that whatever did not kill them made them stronger and even more resilient to their life challenges. Black MSM Resilience Theory asserts that identifying and understanding Black MSM’s strengths and resiliencies lay in the co-occurrence of their racial and sexual identities as Black men. Black MSM Resilience Theory recognizes that they already possess resiliencies imparted to them to survive and thrive as Black men.

**Limitations**

The focus of this study was population- and location- specific. These findings emerged from data collected from HIV-negative Black MSM in New York City, which is the country’s most populous metropolitan city with one of the most diverse Black MSM populations in the US. Its Black MSM population is comprised of Caribbean Blacks, Africans, Latin American Blacks, and African Americans. NYC has a type of Black diversity that is uncommon in other US cities with large Black populations. For this reason, findings from this study may not apply to Black MSM in other parts of the US because Black MSM is not a monolithic population. Black MSM elsewhere may reveal different strengths and resiliencies as compared to their NYC counterparts, which may reflect their geographic location, socioeconomic factors, and seroprevalence rates in their cities and states. Lack of transferability may also relate to local and regional public health interventions and resources. NYC’s Department of Health and Mental Hygiene is one of the foremost health departments in the nation. It has a wide scope of reach via its community partnerships with CBOs and nonprofits that provide social services to Black MSM. It is well resourced and has been able to engage Black MSM in ways different from other departments of health in the nation. Consequently, Black MSM in other cities may have different experiences
with and access to public health HIV prevention interventions and messages.

I recruited participants in this study using a purposive sampling strategy. However, there was the possibility of self-selection bias given that some Black MSM were referrals from my networks of social services providers. Consequently, the sample may not be representative of NYC’s Black MSM population. For instance, I did not enroll any Black MSM who self-identified as African. Unfortunately, I was unable to access any professional or social networks through which I might have recruited African participants. Additionally, I did not enroll any HIV-negative Black MSM aged 60-85 in this study. However, similar to my experience recruiting HIV-negative Black MSM aged 50 and older for the pilot study, it was difficult to find men that age who were not seropositive. As a means of problem solving that recruitment issue, I requested referrals from the few men aged 50 and older whom I enrolled in the study. They all told me that either they knew few other HIV-negative Black men their age or older or that the men they would have known had died from AIDS-related causes. Unfortunately, because I had no African participants or seronegative Black MSM participants in that older age cohort, I was not able include the experiences that they would have provided in my analyses.

Implications

Implications for Policy

The strengths of this research have important implications for policy. This study offers evidence for the importance of strengths-based approaches to HIV prevention with Black MSM whose co-occurring identities are not limited to their behaviors. In 2005, the CDC convened a Black MSM Consultation to engage policymakers, behavioral and social researchers, community leaders, activists, and others in discourse about policy and research initiatives prioritizing the epidemic in Black MSM populations. Over a decade later, Black MSM populations are still a
priority because their seroprevalence rates have not declined; disturbingly, seroprevalence has increased in young Black MSM populations (CDC, 2017b, 2017a).

Public health has advanced its offering of policy-driven research, interventions, and supportive social and medical services for seropositive MSM. Unfortunately, there is a scarcity of comparable policy-driven research, interventions, and supportive social and medical services for seronegative Black MSM. Black MSM Resilience theory and the findings from this study add to the growing body of strengths-based research approaches that highlight the importance of broadening the current HIV prevention agenda to include more HIV prevention initiatives, beyond HIV testing, for HIV-negative Black MSM. Similar to findings from my pilot study, Black MSM expressed feeling frustrated with the lack of support available to them as compared to supports for seropositive MSM. Policymakers can again convene a Black MSM Consultation in order to obtain input, feedback, and suggestions from Black gay behavioral and social researchers, Black gay community leaders, Black gay activists, and the leadership of Black gay social services organizations involved in HIV prevention work with Black MSM. This way, public health policymakers can strategize ways to implement better-informed HIV prevention policy that does not employ the needs of White gay men as a blueprint. Accordingly, policy-driven initiatives for seronegative Black MSM can inform the creation and availability of program-specific services for this population. Commensurate with the supportive programming that was available to HIV-negative White gay men in the late 1980s, Black MSM Resilience Theory-informed programming can attend to the biopsychosocial needs of Black MSM. Programming for these men can include HIV prevention.
Implications for Research

Future research should consider the benefits of matching the researchers’ racial, sexual orientation, and socio-sexual identities with those of the study population. This is particularly important in qualitative studies in which the researcher is the instrument. Most early career researchers choose to investigate a phenomenon because it is of personal and professional interest to them. Those with these vested interests can apply them as assets to understanding Black MSM who maintain their seronegativity. Therefore, researchers whose identities match the study population’s can engage with and be engaged by the participants in ways that a non-Black gay male researchers might not be able to do. For example, Black MSM participants in this study repeatedly committed to opening themselves up by being forthright, honest, and “as real” as possible because they were excited to have a series of deeply personal conversations with “a fellow brotha.” Future research will greatly benefit by having a team lead by Black gay researchers who can conduct the research by utilizing their tacit knowledge about Black MSM in nuanced and in-depth ways that their non-Black counterparts cannot. However, there are limitations of matching researchers’ identities to those of their study population. For instance, transference and countertransference issues may arise, particularly in qualitative research. Issues of transference and countertransference can be addressed by implementing reflexives practices such as memoing and regular debriefing sessions with researchers’ mentors and peers.

Methodologically, for future intervention research, more qualitative and mixed methods studies will further explicate seronegative Black MSM strengths and resilience factors. Because quantitative approaches have been the dominant methodological approach to examine phenomena in Black MSM populations, we still know very little about these men’s strengths and resiliencies. In contrast, qualitative and mixed methods research will offer more breadth and
depth to the research. Advancing our empirical understanding of the phenomenon should move away from pre-established variables for measurement by identifying new ones. Variables from this study emerged from the primary data collected from the participants and reflected constructs indigenous to the Black MSM population. As a result, this study’s qualitative methodology not only surfaced new variables for measurement through survey research, it surfaced Black MSM Resilience Theory that can also be tested and further developed by future research.

Future research that seeks to test or to further Black MSM Resilience Theory should continue to include other interpretive theoretical frameworks such as intersectionality and critical race theory. Both require that researchers purposefully examine the phenomenon through Black MSM’s racial and socio-sexual identities. Moreover, Black MSM Resilience Theory employed with intersectionality and critical race theory will avoid the production of empirical knowledge that privileges White gay men’s experiences as the norm and the source from which all other knowledge originates or to which all other knowledge is compared. Further, future research that takes this approach will better inform policy that will facilitate the development of HIV prevention initiatives with Black MSM populations that are specific to them rather than generalized from the White gay experience.

The development of Black MSM Resilience Theory is a set of concepts in its nascent stage. One avenue for further study and development would be to replicate this study with HIV-negative Black MSM in the Southern region of the US. The South has become the region most affected by the epidemic and has the greatest seroprevalence rates among Black MSM in the country. Replication of this study in the South will allow for the exploration of experiences not identified in their Northern counterparts. Although the research questions would remain the same, replication of this study may result in different themes, emerging theories, and new
variables that would advance Black MSM Resilience Theory.

Future research should include examination of strategies to facilitate an increase in HIV-negative Black MSM’s knowledge and adoption of PrEP. Nearly four years have passed since the FDA released guidance for enhanced PrEP access and provision. Because CDC guidelines indicate that Black MSM are priority candidates for PrEP adoption and utilization, public health prevention research with this population needs to incorporate an examination of what factors deter Black MSM from taking PrEP and what factors would support their adoption of PrEP.

**Implications for Public Health**

Likewise, Black MSM Resilience Theory and these findings have implications for public health. For example, biomedical interventions such as PrEP, PEP, and treatment as prevention are supplanting the few evidence-based interventions (EBIs) developed for Black MSM populations. As much as these biomedical interventions are important means of addressing HIV in seronegative Black MSM, their adoption has been modest at best concerning PrEP (Eaton, Driffin, Bauermeister, Smith, & Conway-Washington, 2015; Elopre, Kudroff, Westfall, Overton, & Mugavero, 2017; Matthews, Herrick, et al., 2016), as reported at the 2018 Conference on Retroviruses and Opportunistic Infections (CROI) (Smith, Van Handel, & Grey, 2018). Black MSM participants in this study voiced how “it’s not fair” that there is a dearth of public health programs and social services to support their seronegativity maintenance. Few men in the study knew much about PrEP, and only four Black MSM were taking PrEP by the end of the study. However, many expressed an interest in PrEP adoption. Black MSM Resilience Theory can be applied to public health’s concerted efforts to increase Black MSM’s PrEP adoption and utilization. By framing PrEP uptake through Black MSM Resilience Theory’s strengths-based lens, public health initiatives can assuage seronegative Black MSM’s doubts and concerns about
PrEP’s efficacy and negative perceptions and stigmatizing assumptions about PrEP users. One PrEP adopter in the study reported that his supports associated his PrEP with contributing to “helping out the [Black gay] community.”

**Implications for Social Work**

Black MSM Resilience Theory also has implications for social work. Because many social workers work in health and public health settings and provide concrete services to HIV-negative Black MSM, knowledge and application of Black MSM Resilience Theory can enhance their practice with this population. Social work’s strengths perspective, person in environment, and systems approaches work well with Black MSM Resilience Theory’s intersectional approach to the inherent strengths and resiliencies in Black MSM. Additionally, social work’s social justice and advocacy imperatives will aid in countering preexisting, pathologizing notions about Black MSM, their knowledge of effective HIV prevention strategies, and how that knowledge informs their constructions of HIV risk. I believe that social work is particularly well positioned to counter extant public health approaches that focus on deficits in Black MSM and criticize prevention initiatives for Black MSM HIV that are not developed specifically for and with this population.

Through this study, I aimed to elevate the voices of HIV-negative Black MSM who expressed feeling silenced, neglected, and pathologized by public health. Many Black MSM opined that they were an “afterthought” once the face of HIV became Black and MSM. Even though, since the beginning, the epidemic had a Black face. Participants repeatedly described feeling stigmatized and discriminated against for being HIV-negative. Most often, they experienced negative feedback when they publicly disclosed their seronegative status. The negative feedback often came from seropositive MSM who felt that their disclosure blamed them
for becoming infected. Social work can help produce and disseminate counter-narratives that 
depathologize, celebrate, and highlight the existence and increase the visibility of seronegative 
Black MSM. In response to feeling ostracized because of their HIV-negative serostatus, Black 
MSM were unlikely to disclose and lived “a lie by omission” in public spaces and in social 
services settings in which seropositive MSM disclosed their status and received positive 
feedback. Social work can collaborate with public health to attend to this issue by developing 
non-PrEP-related campaigns and messages that affirm and celebrate Black MSM’s 
seronegativity.

**Final Thoughts**

When I originally conceived of this research in 2009, I had no inclination about how 
marvelous, rewarding, fulfilling, empowering, affirming, validating, and challenging this journey 
would be. I truly was as affected by my interactions and engagement with the study’s 
participants as they were by me. This study in particular taught me so much about the merits and 
strengths inherent to the subjective nature of qualitative approaches. As an early career 
researcher, I learned how to finesse the alchemy of using myself as the instrument through which 
I collected my data. As a social worker, I learned how to “stay in role” as the researcher while 
mindfully applying my clinical skills to advance my interrogations of the Black men’s 
experiences with them. I learned to appreciate, value, and respect the co-creation of meaning and 
interpretations of the Black men’s experiences.

Memoing provided me with deeper insight into the participants’ lives and into my own 
personal values. Because I was able to establish a level of rapport with most of the men that my 
colleagues considered unprecedented, I took advantage of the opportunity to develop a deeper 
understanding of the phenomenon by appropriately giving back to my fellow Black men a
modicum of what they generously shared with and confided in me. As much as I was mindful of transferential and counter-transferential aspects of the research, I came to understand that this study was much more than a participatory experience for them. Among the cohort of Black men, I saw and experienced a multitude of dimensions of their existence. Not only were they Black men, they were also members of my communities.

I drew strength from my engagement with the Black men and they held me accountable for being the best researcher I could be so that I could capture, translate, and share their stories in ways that others could not or would not. I drew upon the strength that they empowered me with to carry me through the process of writing this research, so that I can enlighten public health about their strengths and resiliencies and debunk preexisting pathological notions about them. Because of who I am and what I brought to the study as the researcher with my background, the men truly trusted me and opened up in ways that speak to the camaraderie that exists among Black men. Consequently, because of my ability to build rapport with the men, the study yielded an interesting by-product.

From my vantage point as the researcher and clinician, I observed just how much the Black men wanted/needed mentors, a role models, confidants, and other forms of support in their lives. In casual conversations with some participants after their first and second round interviews, some stated how they wanted/needed Black men in their lives to whom they could go to for advice and/or suggestions about how to groom and dress for interviews, to review their resumes, and for relationship advice as examples. It became apparent to me how clinical, therapeutic, and/or cathartic their participation in the study was; none of which I had entirely anticipated. When I shared these observations with my mentors, colleagues, and peers, they said simply, “it makes sense.” Given their experiences as Black men and Black gay, bisexual, and
other MSM, it makes sense that they would want to connect with other Black men who can “see them” for who they are. I was reminded of how enlightening individual level interactions can be, and how necessary it is to have more Black gay men leading the work with Black MSM populations. Finally, more than ever, I have become critical of research on Black MSM that does not have Black gay researchers, let alone Black researchers, as the studies’ lead or as members of the research team. Through my research, I am committed to demonstrating the value in having increased representative parity in public health and behavioral and social science research.
Appendix A

Demographic Questionnaire

Project Title: Identifying the Mental Health Strengths and Resiliencies of Black MSM in New York City who maintain HIV-seronegativity

Please answer the following:

1. Age: ________________________

2. Race/Ethnicity: ______________________________________________________________

3. Where do you currently live?
   □ Brooklyn □ Bronx □ Manhattan □ Queens □ Staten Island

4. How long have you lived in NYC? ________________________

5. Where were you born?

   ___________________________________________________________  ___________________________________________________________
   City/State                Country

6. If you were born outside of the US, how long have you been here? ________________________

7. How do you identify (check all that apply)?
   □ Gay □ Same Gender Loving/SGL □ Bisexual
   □ Straight □ Down Low/DL        □ Transgender Loving/Attracted
   □ Queer □ Pansexual               □ I don’t identify as anything specific
   □ Other ____________________________________________
8. What is your gender/gender identity? □ Male □ Transgender woman (male-to-female)
   □ Other ________________

9. You have sex with (check all that apply):
   □ Men □ Women □ Transgender women □ Transgender men □ Other ________________

10. Have you been sexually active with men for: □ More than 3 years □ Less than 3 years

11. Have you had anal sex with another man in the last 3 months? □ Yes □ No

12. How many men have you had anal sex with in the last 3 months? ________________
   a. With how many men did you use condoms? ________________
   b. With how many men did you not use condoms? ________________

13. When was the last time you had anal sex with another man? ________________
   Did you use a condom? □ Yes □ No

14. What was your relationship with the last man you had anal sex with? (Choose best match)
   □ Husband □ Partner □ Boyfriend
   □ Main sex partner (monogamous) □ Main sex partner (non-monogamous)
   □ Casual partner/Hookup □ Friend with benefits □ Other ________________

15. What was the race/ethnicity of the last man you had anal sex with? ________________

16. How old was the last man you had anal sex with? ________________

17. Sexually, how do you self-identify?
   □ Top □ Vers/Top □ Bottom □ Vers/Bottom □ Versatile □ Other ____

18. What do you prefer your partners to be?
   □ Top □ Vers/Top □ Bottom □ Vers/Bottom □ Versatile □ Other ____
19. What kind of sex do you have? Check all that apply.

Oral sex:
- □ I give (w/ condom)
- □ I give (w/o condom)
- □ I receive (w/ condom)
- □ I receive (w/o condom)
- □ It does not apply

Anal sex:
- □ I top (w/ condom)
- □ I top (w/o condom)
- □ I bottom (w/ condom)
- □ I bottom (w/o condom)
- □ It does not apply

Other: __________________________________________________________________

20. What is your HIV status? □ Negative □ Positive □ I don’t know/Uncertain

21. When was your last HIV test? _________

22. Do you have documentation (paperwork) of your last test result within the last 6 months?

□ Yes □ No

23. How often do you test?
- □ Every 3 months
- □ Every 3-6 months
- □ Every 6-12 months
- □ Once a year
- □ Other _____________________________

24. Do you know the HIV status of the last man you had anal sex with?

□ Negative □ Positive □ I don’t know/Uncertain

How did you find out what his status was (if applicable)? _______________________________
______________________________________________________________________________

25. Current drug & alcohol use:
- □ Yes, I use drugs and/or drink alcohol □ I inject drugs
- □ No, I do not use drugs or drink alcohol □ I do not inject drugs

If “Yes,” briefly describe (a) what you use, (b) how often, and (c) when you typically use.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
26. Highest level of education completed:

- □ Did not complete High School
- □ High School
- □ GED
- □ Some College (AA, 2-year degree)
- □ College (BA, 4-year degree)
- □ Graduate School (MA, MS, etc.)
- □ Graduate School (PhD/MD, etc.)
- □ Other ____________________

27. Are you currently employed?  □ Yes  □ No

28. If you are not employed, what was your last date of employment? ______________________

29. What was your income last year:

- □ Less than $10,000
- □ $10,000-$19,999
- □ $20,000-$29,999
- □ $30,000-$39,999
- □ $40,000-$49,999
- □ $50,000-$59,999
- □ $60,000-$69,999
- □ $70,000-$79,999
- □ $80,000-$89,999
- □ $90,000-$99,999
- □ $100,000 or more  □ I don’t know

30. Are you receiving (check all that apply)?

- □ Public assistance/general assistance
- □ Social security insurance (SSI)
- □ Disability insurance
- □ Worker’s compensation
- □ Other type of assistance (please describe) ____________________________________________

31. What is your religious affiliation, belief system, or spiritual practice?

___________________________________________________________________________

32. How important is your religious affiliation, belief system, or spiritual practice?

Very important  Important  Somewhat important  Not important at all
Appendix B

Interview Guide

Project Title: Identifying the Mental Health Strengths and Resiliencies of Black MSM in New York City who maintain HIV-seronegativity

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**Interview Questions**

**Social Support:** Let’s talk about whom you go to when you want or need to talk about stuff that’s going on in your life.

1. Tell me, who are the people in your life you talk to about your “personal stuff” (e.g., dating, sex, intimacy, mental health, etc.)?
   a. Who do you tell *what* and *why* do you talk to her/him/them about it?
   b. Describe the other supports you have.

**Partners:** Let’s start by talking a little about your partners. In our community, people partner in many different ways.

2. How do you meet your current partner or partners?
   a. Tell me about what qualities and characteristics you look for in partners.
   b. What kind of partner are you looking for when you want to have sex?
   c. Tell me about the partners you’ve had within the last three months [*If none: Tell me about the partners you’ve had in the last six months*].
      i. How and where did you meet them?
ii. Describe your relationships with them (e.g., dating, boyfriend, friend with benefits, hookup, short-/long-term, etc.).

iii. How long did you know them before having sex with them?

iv. What were their HIV statuses?

**On being HIV-negative:** Let’s talk about what it’s like for you as a HIV-negative Black gay/bi/SGL man.

3. Tell me: What’s it like for you being HIV-negative, given that there are lots of HIV-positive Black gay/bi/SGL men in NYC?

4. How do you think have you been able to remain negative?
   a. How important is being HIV-negative to you? Why is it/isn’t it?
   b. Is it important to anyone else in your life that you stay negative? Who and why is it important to this person/these people?
   c. On the questionnaire, you said that you test _______. Why do you test this often?

5. I think that I’ve already answered this question but I want to ask it a different way, why do you think you haven’t become positive?

**Talking about HIV:** Let’s talk about discussing HIV and/or HIV status with your partners.

6. On general, how and when does HIV come up with you and your partner(s)?
   a. Tell me about a time you found out about a partner’s HIV status.
      i. Who brought it up? *When, why, and how* did it come up?
      ii. Does it always happen this way? If not, tell me about a time when it was different.
   b. How do you discuss and/or negotiate what you will do sexually after talking about HIV statues with your partner(s)?
c. How do you discuss and/or negotiate what you will not do sexually after talking about HIV statues with your partner(s)?

d. Tell me if what we just talked about is the same or has been the same with other partners.

**Sexual Practices:** Let’s talk about your sex life and what you do when you have sex.

7. How would you describe your sex life?
   a. Why do you have sex?
   b. Any other reasons why you have sex?
   c. How often do you have sex?

8. What are your sexual practices? For example, what do you like to do with your partners?
   Please describe them with as much detail as you feel comfortable.
   a. How has the HIV epidemic affected your sexual practices?
   b. What does the term “safer sex” mean for you? (How do you define it and/or understand it for yourself?)
   c. How often and with whom do you practice safer sex, according to your definition? Why?
   d. How often and with whom do you not practice safer sex, according to your definition? Why?
   e. Tell me about what else you do to reduce your risk of getting HIV [Besides using condoms]?
      i. How did you find out about this way to reduce your HIV risk?
      ii. Why do you do this thing/these things?
      iii. How has it/have they worked?
iv. How do you get your partner to do this/these?

v. Have you heard about PrEP (preexposure prophylaxis)?
   • Tell me what you know about PrEP.
   • Are currently on PrEP? If not, how interested in PrEP are you?
   • Do you know anyone taking PrEP? Tell about them.

9. Tell me, what influences or informs your sexual decision-making (i.e., with the same partner, different partners, or in different contexts/situations with a partner or partners)?
   a. Regarding your sex role (i.e., top, bottom, vers, etc.) with a partner or partners and what kind of sex you have with him or them.
   b. Whether you’ll use condoms with a partner or partners?
   c. Whether you’ll have raw/bareback sex with a partner or partners?
   d. Whether you’ll use other risk/harm reduction strategies with a partner or partners?

Closing Questions

As someone who has been able to remain HIV-negative...

10. What do you think we need or can do to decrease HIV infection in Black men who have sex with men in NYC?

11. Specifically, how can we help Black men who have sex with men in NYC stay HIV-negative?

12. Tell me if there anything else that you think would be helpful to know or to add for this study.

13. Do you have any questions for me?
Thank you very much for participating in this study. I appreciate the time you’ve taken to discuss these topics with me. I want to remind you that the discussion we’ve had here today is confidential and will not be connected to your name or any other identifying information.
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