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Sexual Behavior and HIV Risk Among Age-Discrepant, Same-Sex Male Couples

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Abstract

Research has suggested that men who have sex with men with older sexual partners are at increased risk of HIV infection. However, while studies have explored risk among men in age-discrepant non-primary partnerships, only two have explored age discrepancy and risk in primary same-sex male relationships. We used data from semi-structured in-depth interviews to explore sexual behaviour and HIV risk among 14 Black, White and Interracial (Black/White) same-sex male couples with an age difference of 10 or more years. Most couples regularly used condoms and sexual positioning tended to lead to lower risk for younger partners. Some serodiscordant couples abstained from anal sex, while others used seropositioning to avoid transmission within the relationship. Within some couples, older partners acted as mentors on HIV prevention and broader life lessons. Future studies should further explore the potential risks and benefits of large age differences in same sex male primary relationships.

Keywords

gay couples; age mixing; older partners; men who have sex with men; HIV risk; USA

Introduction

Men who have sex with men continue to constitute the largest proportion of estimated new HIV infections in the USA, with White and Black men who have sex with men accounting for the majority of new infections (Centers for Disease Control and Prevention 2012). Since the 1990s, studies have suggested that men who have sex with men with older sexual partners are at increased risk of HIV infection (Berry, Raymond, and McFarland 2007, Bingham et al. 2003, Blower, Service, and Osmond 1997, Coburn and Blower 2010, Hurt et al. 2010, Joseph et al. 2011, Morris, Zavisca, and Dean 1995, Mustanski, Newcomb, and Clerkin 2011, Service and Blower 1995). This increase in risk can be partially explained by

a number of factors. First, in a diverse sample of men who have sex with men from 21 US cities, HIV prevalence was higher among older men than younger men (Centers for Disease Control and Prevention 2010). Thus, in choosing an older partner, men who have sex with men may have a greater chance of being exposed to HIV (Bingham et al. 2003, Blower, Service, and Osmond 1997, Hurt et al. 2010). Second, there is some evidence that age discrepancies within relationships may impact on decision-making power and sexual risk behaviour. In a study of Asian men who have sex with men in Los Angeles, men who were older than their partners had greater odds of reporting unprotected anal intercourse in which they were the insertive partner, which the authors argue may be the result of younger partners having less confidence in advocating for safer sex (Choi et al. 2003). Other researchers have found that Black men who have sex with men are more likely than White men to have sex partners that are ten or more years older (Berry et al., 2007), and Black and Latino men who have sex with men with older partners had greater odds of reporting unprotected anal intercourse in which they were the receptive partner (Joseph et al. 2011). Further, among Latino men, if a sex partner is younger, a greater proportion of respondents stated that they would likely top than the proportion that said they would bottom (Carballo-Dieguéz et al. 2004). And Mustanski, Newcomb, and Clerkin (2011) found that among young men, rates of unprotected anal intercourse increased progressively as the age difference between partners increased.

However, all of the above research on age discrepancies and HIV risk is based on individual-level, quantitative data. And nearly all focus solely on anal sex partners or non-primary partners versus men in primary relationships. This may leave important gaps in the literature. As we noted in a recently published review of the literature on HIV risk among same-sex male couples (Hoff et al. 2016), there is inconsistency in the terminology used to describe same-sex couples. Terms used to denote a partner with whom one is in an ongoing sexual relationship include 'primary partner', 'steady partner', 'serious partner' and 'main partner'. Others refer to the couple as 'same-sex male couple', 'gay couple', or a 'romantic relationship'. Further, the minimum length of relationship varies from study to study. Here, we will use the respective terminologies of the authors being referenced. In a study that included both 'casual' and 'serious' partners, Mustanski, Newcomb, and Clerkin (2011) found that being in a 'serious' relationship was a significant driver of risk, and that risk increased along with increases in age difference. However, the authors did not report any interactions between age differences and the serious or casual nature of the relationships. Findings from Sullivan et al. (2009) suggest that more than half of HIV infections among men who have sex with men in the US are from 'main' partners, although these estimates have not been replicated outside the USA. Other findings suggest that among men in 'regular partnerships', younger men are more likely to be in the receptive position during anal sex, which may drive the increased risk for younger partners, not an increase in unprotected anal intercourse overall (Prestage et al. 2013).

In the USA, age differences are more common among same-sex couples than among opposite-sex couples (Jepsen and Jepsen 2002, Vespa, Lewis, and Kreider 2013). In a study of 566 same-sex male couples in the San Francisco Bay Area, 42% of couples had age differences of seven or more years (Hoff et al. 2010), while in other studies, couples with age differences of five or more years constituted 33% (Mitchell, Champeau, and Harvey

2012) and 57% (Hickson et al. 1992) of samples. Previous studies have found relationships between increased HIV risk and age discrepancies of varying magnitudes including 4 or more years (Joseph et al. 2011), 5 or more years (Bingham et al. 2003), and 10 or more years (Berry, Raymond, and McFarland 2007). Furthermore, large age differences have been found to affect same-sex male relationship dynamics. For example, findings from a sample of men in England and Wales, suggest that same-sex male couples with larger age differences, are more likely to have open relationships (Hickson et al. 1992). Lastly, among same-sex couple with civil unions in Vermont, larger age differences were significantly associated with lower couple-level relationship satisfaction (Todosijevic, Rothblum, and Solomon 2005); and relationship satisfaction has been linked to unprotected anal intercourse with primary and outside partners (Darbes et al. 2013, Davidovich, Wit, and Strobbe 2006).

Increasingly, researchers are looking beyond individual-level risk behaviours to explore relationship dynamics and HIV risk within the context of primary, same-sex male relationships (Beougher et al. 2012, Campbell et al. 2013, Crawford et al. 2001, Gomez et al. 2012, Kippax et al. 2003, Moreau-Gruet et al. 2001). One study in Canada found that mentorship, decisiveness and sexual maturity are factors that may draw some younger men to older partners, while older men described ‘malleability’, ‘finding a bottom’, and the opportunity to teach a sex partner ‘what good sex is all about’ as reasons that they seek younger partners (Adam 2000, 426). Other findings, from Southeastern Europe suggest that younger men may seek out older men who can provide material resources, while older men find younger men more attractive than men their own age (Longfield et al. 2007). These motivations for age-discrepant partnerships may also influence sexual risk behaviours within these partnerships, but the extent to which this occurs is not clear from existing literature.

In a qualitative study, in the UK, Flowers et al. (1997) found that sex in ‘romantic’ relationships is fundamentally different from sex in ‘casual’ relationships. The difference lies less in the sexual behaviour itself, than in the meanings it carries. Narratives of casual sex relationships had a strong theme of detachment and minimal self-involvement; whereas in romantic sexual relationships, anal sex reflected a deep commitment to the relationship and one’s partner. The authors distinguish between the ‘health rationality’ that is commonly used as the basis for understanding risk behaviours, and what they call a ‘romantic rationality’. Within a health rationality framework, condom use and other sexual decisions are made in the service to preserving and protecting health. These decisions are primarily seen a cost and benefit analysis that weighs HIV prevention against pleasure. The concept of romantic rationality provides an alternate way of examining sexual decision-making processes among gay men in relationships. Decisions around condom use and sexual positioning, for example, may be based on the desire to show commitment or desire (Flowers et al. 1997).

In this study, we employ a romantic rationality framework to explore the sexual relationships of men in age-discrepant relationships. Doing so in a qualitative study, allows us to explore the sexual decision-making and the relationships between age-differences and risk using men’s own narratives. We suggest that in age-discrepant same-sex male relationships, a romantic rationality may manifest itself in ways that may be protective for the younger partner. Specifically, sexual decision making may be influenced by commitment to and care

for a romantic partner, as well as mentorship by the older partner, one or both of which may not be present in non-primary age-discrepant sexual partnerships.

Several studies have documented risk-reduction strategies employed by same-sex male couples. These strategies include: negotiated safety (Hoff 2005, Kippax et al. 1997); relationship agreements (Hoff et al. 2010); seroadaptation, which refers to HIV status-based sexual decision making such as serosorting and seropositioning (Cassels and Katz 2013, McConnell et al. 2010, Mitchell 2013); condom use (Campbell et al. 2013, Moreau-Gruet et al. 2001); and monogamy (Darbes and Lewis 2005, Worth, Reid, and McMillan 2002). In this analysis, we explore sexual behaviour and risk reduction strategies among same-sex male couples with an age discrepancy of 10 or more years.

Methods

Participants

Stratified, purposive sampling was used to recruit and enroll 26 concordant HIV-negative couples and 22 HIV-discordant couples in the San Francisco and New York City metropolitan areas into a study investigating relationship power, race and HIV risk. The sample was stratified by race and included Black, White, and interracial (Black-White) couples. Participants were recruited by: distributing recruitment cards, flyers, posters; advertisements in Internet and print media; and through active recruitment in community-based venues frequented by men who have sex with men, including bars, community centers, churches, street fairs, and local businesses.

Potential participants were screened via telephone individually. To be eligible for the study, couple members had to: be at least 18 years old; know their own and their partner's HIV status; have lived in the USA since age seven or younger; and have been in a relationship with their primary partner for at least six months. For the purposes of this study, we define partner as 'a person whom you have had sex with and are committed to, above anybody else'. Additionally, at least one partner in the relationship had to report engaging in anal sex within the previous three months. All participants had to self-identify as either Black or White. Couples in which either partner identified as transgender were not eligible, nor were couples where members provided discrepant reports of their partner's HIV status.

The current qualitative analysis includes each of the 14 couples (i.e., 29% of the couples enrolled in the larger study) who had an age difference of 10 or more years was present. Among couples with age differences, five couples were concordant HIV-negative and nine were HIV-discordant; four couples were White, three were Black, and seven were Interracial (Black-White). Mean relationship length was 5.2 years (range: 6 months-18 years), with a mean age difference of 15.4 years. Among HIV-positive men in this sub-sample, 8 were White and 2 were Black. Nearly three quarters (73%) of White men reported having completed an associate's degree or higher, compared to 31% of Black men. Consistent with racial disparities in employment status and income in the USA (DeNavas-Walt, Proctor, and Smith 2013), a greater proportion of Black men were unemployed (77%), and had annual income under \$30,000 (69%), compared to White men, of which 47% were unemployed and 53% had an income under \$30,000. Descriptive characteristics are presented in Table 1.

Procedures

Between March and November 2011, we conducted semi-structured, in-depth, individual qualitative interviews; each averaged 90 minutes in length. Both members of the couple provided written informed consent prior to being interviewed. Interviews were conducted separately and simultaneously to ensure confidentiality and to allow each partner the opportunity to share sensitive information about relationship dynamics, power, and HIV risk without the influence of his partner's presence. Further, although our analyses and findings include the perspectives of both partners, in order to limit the possibility that participants recognise their own quotes, and those of their partners, we only included extended quotes from both partners side-by-side on a limited basis. Interview domains in the larger study focused on relationship history and dynamics, including power and conflict; masculinity; decision-making, experiences of racism and homophobia; sexual relationships and agreements; and health. The current analysis focuses on interview domains of age, HIV, relationship characteristics, and sex and describes risk reduction strategies that emerged among couples with age differences of 10 years or more.

Interviews were digitally recorded and transcribed verbatim. Using a grounded theory approach (Denzin and Lincoln 2003, Lindlof and Taylor 2002), members of the study team conducted an initial analysis of 36 transcripts to inform the development of the codebook. Eight members of the study team were each the primary reader for two couple interviews (four transcripts), and the secondary reader for two additional couple interviews (four transcripts). The primary reader summarised the interviews and led a discussion that underscored primary and secondary themes with the research team. The secondary reader also read the interview in detail and made additions and edits to the summary. All other members of the study team read the interviews before each in-depth team discussion. During these discussions, the team came to agreement on common primary and secondary themes, from which the initial codebook was developed. Four Masters-level research staff members applied the codes to a transcript to verify code definitions and application consistency. This process was repeated twice until agreement was reached among research staff. Four research assistants independently applied codes to all interview transcripts using Transana qualitative analysis software (Woods and Fassnacht 2007). One quarter of the transcripts were randomly selected and independently coded by a second coder and verified by senior staff members to ensure consistency and accuracy in the application of codes.

Findings

In the results that follow, we explore relationship and sexual dynamics, sexual behaviour, HIV risk, and risk reduction strategies among our subset of age-discrepant same-sex male couples. These couples employed a number of strategies to reduce HIV risk. Some (e.g., condom use and relationship agreements) were shared across the sample while others (e.g., seropositioning and abstaining from anal sex within the relationship) were specific to HIV discordant couples. Regardless of the strategy used, each couple appeared to prioritise protecting themselves from HIV transmission within the relationship. Most couples did not specifically describe their age differences as shaping their sexual relationship. However, previous findings suggest that risk is associated with age differences between sex partner

(Berry, Raymond, and McFarland 2007, Bingham et al. 2003, Blower, Service, and Osmond 1997, Coburn and Blower 2010, Hurt et al. 2010, Joseph et al. 2011, Morris, Zavisca, and Dean 1995, Mustanski, Newcomb, and Clerkin 2011, Service and Blower 1995), and recent findings suggest that sexual positioning may be the cause of increased risk in age discrepant partnerships (Prestage et al. 2013). Thus, the results that follow reveal sexual relationship patterns that may have important implications for understanding risk among age discrepant SSM couples. All names used with the quotes below are pseudonyms.

Older Partners as Mentors about HIV-Related Information

In 9 out of the 14 couples in this sample, there was a clear element of mentorship in the relationship that had the goal of protecting the health of younger partners and sharing broader life wisdom and experience. As one man described, 'I understand he's young. I really believe that feels good that I do take charge as far as making sure he straps up [wears a condom] and stuff like that.' (Charles, 30, Black, HIV-neg; [Partner: Lance, 20, Black, HIV-neg]) As described by this man, older partners took an active role in protecting their younger partners from HIV risk, both within and outside of the relationship. Another man in an open relationship described his reaction to his partner engaging in risky behaviour with outside partners: 'I've seen him engage in unsafe sex with people, and I tell him, "Don't do that because you are taking a risk"...He says, 'Well I didn't insert it all the way. I just put it in a little bit.' I said, 'Yeah but you really should use a condom, and I'm only looking out for your welfare.' (John, 64, White, HIV-pos; [Partner: Carl, 54, Black, HIV-neg])

Other younger partners saw their relationships as not only sexually erotic but as an opportunity to benefit from their older partner's life experience. One man described, 'I like messing with the older guys, and I like older guys more than my own age group and stuff like that because, you know, I like to find out more about things.' (Terrence, 30, Black, HIV-neg; [Partner: Nick, 60, White, HIV-neg]) Another man described this by explaining what attracted him to his partner: 'He was older and knew a lot more than me and he could teach me something. And I really like a person who can teach me something.' (Peter, 32, Black, HIV-neg; [Partner: Frank, 57, White, HIV-pos]) His partner explained, 'As an older person, I feel that it's my responsibility to be a little bit mentoring...I think that HIV is a manageable situation but it just makes life complicated.' In both of these relationships, the age difference was more than 20 years and the White partner was older which may indicate a more paternal dynamic, and possibly a racialised power differential. In particular, the older White partners in these relationships held the financial decision making power, and had control over the space the couple inhabited or spent time in. Structural factors, such as unemployment, under employment, lower education, and a history of incarceration, as well as expectations to fulfill sexual stereotypes placed these Black men in lower power positions in their relationships. Further, the younger partners each described being attracted to their partners, at least in part, by the opportunity to learn from their older partners' personal and professional experience and knowledge.

For other, HIV-positive older partners, the knowledge of what led to their seroconversion inspired them to use those experiences as cautionary tales for their younger partners. One man described his seroconversion as being a result of 'a lot of risky behaviour' and 'all this

wild sex.’ As a result of his own experience, he was committed to doing what he could to help his partner be safe and stay negative.

Age and Sexual Positioning

In most cases, sexual positioning tended to place the younger partner at lower risk than the older partner. For example, among discordant couples, the younger partner was more frequently in the insertive role during anal sex. This was true in most cases where the younger partner was the HIV-negative partner. In most couples where the younger partner was HIV-positive, however, the couples described themselves as versatile and regularly switched roles. In all but one of the HIV-negative couples, the younger partner was regularly the top during anal sex. For these couples, participants did not describe much sexual negotiation around positioning, and men stated that this was simply a matter of preference. As one man described, ‘I like being a bottom, and I don’t even have a desire of being a top.’ (Charles, 30, Black, HIV-neg; [Partner: Lance, 20, Black, HIV-neg]) Couples’ narratives did not explicitly describe protecting the younger partner as a motivator in sexual positioning. However, the sexual relationships, described by the age-discrepant couples in our sample, revealed patterns of sexual positioning that resulted in lower levels of risk for younger partners.

Risk Reduction Strategies among HIV-Discordant Couples

Some risk reduction strategies were implemented by most age-discrepant couples regardless of HIV status. There were, however, certain strategies that were exclusively employed by serodiscordant couples to prevent HIV transmission within the relationship. For the nine HIV-serodiscordant couples, they perceived that their lower HIV risk was driven by several factors, including stigma, fear of HIV transmission, erectile dysfunction, and the HIV-positive partner’s awareness of and concern for their HIV-negative partner’s health. Within most of these couples, the HIV-positive partner took an active role in keeping their HIV-negative partner negative.

Among the HIV-discordant couples who did have anal sex, some engaged in seropositioning to reduce the risk of HIV transmission. Some of these couples believed that so long as the negative partner was in the insertive position, their risk was lower. One HIV-negative man described, ‘... [topping] just makes me feel better cause I know, well I’m under the impression that it puts me at lower risk of HIV contraction...And it scares me to think that you know he could be topping and the condom break while he’s inside me. That really scares me.’ (Mark, 27, Black, HIV-neg; [Partner: Kevin, 38, White, HIV-pos]) His partner accepted the bottom role given that ‘... [his partner] hasn’t done it as much as I have I guess cause I’m older or whatever...I don’t want to make him think he has to [bottom]’. He also described condoms as ‘just something we do,’ as they were both committed to maintaining the negative partner’s status. Another HIV-positive man described a limitation to sexually pleasing his partner because his fear of transmitting HIV prevented him from being the insertive partner during sex: ‘he would like me to fuck him and maybe I will, but I’m HIV-positive, and I don’t particularly like condoms. I’m undetectable, but I don’t think I’d want to.’ (Frank, 57, White, HIV-pos; [Partner: Peter, 32, Black, HIV-neg]). His partner described

the commitment to staying negative as a ‘conflict’ and added, ‘I can’t do too much in return for him.. I’m definitely trying to stay negative and he’s trying to keep me to stay negative.’

Another couple found ways to engage in sexual activity with each other and with outside partners to satisfy their sexual desires.

... I’d say the last time we had sex was a couple of weeks ago, and I basically manually stimulated him and he came. He would really like me to penetrate him anally, and I’ve always had a difficult time keeping it hard enough to do that successfully... I’m more afraid to take him into my mouth because for a long time he had undetectable viral load but he’s gone on and off of his AIDS medicines a lot... And as a result his viral load, which was undetectable, is now on up there.
(Christopher, 64, White, HIV-neg; [Partner: Paul, 51, White, HIV-pos])

As a result of the HIV-positive partner’s elevated viral load, the HIV-negative partner was uncomfortable having both anal and oral sex with his partner. The HIV-negative partner suffered from erectile dysfunction, which made it difficult for him to be the insertive partner during anal sex. This couple found intimacy in their relationship through kissing and cuddling and regularly manually stimulating each other in an effort to engage with each other sexually but safely.

The majority of the HIV-discordant couples described their relationship agreement as closed and nearly all used condoms as a risk reduction strategy. For some, condom use depended on the role they took on during a sexual encounter. As one man explained, ‘He doesn’t like to use them (condoms) if he fucks me... but I’m already HIV-positive, and I don’t think that one can become positive from having that kind of sex with someone who’s undetectable.’ (Frank, 57, 57, HIV-pos; [Partner: Peter, 32, Black, HIV-neg]). For this couple, when the negative partner was the top, they felt safe having unprotected sex. Another discordant couple that reported regular, unprotected sex, monitored the positive partner’s viral load and CD4 count, and refrained from sex when they perceived the greatest risk of transmission. As the older positive partner explained, ‘...I had a change in my numbers, my viral load started coming up, my T cells started going down. So we didn’t have sex for like two months, nothing, no blowjobs, no nothing.’ (Dan, 36, White, HIV-pos; [Partner: Devin, 22, White, HIV-neg]).

Discussion

This study examined sexual behaviour and HIV risk among a sample of Black, White and interracial same-sex male couples with an age difference of 10 or more years. Findings make an important contribution to the literature examining risk in age-discrepant partnerships. Because most data on risk among men with older sex partners have not focused on primary partners or couples, our data are unique in that we interviewed both partners in primary same-sex male relationships. The sexual behaviour described by same-sex male couples, in our particular sample, with age differences ranging from 10 – 30 years suggests that, as Flowers et al. (1997) noted, sexual behaviour in a romantic relationship is likely different from that in a ‘casual’ sex partnership. It appears that a ‘romantic rationality’ may have led age-discrepant couples in this sub-sample to engage in intentional risk reduction strategies

and lower risk sexual behaviours, compared to previous samples of men with non-primary partners.

For example, HIV-discordant couples employed strategies such as seropositioning, condom use, and abstinence from anal sex within the relationship to reduce or eliminate the risk of HIV transmission. These risk reduction strategies were largely driven by the older, HIV-positive partners in an effort to protect their younger partners. Examining the various characteristics and dynamics of sexual and romantic relationships is worthwhile in an effort to understand the circumstances under which HIV continues to be transmitted in some communities of men. Here, we highlight the multiple rationalities that may exist in primary same-sex relationships. Perhaps most importantly, these rationalities reflect a commitment to partners and relationships that stand in sharp contrast to the detachment in non-primary sex partnerships described by Flowers et al. (1997).

Findings that sex with older partners is associated with increased risk for young men are useful in addressing the continued spread of HIV among some populations of men who have sex with men. Similarly, our findings suggests that primary relationships have strengths that may mitigate this increased risk, and provide opportunities for interventions that strengthen relationship communication and decision making. Previous studies have found that men with older partners have an overall higher risk for HIV infection (Berry, Raymond, and McFarland 2007, Bingham et al. 2003, Blower, Service, and Osmond 1997, Coburn and Blower 2010, Hurt et al. 2010, Morris, Zavisca, and Dean 1995, Mustanski, Newcomb, and Clerkin 2011, Service and Blower 1995). The literature suggests that this may be due, at least in part, to the increased likelihood of receptive unprotected anal intercourse for younger partners and a lack of decision making power. However, the findings in these studies do not take into account the ways in which the dynamics of a primary relationship differ from those of a non-primary partnership. Thus, those attempting to develop new HIV prevention strategies targeting men with older partners are left without important information that can inform their efforts. The narratives of both HIV-negative and -discordant couples in our sample described intentional engagement in risk reduction strategies ranging from monogamy and condom use to seropositioning. While these couples may not significantly differ from non age-discrepant couples, they may, in fact, differ from age-discrepant non-primary sexual relationships. Indeed, the narratives of the couples in our study stood in contrast to the findings of quantitative studies focused on men with older non-primary partners. In most cases, younger partners were the insertive anal sex partner. This finding is particularly striking in the context of previous data that indicates higher rates of receptive anal sex among men with older partners (Joseph et al. 2011), and the findings of Prestage et al. (2013) that positioning may be the mechanism through which risk is increased. Among HIV-discordant couples where the older partner was HIV-negative, partners described themselves as versatile and regularly switched roles. However, among HIV-discordant couples where the younger partner was HIV-negative, he was more often the insertive partner. Previously published data from the larger study describe condom use and negotiation among couples in our sample (Campbell et al. 2013). Couples with large age-discrepancies did not differ from the larger sample in condom decision-making processes. As a result of the strategies these participants described, HIV risk appeared to be relatively low, particularly for the younger partners, among this sub-sample of age-discrepant couples.

Older men who had witnessed more of the HIV epidemic saw themselves as well positioned to share their experience and knowledge of how to protect themselves and/or their partners from HIV infection. This was evident in the nature of older partners encouraging condom use and in using their knowledge of seropositioning during anal sex to reduce the risk of transmission to their partners. These findings are particularly important to highlight as the mentorship described by our couples suggests that age discrepant relationships may have positive benefits despite the often-reported risks associated with age discrepant sexual partnerships.

It is worth noting that in six of the seven interracial couples with large age differences, the White partner was older, and in each of the four interracial, HIV-discordant couples, the White partner was HIV-positive and the Black partner was HIV-negative. Given the heightened risk for Black men with older sex partners (Berry, Raymond, and McFarland 2007, Bingham et al. 2003, Joseph et al. 2011), this may be an important dynamic to investigate further. Future analyses that examine the race and serostatus makeup of age-discrepant partnerships are warranted in order to explore how age, race, serostatus, power and interpersonal dynamics impact HIV risk.

Our findings are based on the narratives of both partners in same-sex male relationships, not just one partner or single men who have sex with men. This strengthens our study, as each partner's perspective is represented in our analysis. While other studies have examined HIV risk for men who have sex with men with older sexual partners, our study is unique as it is the first to qualitatively explore the sexual relationships and HIV risk reduction strategies of age discrepant primary, same-sex male relationships.

There are a number of limitations to this study. This purposive sample was recruited in two large metropolitan areas in the USA. Consequently, the narratives of these couples are likely shaped, in part, by the politics and culture of these progressive cities with populations of men who have sex with men that are relatively well educated on HIV and risk reduction. Additional studies are needed to explore the experiences of age-discrepant same-sex male couples in other regions of the USA and around the world. Additionally, there was no HIV testing carried out in this study and thus HIV status was self-reported. Lastly, we only enrolled couples if both partners were aware of their own and their partner's HIV status. This may bias our sample in the direction of more egalitarian couple dynamics and/or sexual decision-making and fails to capture the HIV risk that occurs when one partner is unaware of his status and may have an undiagnosed infection.

Overall, it is clear that age differences operate in complex ways within primary same-sex male relationships. Our findings raise important questions about the nature of age-discrepant primary same-sex male relationships. While studies revealing greater risk for younger gay men with older non-primary sex partners provide important information for addressing the epidemic, it is equally important to fully explore and understand the nuances of primary same-sex male relationships. While we would not suggest intervening on organically-formed, age-discrepant relationships, the factors influencing relationship agreement negotiation and communication between men in primary relationships with older or younger partners may differ from those in non-age discrepant relationships. Future quantitative

studies examining the overall dynamics of age-discrepant primary same-sex male partnerships should be conducted in order to examine the extent to which age difference-related risk differs between primary and non-primary partnerships. Doing so will provide important and useful information in our continued effort to understand and intervene on the HIV epidemic among men.

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Table 1

Couple Characteristics

		White		Black		Interracial		Total (N=14)
		Neg (n=1)	Discord (n=3)	Neg (n=1)	Discord (n=2)	Neg (n=3)	Discord (n=4)	
Age Difference	Mean (Yrs)	11	12.67	10	19.5	18	16	15.42
	Median (Yrs)	11	13	10	19.5	13	14.5	12.5
	Range (Yrs)	11	11–14	10	12–27	11–30	10–25	10–30
Length of Relationship	Mean (Yrs)	3	6.83	.58	1	2.5	9.75	5.18
	Median (Yrs)	3	10	.58	1	2.5	10	2.75
	Range (Yrs)	3	.5 – 10	.58	1	2–3	1 – 18	.5 – 18

Table 2

Participant Characteristics

		White (N=15)	Black (N=13)	Total (N=28)
Participant Age	Mean (Years)	46.53	37.77	42.46
	Median (Years)	48	32	42.5
	Range (Years)	22–64	19–66	19–66
		% (n)	% (n)	% (n)
HIV Status	Positive	47 (7)	15 (2)	32 (9)
	Negative	53 (8)	85 (11)	68 (19)
		% (n)	% (n)	% (n)
Income	Less than \$10k	26.67 (4)	46.15 (6)	35.71 (10)
	\$10000–\$29999	26.66 (4)	23.07 (3)	25 (7)
	\$30000–\$59999	26.67 (4)	7.69 (1)	17.86 (5)
	\$60000–\$99999	13.33 (2)	15.38 (1)	14.28 (4)
	\$100K or more	6.67 (1)	7.69 (1)	7.14 (2)
		% (n)	% (n)	% (n)
Education	Less than High School	-	23.08 (3)	10.71 (3)
	High School or GED	6.67 (1)	30.77 (4)	17.86 (5)
	Some College	20 (3)	15.38 (2)	17.86 (5)
	Bachelors or AA	33.33 (5)	23.08 (3)	28.57 (8)
	Masters or Higher	40 (6)	7.69 (1)	25 (7)