Published in final edited form as:

AIDS Behav. 2020 November ; 24(11): 3044–3055. doi:10.1007/s10461-020-02852-y.

Perceived HIV risk among Black MSM who maintain HIV-negativity in New York City

Jagadisa-devasri Dacus, Theo G. M. Sandfort

HIV Center for Clinical and Behavioral Studies, Columbia University and New York State Psychiatric Institute, New York, NY

Abstract

Black men who have sex with men (MSM) are disproportionately burdened by the HIV epidemic. Although there has been an increased focus on reducing HIV prevalence in Black MSM, little attention has been given to how and why Black MSM are able to remain HIV-negative, beyond believing that they are lucky. The purpose of this qualitative study was to explore how Black MSM try to stay HIV-negative. Guided by constructivist grounded theory and a strengths-based approach, we conducted in-depth interviews to explicate how Black MSM demonstrate resilience by staying seronegative amidst high seroprevalence. Results from this study suggest that it is their perceptions of HIV risk that translate into protective strategies that enable them to prevent infection. Our study offers insight into their reasoning processes that guide their efforts to stay HIV-negative.

RESUMEN

Los hombres Afro-Americanos que tienen sexo con hombres (HAASH) son desproporcionadamente afectados por la epidemia del VIH. Aunque ha habido un mayor enfoque en la reducción del VIH en HAASH, no se ha prestado tanta atención a los que son VIH negativos. Muchos HAASH son seronegativos y es importante identificar como siguen siéndolos a pesar de que HAASH crean que es por suerte. El propósito de este estudio cualitativo fue explorar como HAASH tratan de mantenerse VIH negativos. Guiados por “constructivist grounded theory” y un enfoque en las fortalezas, llevamos a cabo entrevistas individuales para explicar como pueden mantenerse seronegativos a pesar de una alta seroprevalencia. Los resultados de este estudio sugieren que sus percepciones del riesgo son los que se convierten en estrategias de protección que les permite prevenir la infección. Nuestro estudio ofrece información sobre sus procesos de razonamiento que guían sus esfuerzos para mantenerse VIH negativos.

Corresponding Author: Jagadisa-devasri Dacus, PhD, LMSW, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 15, New York, NY 10032, Phone: 646-774-6970, Fax: 212-543-6003, jd3558@cumc.columbia.edu.

Conflict of Interest

The authors declare that they have no conflict of interest.

Ethical Approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee (CUNY Institutional Review Board, CUNY IRB #582023–1) and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards

Informed Consent

Informed consent was obtained from all individual participants in the study.

Keywords

Black MSM; HIV-negative; perceptions of risk; strengths-based; qualitative

INTRODUCTION

HIV surveillance data continue to indicate that Black gay, bisexual, same gender loving, and other men who have sex with men (MSM) carry the greatest HIV burden in the US (1). When Black MSM are examined by age groups, the epidemic is most burdensome among those aged 13-29 (2-4). The primary mode of HIV transmission for Black MSM continues to be condomless anal sex (CAS) (1,2). Even though HIV seroprevalence is high in Black MSM, research has shown that Black MSM engage in less high risky sex-related behaviors than their non-Black MSM counterparts (5-7). For instance, they are more likely to report less CAS, test regularly for HIV, and have fewer lifetime male sex partners (6,8-10). This HIV paradox in Black MSM has been described as “less risk, more effect” (6). Because the reasons for this paradox remain unclear, in addition to focusing on their sexual behaviors, researchers have also explored how the composition of Black MSM’s social and sexual networks, as well as their intraracial partnering commonly referred to as homophily, may have contributed to their greater seroprevalence (10-15). Studies have suggested that HIV-negative Black MSM with Black MSM partners were less likely to serosort (purposely select HIV-negative partners) and have CAS, but were more likely to seroconvert compared to other MSM (10,13).

Prevention research in Black MSM has taken some innovative and effective approaches, such as by examining syndemics. In the context of HIV infection, the Centers for Disease Control and Prevention (CDC) (16) describes how syndemics occur when multiple epidemics interact synergistically and contribute to an excess burden of HIV infection within a specific population. By taking a syndemic approach to HIV prevention, researchers have examined how the combination of biological, social, and cultural factors have contributed to greater seroprevalence in sexual minority men (17-19). Conditions such as depression, drug abuse, and violence victimization have been studied to understand their contribution to the HIV burden among sexual minority men (20). Therefore it is common for HIV prevention research to explore syndemic phenomena in Black MSM populations as a means of understanding drivers of the epidemic (20-22).

Findings from syndemic-focused studies have guided necessary intervention development for this population (10,15). Known as evidence-based interventions (EBIs), based on empirical evidence and evaluated rigorously, they have demonstrated efficacy among populations at high-risk for HIV (23). However, there are only two EBIs developed specifically for Black MSM, which limits the number of options available for implementation. More important, there is a need for EBIs that are designed based on a strengths-based approach to prevention by reinforcing how and why Black MSM are able to prevent HIV-infection, therefore demonstrating resilience. Our research offers a necessary critique related to the dearth of public health initiatives that take strengths-based approaches to HIV prevention through the lens of seronegative Black MSM.

Research is warranted to expand the limited knowledge and understanding of how HIV-negative Black MSM prevent HIV infection. In this paper, we offer an alternative approach to prevention research with this population. In this constructivist grounded theory study (24), we inductively sought to understand maintained HIV-negativity with knowledge of seronegative Black MSM's experiences. Constructivist grounded theory enabled us to qualitatively explore how Black MSM try to stay seronegative in order to generate a data-driven theory. Also, we took a strengths-based and intersectional approach to explicating how Black MSM in NYC have been able to remain HIV-negative. Our method of inquiry was framed by gay resilience theory (25,26). Gay resilience theory broadly contends that gay and bisexual men have uniquely evolved personal attributes related to resiliency that protect them from contracting HIV and questions the efficacy of current public health HIV prevention interventions that operate from a deficit-based approach. A limitation of this approach is that it does not offer specifics about resilience factors in Black MSM, whose experiences of intersectional marginalization and discrimination contribute to their HIV disparity. By exploring sensitizing concepts from gay resilience theory using constructivist grounded theory, we illuminated those strengths and resiliencies specific to Black MSM. Further, with our approach, we offer empirical knowledge that focuses on assets, which are not as frequently highlighted in HIV-negative Black MSM.

Although the reasons for higher HIV rates in Black MSM remain unclear, it is equally important to understand the reasons why many of them do not contract HIV despite predictive modeling that suggests that if current trends continue, most will contract HIV (2,27). Some Black MSM believe that they are "just lucky," as found in a previous study of Black MSM who stay seronegative (28). Their ability to stay HIV-negative goes beyond being lucky. Black MSM are very literate about HIV prevention and make efforts to remain seronegative. What we present in the current study stems from a larger study that more broadly explored the strengths and resiliencies in a cohort of Black MSM in NYC who maintain an HIV-negative serostatus. In this larger study, we examined critical concepts with the participants pertaining to social determinants of health, as well as syndemics, and we identified several major themes. The focus of this paper is on one of those major themes: It offers insight into how perceptions of HIV risk in this cohort of HIV-negative Black MSM translate into protective strategies that enable them to stay HIV-negative. By understanding Black MSM's perceptions of risk and how these perceptions inform their sexual practices, we can develop new and/or innovative interventions to help prevent their predicted 50% lifetime chance of seroconverting (2,27).

METHODS

Participants

We recruited 25 HIV-negative Black MSM in NYC from August 2014 to February 2015 for in-depth interviews. Gatekeepers and key informants from our professional network of local health, mental health, and social services providers referred potential participants to the study. The first author, a Black gay man and social worker by training, also directly recruited Black MSM at community events for Black gay men in Manhattan and Brooklyn, the two boroughs that have high HIV incidence in Black MSM (4). The first author also interviewed

the participants and conducted the focus groups given his prior experience providing services to and conducting research with Black MSM.

To participate in the study, participants had to (1) be at least 21 years old; (2) self-identify as Black; (3) live in one of the five NYC boroughs; (4) have been assigned male sex at birth; (5) report being sexually active with other men for a minimum of three years and with at least one man in the last three months; (6) provide an HIV-negative test result within the last six months; and (7) report no injection drug use within the last year. We excluded people who inject drugs from this study because their prevention and harm reduction strategies would have introduced confounding behaviors, as this study focused on sexual behaviors. The first author screened all participants by phone to determine eligibility and to begin building rapport. He provided the participants with reasons for why he was conducting the study and details such as his professional background and training. Recruitment procedures ended once we reached saturation in the narrative content, that was until no new properties in our codes emerged, and when the codes contained enough breadth and depth for understanding the phenomenon. Participants received \$50 in cash and a round-trip New York City Subway MetroCard for a completed interview. The CUNY Institutional Review Board (CUNY IRB #582023-1) approved all study procedures.

Data Collection

We collected narrative information through three subsequent in-depth semi-structured interviews with each participant. Participants completed a demographic questionnaire at the beginning of the initial interview. In the interviews we aimed to explore their maintained HIV-negativity in temporal, cultural, and structural contexts by following the constructivist grounded method (29). As prescribed by the method, each interview entailed a collaborative process of researcher-participant meaning making of the participants' narrations. The researcher-participant interaction "produces the data, and therefore the meanings that the researcher observes and defines" (30) and enhanced the rigor of our data collection process (24,31). As we gathered the participants' narratives, we accumulated an aggregate body of stories that corroborated one another, provided different dimensions for the same phenomenon, and helped establish themes and patterns to analyze.

At the first interview, we obtained written and verbal consent and for each subsequent interview, we obtained verbal assent. Each interview averaged two hours, was digitally recorded, and transcribed verbatim. Each first interview served to collect baseline narrative information from participants about their ability to remain HIV-negative. We speculated that after their initial interviews, participants would become more aware of their behaviors, conceptions, and processes. With a heightened awareness, they would be better able to articulate their understanding of *how* and *why* they have prevented contracting HIV. The collaborative process of researcher-participant meaning making would also facilitate a deeper understanding of their ability to do so. At the second interview, three to four weeks later, we followed up with them on content and emerging themes from their previous interviews, and as applicable, from those of other participants. The final interview occurred two to three weeks later and was designed to gather more in-depth narrative information related to what we understood, based on themes from among the participants' narratives.

Additionally, midway through the data collection process we collected narrative content from three member-checking focus groups on our preliminary findings. The focus groups' feedback was used primarily in the analysis (see Data Analysis below). We conducted three mixed-age focus groups with a total of 15 participants who were already enrolled in the study.

The initial version of the interview guide was piloted with a group of six HIV-negative Black MSM in NYC. The interview guide evolved during the study through an iterative process driven by the concurrent analysis (see Data Analysis below). The interview guide contained questions such as, "How do you think have you been able to remain negative?" and "Why do you think you're not positive?" We included some questions that asked how the participants thought they could be supported to stay seronegative, "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 or PrEP?" In order to understand how they made sense of their ability to prevent contracting HIV, the guides also included probes and follow-up questions to facilitate more in-depth discussions. We developed a separate interview guide for the focus groups. Since the focus groups were mainly for the purposes of member-checking, the interview guide included questions about the emergent themes and nascent theory. The feedback, as well as additional data, from the focus groups helped further our analysis and refinement of the emergent themes and informed our theory development.

Data Analysis

As prescribed by constructivist grounded theory, narrative analysis was concurrent with narrative collection (24). Our analysis was also guided by sensitizing concepts about race from critical race theory and intersectionality, and about sex, sexuality, and gender from queer and feminist theories. We also used sensitizing concepts from gay resilience theory. These concepts included resilience, social support, outness, and limit setting to reduce HIV risk. In the analysis, these concepts provided a foil for the indigenous concepts as possible themes about strengths and resilience in seronegative Black MSM.

After the first author verified the transcripts for accuracy against the audio files, we coded them using the NVIVO qualitative data analysis (QDA) and management software program (32,33). NVIVO allowed us to manage a progressive coding process that consisted of initial line-by-line open coding, followed by focused coding that ultimately lead to theoretical coding. To achieve intercoder agreement, we used NVIVO's intercoder reliability function. We coded selected sets of the same data and established an intercoder agreement rate of 92%. In NVIVO, we were able to compare and contrast all the individual interview transcripts to establish analytic distinctions. Using the constant comparison method, the process of comparing among and between the participants' narratives, we were able to make comparisons at each stage of our analytic process. We found similarities and differences among the narratives that supported the trustworthiness and credibility in the narrative content.

Additionally, we increased our confidence and trustworthiness in the narrative content by triangulating two forms of data in the analyses. We triangulated narrative content from the

individual interviews, and from member checking focus groups and our memos. We presented preliminary findings to three focus groups of participants so that they could provide feedback on the quality of our analysis and to validate/invalidate the emerging themes. At the focus groups, we also collected additional narrative information by recording our discussions about our preliminary findings with the participants. We analyzed these additional narratives and coded them using the constant comparison method. Lastly, we used memos to increase the abstraction level of our ideas and for examining our codes and coding processes, particularly in the early stages of the analytic process (34). Furthermore, memoing allowed us to be reflexive and to document our ideas, thoughts, and insights about the interviews and the emerging theories.

RESULTS

Sample

The 25 HIV-negative Black MSM participants in this study were aged 21-86 ($M = 37$, $SD = 15.3$). Seventeen of the men self-identified as gay, four as bisexual, two as same gender loving, one as down low, and one participant self-identified as pansexual. When asked about the race of their partners in general, participants said that they predominately had sex with Black cisgender male partners; a few participants reported having sex with Latinx cisgender male partners. Four participants reported a history of sexual experiences with cisgender women, transgender women, and/or transgender men. Yet, when specifically asked about the race and ethnicity of their last sex partner, every participant had been with another Black cisgender male partner before the initial interview. In terms of sexual positions, eight participants indicated being exclusive tops (insertive partners), five were versatile tops (insertive partners who will occasionally bottom), eight participants said they were versatile (insertive or receptive partners), two said they were versatile bottoms (receptive partners who will occasionally top), and two participants were exclusive bottoms (receptive partners). Participants reported a range of 1-23 sex partners in the last three months. Most participants ($n = 23$) reported having had eight or fewer partners in the last three months. There were two outliers who had a greater number of sex partners in the last three months (15 and 23). The participants categorized their last sex partners generally as “hookups (casual encounters),” boyfriends, or “friends with benefits.” When asked about condom use in their last sexual encounter, 17 men reported having used condoms and eight reported no condom use. Regarding HIV testing, 14 participants tested every three to six months, six tested every six months to a year, and five tested once a year or less. Concerning knowledge of their last sex partner’s HIV status, 14 reported that their partners were HIV-negative, four were HIV-positive, and seven were of unknown serostatus. The participants got information about their last sex partner’s serostatus by having “The Talk” about HIV status ($n = 10$), testing together ($n = 6$), and exchanging HIV test paperwork ($n = 2$). Others reported getting information because their last sex partner was a friend or acquaintance, or because they “trusted him.”

Perceived HIV Risk

Participants in this study knew a lot about HIV risk as well as the public health prescribed methods for preventing infection. The major theme that emerged from our analysis of the participants’ narratives was *perceived HIV risk*. This theme had several subthemes about the

participants' reasoning processes that motivated them to employ protective and risk reduction strategies for staying seronegative. In principle, the ways by which they perceived their risk were based on the belief that each sexual encounter had the potential to result in contracting HIV because of their intersecting identities as Black men and MSM. None of them believed that they were not at risk. The participant's perceptions were premised mainly on what they could learn about their partners' HIV status.

The participants' perceptions of HIV risk entailed an *if-then* process in which they reasoned about and subsequently assessed their risk. We identified this reasoning process as happening in three ways and describe each one as a subtheme with a label we used as an in vivo code in our analysis. One type of reasoning process was interpersonal. This way of reasoning was described by them as "wanting to know from the jump [beginning]," because it was about obtaining information about HIV their partners' status before the sexual encounter. As part of this process, participants were more likely to initiate "The Talk" about HIV status and testing as the most rational way of obtaining information from their partners. The information that they got from "The Talk" informed which risk reduction strategies they would use. The other two reasoning processes were more intrapersonal. We found that participants commonly referred to these processes as "topping theory" and "being loose." Topping theory was predicated on the understanding that being the insertive partner or "top" posed less HIV risk. Being loose, on the other hand, had dual meanings related to perceived or assumed promiscuity of potential sex partners. Most participants used the term mainly to describe potential partners they believed were promiscuous. While others used this term similarly, they also used it to describe partners with "loose" anal sphincter muscles they had digitally inspected. Participants reasoned if their partners' anal sphincters were loose, then they were promiscuous and posed an increased HIV risk. What follows is more detail about each reasoning process as subthemes of the major theme, *perceived HIV risk*.

Wanting to Know from the Jump

Many participants explained that in order to obtain information about their partners' HIV status, they were more likely to be the ones to initiate "The Talk" ...because I want to know from the jump [beginning]." Participants who initiated "The Talk" before having sex considered it to be a prevention strategy, which often included either asking to see their partners' most recent HIV test and sharing their own test results. For them, having "The Talk" was important because it was the most direct way to talk about HIV status. Participants would specifically ask about when their partners last tested and what their test results were. In the age of dating and hookup apps, most participants used "The Talk" as part of their practice for verifying if their partners' online information and details were consistent and accurate. Because their perceptions were based on the belief that each sexual encounter could result in HIV infection, they did their best to obtain accurate information about their partners' HIV status. Having "The Talk" about testing history and HIV status was the most common way they did this. Lorenzo (age 26) described:

I just tell him, like, you know, even though we just met, I don't know what you have. I didn't really say it like so, so upfront about it, but he understood what I was saying...I would say, I'm getting older and, I would say, it's not attracting –it's not attractive no more, it's my personal belief, not attractive no more to be, just, to be

getting slayed [fucked] all through New York City. It's not safe. It's not safe. I'm a bottom and I'm always at risk [for getting HIV].

Some participants would share and ask for their partners' recent HIV test documentation, which they referred to as "papers" or "paperwork." In some cases, this meant deliberately testing with partners before having sex. Using this strategy, they would definitively know from the jump as Billy (age 26) explained,

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.

Participants reasoned that if they could obtain as much credible information as possible at the beginning of a sexual relationship, they could assess their HIV risk and determine which prevention strategies they would negotiate and/or use with their partners. If they were not able to gain credible information from partners, some of the strategies they used included: (a) using condoms for penetration, (b) having condomless anal sex (CAS) without ejaculation, and (c) strategic positioning, the adoption of a sexual position that reduces the risk of HIV, where they were more likely to be the insertive partner or top.

By knowing from the jump, the participants were able to assuage their concerns about seroconverting. For most, their concerns about contracting HIV motivated them to focus on their sexual health. This is why they attempted to equip themselves with as much knowledge as possible and skills necessary to protect themselves. They gleaned information from public health HIV prevention research, messages, and programs and gained skills from exposure to interventions. Those who were exposed to interventions felt particularly equipped to protect themselves, especially if they had sex with HIV-positive partners, which was probable. Serosorting or exclusively choosing seronegative partners was not a frequently mentioned prevention strategy they used. Rather, several participants expressed how knowing from the start that a partner was HIV-positive was not a deal-breaker, rather it was more of a "relief" because, "if I know he positive, then I know what I need to do with a brotha who's poz to stay safe." Participants like Paul (age 21) shared:

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....at least I knew. I knew from the jump that he was positive and I was ok with it.... I knew he was safe because he took his meds and was undetectable.

Other participants shared similarly of wanting to know about their partner's HIV-positive status at the onset since: "...the fear of HIV is there and then it isn't...I just prefer to know upfront [about a partner's HIV status]." For the participants who bottomed or took the receptive role, if they knew from the beginning that their partners were HIV-positive, then they were likely to be assertive about protecting themselves: "I always watch to make sure—the top always uses condoms when I get fucked" (Theo, age 33).

When it came to dealing with partners of unknown serostatus, most participants voiced that (a) if their partners did not know their HIV status or (b) if they assumed they were HIV-negative or (c) if they could not provide proof of a recent HIV test, then sex with them posed a greater HIV risk. Under these circumstances, they asserted that these kinds of partners were more likely to “wanna fuck raw [have CAS],” to engage in CAS with multiple concurrent partners (“threesomes,” “foursomes,” or “orgies”), and to try to share bodily fluids (“he was trying to nut [ejaculate] in my mouth”). Participants reasoned that if they did choose to have sex with this kind of partner, then they needed to gather as much concrete information as possible to further assess their risk, in addition to being extra cautious and insistent about their condom use and limiting their exposure to bodily fluids.

Even for those two participants on PrEP, dealing with partners of unknown HIV status was perceived as risky, although they knew PrEP could prevent infection. For example, Hassan (age 54), an early PrEP adopter, recalled an experience with a “fuckbuddy” (casual sex partner) who had “always been shady [vague]” about his HIV testing history. Because he was not able to obtain specifics about when his casual partner’s status, but enjoyed having sex with him, Hassan made sure that they used condoms, except for the one time they had a threesome at a sex party. Even though Hassan consented to condomless sex with both men at the sex party, he was concerned about it and could only follow up later with his casual partner afterward. He stated,

Yeah, dude still couldn’t tell me when he last tested...or thought he had tested recently....I don’t really think that dude was at all concerned and that bothered me, so I had to bring it up because I don’t think dude would’ve [brought it up].

Hassan and the other participant on PrEP both felt discomfort with having ambiguous information about their partners’ HIV status, even though PrEP protected them. Their reasoning was that if they found themselves with partners of unknown status, then they committed to the strategy of having “The Talk” beforehand. Regardless of the outcome of “The Talk,” they would insist on condom use.

Topping Theory

How participants understood and interpreted the connection between their sexual position preferences (top, bottom, or versatile) and HIV risk was an important factor of their reasoning processes and risk reduction strategies. Distinctly, some participants proclaimed their sexual position as something that prevented them from acquiring HIV. We heard participants repeatedly make statements denoting what they coined as a “topping theory.” James (age 59), a self-described “total (exclusive) top,” described topping theory as the belief that “[if] by not getting penetrated at all, [then] it also prevented me from contracting HIV.” As a subtheme of perceived HIV risk, topping theory supported a reasoning process not only among participants who used condoms consistently, but also among those who used condoms intermittently or not at all. Regardless of their condom use, believers in topping theory spoke strongly about topping as an effective prevention strategy because they all continued to test HIV-negative. As Omari (age 48) proudly stated, “[if] every time I’ve taken these tests, they’ve come back negative...[then] so I do believe that I’m HIV-negative today,

after always being gay and having sex unsafely [condomless], but never [been penetrated] unsafely [condomless] anally.”

The participants’ topping theory was not entirely unfounded. Public health has given credence to the increased HIV risk for the receptive partner during CAS (35). Based on this public health information, believers in topping theory translated this as evidence of how, as Carl (age 27) asserted, “topping is not as risky as bottoming, and it’s been proven. That’s what the CDC says.” Therefore, based on this perception of risk, topping became an intentional risk reduction strategy as Alvin (age 33) shared, “If I top most of the time, then I’m at less risk for HIV. That’s why I don’t bottom like that.”

Topping theory was not limited solely to the participants who topped. Even participants that bottomed had their own version of topping theory. Theo (age 33), a self-identified “total (exclusive) bottom,” expressed his understanding of topping theory,

I feel that [if] the person who’s supposedly the top partner is [then] more—more likely to be negative. I mean I—I—I definitely see results [HIV test results], I don’t go into it just like assuming it, but 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 [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, 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, like other participants who bottomed exclusively, went on to state that he would deliberately only bottom for men he believed were total tops. However, because if he could only take “their [tops’] words at face value” then he would make sure that his partners wore condoms while penetrating him.

Furthermore, topping theory resonated the strongest as a reasoning process among participants aged 50 and older. Many of them had been having sex with other men during the early days of the epidemic. Some participants opined, “That it seemed like everybody who was getting sick were the ones who were bottoms...[men who] were letting somebody fuck them [condomless] and ejaculate in them” (Michael, age 50). Particularly among the older participants who topped, there was a “school of thought that, if all the bottoms were just bottoms and all the tops were just tops, then it would be harder to pass HIV” (James, age 59). James’s statement summarized a common perception among his age peers about maintaining exclusive sexual positions as either tops or bottoms, with topping being the most purposeful way to not contract HIV. However, this perception of risk was not exclusive to only the older participants in the study. Even the younger participants corroborated the existence of topping theory as a reasoning process. One of the younger men, Gary (age 28), said,

I think that’s why. If I think about it it’s because I’m a top....[then] 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 [exclusive] top since all those years, and

which I also learned that that can also reduce your chance of being infected with HIV.

Participants also explained how topping theory implied a responsibility based on sexual position. Many participants who topped felt “very responsible” for not only their own sexual well-being but for that of their partners as well. James (age 59) stated matter-of-factly that the onus was on him to be the sexually responsible partner as the top: “If I don’t bring up condoms, I don’t think these boys will either. Again, if I don’t do it, then they sure ain’t gonna do it. And if I don’t do it, then I’m putting myself at risk.” Participants that exclusively topped expressed similar sentiments about feeling this kind of responsibility the most. Some of the participants said that when necessary, as a prevention strategy, they played being “the aggressive top.” If they found themselves with a partner who did not want them to wear a condom, then the participants presented as “the top that takes charge.” They said that when this happened, rarely were their partners resistant to them using condoms for anal sex.

Being Loose

The third subtheme of perceived HIV risk pertained to participants’ beliefs about their partners “being loose.” For most participants in this study, “being loose” was a phrase with dual meanings. The first meaning of being loose implied that potential sex partners were promiscuous. The majority of the participants used the popular expression “thirsty” to describe men they thought were promiscuous. Others furthered this description by characterizing thirsty, aggressive men as “loose and thirsty.” The second meaning of “being loose” concerned to the actual tightness, or lack thereof, of a receptive partner’s anal sphincters or “walls.” Participants like Gary (age 28) shared with us how “I be checking them walls [his partner’s anal sphincters] to see how tight they are.” This act of checking they used as an assessment strategy. Participants believed that if their partners’ anal sphincters were loose, then they were promiscuous, and consequently posed a greater HIV risk.

Being thirsty—“Being thirsty” was synonymous with “being loose.” Participants said being thirsty applied to “lots of those” gay men they saw regularly at social gatherings and in bars and clubs. Participants described thirsty men as those men who aggressively tried to hookup and have sex with them. According to Royce (age 32), “[T]hirsty is thirsty, whether you be a top or a bottom or vers [versatile],” but Quincy (age 23) argued that “thirsty [desperate, needy, horny] men” were more likely to be gay men who bottomed and actively “looked for tops to hook up with.” Participants talked more about “loose, thirsty bottoms” and HIV risk: “Because, if they’re always thirsty, they must have a lot of random [casual] anal sex and probably raw [condomless]” (Quincy, age 23). Independent of whether the participants preferred to top or bottom with partners, believing that someone was thirsty was a turnoff and typically did not result in any type of sexual engagement. However, some participants did say that they had made some exceptions and hooked up with thirsty partners. For the participants who topped, when they did engage sexually, they reported they were unlikely to have penetrative sex. If they did have penetrative sex, then they would commit to using condom to avoid “getting something, especially HIV because he’s probably been

around” (Alvin, age 33). Similarly, if participants who bottomed chose to be with thirsty partners, then they tended to have a non-negotiable condom use practice.

Several participants said that they did their best to avoid loose or thirsty men entirely, especially when they were being aggressively pursued. These participants tended to be those who recognized their heightened vulnerability to HIV because of their syndemic factors in their lives. Participants such as Yusef (age 45) were aware how his history of homelessness and current drug addiction heightened his HIV risk. Participants like Yusef reported being reluctant to have sex with men who were aggressive because they automatically assumed them to pose an HIV risk. These participants often had limited access to condoms and often lacked the ability to negotiate less risky sexual activities with their partners. Therefore, if they believed that someone thirsty wanted to approach them, then their main strategy was to trying to avoid them if possible because: “[Y]ou 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” (Yusef, age 45).

For those participants not contending with syndemic factors in their lives, their avoidance of thirsty partners was also risk reduction strategy. A few participants had developed their own practices for assessing and vetting partners for determining if they were thirsty, particularly for partners they met on dating and hookup apps. The initial assessment step typically began with “The Talk.” If their partners were reluctant to discuss their HIV status and when they last tested, then they would assume them to be thirsty and would frequently jettison them. Paul (age 21) explained why he was committed to his vetting practice:

Yeah. Oh yeah, I don’t, I don’t, I don’t—no, I ask questions. I ask *the question* [about HIV, emphasized]. 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].

Some participants described their strategy for vetting loose partners that went beyond simply having “The Talk.” Because “thirsty dudes have no chill [patience],” according to Omari (age 48), his practice for vetting thirsty partners was to see “if we can chill, hang out, smoke some weed, and have some beers.” Participants such as Omari reasoned that if their partners were not willing to “just chill...[then] they are busy chasing the nut [ejaculate]” and were thirsty. If participants were able to establish a more intimate and relaxed connection with a partner, then they felt more confident in their ability to negotiate risk reduction practices while still being able to “get freaky [sexual].”

Checking the goods—The second meaning of “loose” was ubiquitous among the participants. This reasoning process was literally based on how participants would “check the goods” or “walls” or their partners’ anal sphincters by digitally inspecting them for tightness. Participants who did this believed that if their partners’ anal sphincters were “loose,” then “the bottom was having a lot of sex.” Earl (age 50) furthered this line of thinking by adding, “If bottoms are loose like that from having a lot of sex, then they have a higher chance of being positive and putting me at risk and stuff.” In contrast Gary (age 28) stated, “So if they aren’t loose, haven’t had as many sexual partners...[then] that means that

they have not been exposed as much [HIV] and I won't be exposed." For some participants, this reasoning process was so powerful that if they encountered a "loose booty," it was "a turn off...and I will go soft and can't fuck him" (Xavier, age 32). Participants who bottomed shared their thoughts and experiences with "having my walls checked" because they understood the implications of being deemed as someone who was considered to be "loose." For instance, Royce (age 32), who bottomed more often than not, recognized how and why his partners preferred his tight anal sphincters or "walls":

So because I'm a little bit kind of hard to get into [be penetrated]...they have to take their time because I'm tight...this way they know I don't really do that much, you know, get around [have a lot of sex]. My walls aren't loose because I'm not out there like that, getting slayed [fucked] all up and down NYC. I'm very safe and want to stay that way.

The act of checking the goods had significant meaning for both participants who topped as well as those who bottomed. Participants who topped associated partners with "loose" anal sphincters as posing more HIV risk. None of the participants who bottomed suggested that they had loose "walls." Rather, they were apt to stress how "my walls are tight," "firm baby," and "solid" as a means to counter assumptions about them being promiscuous and risky partners.

DISCUSSION

In our study of how Black MSM in NYC try to stay HIV-negative, we identified several ways that they understood and perceived their HIV risk. *Perceived HIV risk* emerged as a theme that described how the participants formed ideas and held beliefs ("if...") based on conceptual elements and possible consequences that made sense to them ("then..."). Because of their intersecting identities as Black men and MSM, they had a heightened awareness of risk. As a result of their awareness, the participants developed a reasoning process that informed their risk reduction strategies for preventing HIV infection. By interrogating this theme, we identified two types of reasoning processes they used to evaluate their HIV risk: interpersonal and intrapersonal. Their perceptions of risk existed within the context of the HIV environmental "riskycape," the environment in which there exists both protective and risk factors associated with HIV acquisition (36,37).

Since participants were very knowledgeable about the high HIV rate in NYC's Black MSM population, they preferred "knowing from the jump [the beginning]" about their partners' serostatus. Since they were likely to pursue, attract, and preferred other Black male partners, they normalized the likelihood of meeting Black men living with HIV. The participants were open and crossing the sero-divide" (38) and not exclude potential partners on the basis of their HIV-positive serostatus. Hence, serosorting was not one of their expected protective strategies. On the contrary, they expressed "relief" knowing from the get-go that their partners were seropositive, because then there would be no guesswork about what precautions they needed to take to protect themselves. This is why "The Talk" was important to them. Having "The Talk" with their partners was intended to initiate discussion about HIV testing and serostatus. Information they were able to get from "The Talk" was used to evaluate their understood risk and to make choices to reduce their risk based on that

information. The participants recognized the limitations of “The Talk.” Their partners could believe that they were HIV-negative, lie about their status, or simply not know their HIV status. The participants made calculated sexual decisions and choices based on the information they could get and/or on thought was true about their partners’ HIV status. To resolve any ambiguity about HIV status, it was common for the participants to take HIV tests with new partners before having sex with them.

Most participants asserted that their sexual position roles facilitated their ability to stay HIV-negative, particularly if they preferred to top. They described this specific type of reasoning as “topping theory.” Those who topped asserted that if they were not being anally penetrated, then they were reducing their risk. Their assertion was grounded in some truth because HIV risk is lower for the insertive partner (35). Those participants who topped, and either used condoms inconsistently or not at all, believed that topping had prevented them from contracting HIV. For most, topping was an intentional prevention strategy. Even participants that bottomed corroborated the existence of topping theory. They reasoned if they had sex with men who exclusively topped, then they were at less risk for being infected. Their line of reasoning aligned itself with that of those participants who exclusively topped.

Another aspect of topping theory concerned how the participants’ sexual position preferences factored into their risk reduction strategies. Many participants who topped believed the onus was on them to be sexually responsible by protecting both themselves and their partners. They associated this kind of sexual responsibility with heteronormative sex roles and ideals of masculinity in which the insertive partner had to be the responsible one. The participants’ articulations of topping theory align 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 (39-41). For some participants their intentionality about topping to reduce their HIV risk was likely compensatory. They topped as a means to decrease their HIV risk based on their increased perception of how they were at risk. It is important to note that the participants’ topping theory was not infallible; insertive partners have contracted HIV. None of the participants believed that they had no risk, though. Topping theory functioned as a way for participants to theoretically mitigate their anxiety about how each sexual encounter implied an HIV risk.

Lastly, participants did their best to avoid men they thought were “being loose.” “Being loose” was a phrase that had dual meanings related to presumed promiscuity of potential partners. Unfortunately, the participants use of this phrase and its synonym “being thirsty” reinforced negative sexual stereotypes that research has frequently ascribed to Black men and Black MSM by problematizing their sexualities (42-44). “Being loose” also implied some “bottom shaming” as it was more commonly used to describe thirsty, aggressive men who sought partners that topped. In addition, being loose was used to describe perceived or assumed promiscuity related to the tightness, or lack thereof, of their receptive partners’ anal sphincters. According to the participants who topped, if they were able to penetrate their partners’ anuses with multiple fingers easily, then they concluded that their partners were having a lot of sex, with multiple men. Following their reasoning, men who had a lot of sex partners posed more 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 participants, they were “checking the goods,” which has been a recommended risk reduction strategy that emphasizes the importance of a visual inspection of partners’ genitals and anus for signs of possible STIs.

Limitations

A limitation of this study is that the findings emerged from narratives collected from participants in the country’s most populous metropolitan city with one of the most diverse Black MSM populations in the US. 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 the Black MSM is population not monolithic. Black MSM elsewhere may employ different risk reduction strategies as compared to their NYC counterparts. These differences 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 policies, programs, interventions, and resources. NYC’s has one of the foremost health departments in the nation with a nationally recognized and well-resourced Bureau of HIV/AIDS. NYC’s health department has a wide scope of reach via its community partnerships with CBOs and nonprofits that provide healthcare and social services to Black MSM. Consequently, exposure to public health HIV prevention initiatives for Black MSM in other cities may have a different impact on those populations. Moreover, we collected these data from 2014 to 2015, at a time when the HIV prevention landscape was different from how it is today. Since that time, there has been an increase in the availability and utilization of PrEP in Black MSM, federal acknowledgement that viral suppression prevents HIV transmission (i.e., undetectable means untransmittable, “U = U”), and adoption of an HIV status neutral approach to HIV prevention, treatment, and care. Although salient, the findings from the current study do not reflect the advent of many of these prevention advances.

Future Studies

We still know very little about how Black MSM manage to stay HIV-negative. More qualitative research is needed to deepen our knowledge about their perceptions of risk and what they do to protect themselves from acquiring HIV. With a better understanding of their perceptions of risk we can develop public health strategies that facilitate an increase in their knowledge of and interest in adopting PrEP as an additional prevention strategy. More strengths-based qualitative and/or mixed-methods studies that use an intersectional frame are needed to inform intervention development to support maintained seronegativity in Black MSM, particularly those that address the social, structural, and institutional level factors that impact their risk. Another avenue for future research is to conduct similar research in other metropolitan cities that have high seroprevalence in Black MSM, such as those in the Southern U.S. For our prevention efforts to be optimal, we need to advance our understanding of the heterogeneity in Black MSM and how it influences their perceptions of risk and protective behaviors and strategies.

CONCLUSIONS

In this paper, we discussed the ways in which HIV-negative Black MSM in NYC perceived their HIV risk and how their perceptions translated into protective behaviors and strategies. Their perceptions of risk included several *if-then* processes that were interpersonal and intrapersonal. Having “The Talk” about HIV status and testing history with their partners, was a strategy Black MSM employed because of their awareness that their sexual encounters carried the risk of contracting HIV. This discussion often resulted in them sharing HIV test documentation, and in some cases, testing together before having sex for the first time. “Knowing from the jump (beginning)” was important to the participants because then they could determine which preventative strategies to employ based on their partners’ serostatus. Regardless of their sexual position preference, they also maintained a “topping theory” about how the insertive partner or top was at less risk for infection. Also, most participants held beliefs about potential partners they assumed were promiscuous. Described as “being loose,” the participants shared how they purposefully avoided men they saw as sexually aggressive or “thirsty.” They reasoned that thirsty men might expose them to HIV. If they did have sex with thirsty men, they made sure to protect themselves by employing a variety of risk reduction strategies such as using condoms, strategic positioning, and not exchanging bodily fluids. Additionally, participants who topped their partners indicated how they would digitally check their partners’ anal sphincters to see if there were loose. If their partners’ anal sphincters were loose, then they interpreted it to mean that their partners were promiscuous and might expose them to HIV. How Black MSM who stay HIV-negative perceive their HIV risk is important for public health prevention efforts. With a better understanding of their perceptions of risk, our efforts can focus on how to reinforce the strengths and resilience in Black MSM so that they remain seronegative.

Acknowledgments

FUNDING

This research was supported by the National Institute of Mental Health of the National Institutes of Health under Award Number, R36 MH106357 (Principal Investigator, Jagadisa-devasri Dacus, Ph.D.) and by Award Number T32 MH019139 (Principal Investigator, Theodorus Sandfort, Ph.D.) from the National Institute of Mental Health. Dr. Sandfort’s contribution to this paper was supported by an NIMH center grant (P30-MH43520; Principal Investigator, Robert Remien, Ph.D.) The content is solely the responsibility of the authors and does not necessarily represent the official views of National Institute of Mental Health or the National Institutes of Health.

REFERENCES

1. Centers for Disease Control and Prevention. HIV among gay and bisexual men [Internet]. 2017 Available from: <https://www.cdc.gov/hiv/group/msm/index.html>
2. Centers for Disease Control and Prevention. CDC Fact Sheet: HIV among African Americans [Internet]. 2017 (Morbidity and Mortality Weekly Report). Available from: <https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-hiv-aa-508.pdf>
3. National Alliance of State and Territorial AIDS Directors. HIV/AIDS: Crisis among young Black and Latino gay men and other men who have sex with men (MSM) [Internet]. 2009 p. 1–12. (Youth Issue Brief). Report No.: 2. Available from: http://www.nastad.org/Docs/highlight/2009130_Youth%20Issue%20Brief%20No%201.pdf
4. New York City Department of Health and Mental Hygiene. HIV surveillance annual report, 2015. [Internet]. 2017 Available from: <http://www1.nyc.gov/assets/doh/downloads/pdf/dires/hiv-surveillance-annualreport-2015.pdf>

5. Millett G “Stuck”: Contextualizing the US HIV epidemic among Black MSM [Internet]. Webinar [PowerPoint slides] presented at; 2015 4 13 Available from: <https://www.hanc.info/cp/resources/Pages/Legacy-Project-Webinars.aspx>
6. Millett GA, Peterson JL, Flores SA, Hart TA, Jeffries WL, Wilson PA, et al. Comparisons of disparities and risks of HIV infection in Black and other men who have sex with men in Canada, UK, and USA: A meta-analysis. *The Lancet*. 2012;380(9839):341–8.
7. Millett GA, Peterson JL, Wolitski RJ, Stall R. Greater risk for HIV infection of Black men who have sex with men: A critical literature review. *Am J Public Health*. 2006;96(6):1007–19. [PubMed: 16670223]
8. Eaton LA, Kalichman SC, Cherry C. Sexual partner selection and HIV risk reduction among Black and White men who have sex with men. *Am J Public Health*. 2010;100(3):503–9. [PubMed: 20075328]
9. Hussen SA, Stephenson R, del Rio C, Wilton L, Wallace J, Wheeler D. HIV testing patterns among Black men who have sex with men: A qualitative typology. Kumar A, for the HPTN 061 Protocol Team, editors. *PLoS ONE* [Internet]. 2013 9 19 [cited 2015 Mar 23];8(9):e75382 Available from: <http://dx.plos.org/10.1371/journal.pone.0075382>
10. Millett GA, Flores SA, Peterson JL, Bakeman R. Explaining disparities in HIV infection among Black and White men who have sex with men: A meta-analysis of HIV risk behaviors. *AIDS*. 2007;21(15):2083–91. [PubMed: 17885299]
11. Bohl D, Raymond H, Arnold M, McFarland W. Concurrent sexual partnerships and racial disparities in HIV infection among men who have sex with men. *Sex Transm Infect*. 2009;85(5):367–9. [PubMed: 19773457]
12. Millett GA, Peterson JL. The known hidden epidemic: HIV/AIDS among Black men who have sex with men in the United States. *Am J Prev Med*. 2007;32(4):31–3.
13. Ellis K HIV more prevalent among Black MSM despite fewer risk behaviors. *Helio Infect Dis News* [Internet]. 2008 1 [cited 2015 Apr 12]; Available from: <http://www.healio.com/infectious-disease/hiv-aids/news/print/infectious-disease-news/%7Bd8aa870f-9596-4574-9342-beadfb911b21%7D/hiv-more-prevalent-among-black-msm-despite-fewer-risk-behaviors>
14. Mimiaga MJ, Reisner SL, Cranston K, Isenberg D, Bright D, Daffin G, et al. Sexual mixing patterns and partner characteristics of Black MSM in Massachusetts at increased risk for HIV infection and transmission. *J Urban Health*. 2009;86(4):602–23. [PubMed: 19466554]
15. Sullivan P, Peterson J, Rosenberg ES, Kelley CF, Cooper H, Vaughan A, et al. Understanding racial HIV/STI disparities in Black and White men who have sex with men: A multilevel approach. Okulicz JF, editor. *PLoS ONE* [Internet]. 2014 3 7 [cited 2015 Apr 12];9(3):e90514 Available from: <http://dx.plos.org/10.1371/journal.pone.0090514>
16. Centers for Disease Control and Prevention. Syndemics prevention network. Spotlight on syndemics. 2010;
17. Singer MC, Erickson PI, Badiane L, Diaz R, Ortiz D, Abraham T, et al. Syndemics, sex and the city: understanding sexually transmitted diseases in social and cultural context. *Soc Sci Med*. 2006;63(8):2010–21. [PubMed: 16782250]
18. Singer M, Clair S. Syndemics and public health: Reconceptualizing disease in bio-social context. *Med Anthropol Q*. 2003;17(4):423–41. [PubMed: 14716917]
19. Singer M Introduction to syndemics: A critical systems approach to public and community health. San Francisco, CA: John Wiley & Sons; 2009.
20. Safren SA, Reisner SL, Herrick A, Mimiaga MJ, Stall R. Mental health and HIV risk in men who have sex with men. *J Acquir Immune Defic Syndr* 1999 [Internet]. 2010 [cited 2015 Mar 25];55(Suppl 2):S74 Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3074520/>
21. Mustanski BS, Newcomb ME, Du Bois SN, Garcia SC, Grov C. HIV in young men who have sex with men: A review of epidemiology, risk and protective factors, and interventions. *J Sex Res* [Internet]. 2011 2 28 [cited 2015 Mar 23];48(2–3):218–53. Available from: <http://www.tandfonline.com/doi/abs/10.1080/00224499.2011.558645>
22. Stall R, Mills TC, Williamson J, Hart T, Greenwood G, Paul J, et al. Association of co-occurring psychosocial health problems and increased vulnerability to HIV/AIDS among urban men who

- have sex with men. *Am J Public Health* [Internet]. 2003 6;93(6):939–42. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447874/>
23. Effective Interventions. 2019 Available from: <https://effectiveinterventions.cdc.gov/en/HighImpactPrevention/Interventions.aspx>
 24. Charmaz K *Constructing grounded theory*. Sage; 2014.
 25. Herrick AL, Lim SH, Wei C, Smith H, Guadamuz T, Friedman MS, et al. Resilience as an untapped resource in behavioral intervention design for gay men. *AIDS Behav* [Internet]. 2011 4 [cited 2015 Apr 7];15(S1):25–9. Available from: <http://link.springer.com/10.1007/s10461-011-9895-0>
 26. Herrick AL, Stall R, Goldhammer H, Egan JE, Mayer KH. Resilience as a research framework and as a cornerstone of prevention research for gay and bisexual men: Theory and evidence. *AIDS Behav* [Internet]. 2014 1 [cited 2015 Mar 23];18(1):1–9. Available from: <http://link.springer.com/10.1007/s10461-012-0384-x>
 27. Matthews DD, Herrick A, Coulter RW, Friedman MR, Mills TC, Eaton LA, et al. Running backwards: consequences of current HIV incidence rates for the next generation of black MSM in the United States. *AIDS Behav*. 2016;20(1):7–16. [PubMed: 26267251]
 28. Dacus J, Voisin DR, Barker J. “Proud I am negative” Maintaining HIV-seronegativity among Black MSM in New York City. *Men Masculinities*. 2018;1097184X17696174.
 29. Charmaz K *Experiencing chronic illness*. *Handb Soc Stud Health Med*. 2000;277–92.
 30. Mills J, Bonner A, Francis K. The development of constructivist grounded theory. *Int J Qual Methods*. 2006;5(1):25–35.
 31. Hall WA, Callery P. Enhancing the rigor of grounded theory: Incorporating reflexivity and relationality. *Qual Health Res*. 2001;11(2):257–72. [PubMed: 11221119]
 32. NVIVO [Internet]. QSR International; 2014 Available from: <http://www.qsrinternational.com/product/nvivo-mac>
 33. NVIVO [Internet]. QSR International; 2015 Available from: <http://www.qsrinternational.com/product/nvivo-mac>
 34. Creswell JW. *Research design: Qualitative, quantitative, and mixed methods approaches*. Los Angeles, CA: Sage publications; 2013.
 35. Centers for Disease Control and Prevention. Anal sex and HIV risk. 2018 1 21; Available from: <https://www.cdc.gov/hiv/risk/ analsex.html>
 36. Hickson DA, Truong NL, Smith-Bankhead N, Sturdevant N, Duncan DT, Schnorr J, et al. Rationale, design and methods of the ecological study of sexual behaviors and HIV/STI among African American men who have sex with men in the Southeastern United States (The MARI Study). *PloS One*. 2015;10(12):e0143823. [PubMed: 26700018]
 37. McNair OS, Gipson JA, Denson D, Thompson DV, Sutton MY, Hickson DA. The associations of resilience and HIV risk behaviors among Black gay, bisexual, other men who have sex with men (MSM) in the Deep South: The MARI Study. *AIDS Behav*. 2018;22(5):1679–87. [PubMed: 28856456]
 38. Persson A, Eliard J. Bridging the sero-divide: The de-stigmatising potential of serodiscordant stories. In Melbourne, Australia; 2012 Available from: <http://pag.aids2014.org/Abstracts.aspx?AID=3408>
 39. Grace D, Chown SA, Jollimore J, Parry R, Kwag M, Steinberg M, et al. HIV-negative gay men’s accounts of using context-dependent sero-adaptive strategies. *Cult Health Sex*. 2014;16(3):316–30.
 40. Khosropour CM, Dombrowski JC, Hughes JP, Manhart LE, Simoni JM, Golden MR. Operationalizing the measurement of seroadaptive behaviors: a comparison of reported sexual behaviors and purposely-adopted behaviors among men who have sex with men (MSM) in Seattle. *AIDS Behav*. 2017;1–10.
 41. Ober A, Dangerfield D, Shoptaw S, Ryan G, Stucky B, Friedman S. Using a “positive deviance” framework to discover adaptive risk reduction behaviors among high-risk HIV-negative Black men who have sex with men. *AIDS Behav*. 2017;1–14.
 42. Bowleg L, del Río-González AM, Holt SL, Pérez C, Massie JS, Mandell JE, et al. Intersectional epistemologies of ignorance: How behavioral and social science research shapes what we know,

think we know, and don't know about US Black men's sexualities. *J Sex Res.* 2017;54(4–5):577–603. [PubMed: 28287844]

43. Calabrese SK, Earnshaw VA, Magnus M, Hansen NB, Krakower DS, Underhill K, et al. Sexual stereotypes ascribed to Black men who have sex with men: An intersectional analysis. *Arch Sex Behav.* 2018;47(1):143–56. [PubMed: 28224313]
44. Lichtenstein B, Kay ES, Klinger I, Mutchler MG. Ricky and Lucy: gender stereotyping among young Black men who have sex with men in the US Deep South and the implications for HIV risk in a severely affected population. *Cult Health Sex.* 2018;20(3):351–65. [PubMed: 28720021]