

## Health, Trust, or “Just Understood”: Explicit and Implicit Condom Decision-Making Processes Among Black, White, and Interracial Same-Sex Male Couples

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Article available from Archives of Sexual Behavior [here](#).

### *Suggested citation*

**Campbell, C.K.**, Gomez, A.M., Dworkin, S., Wilson, P., Grisham K., McReynolds, J., Vielehr, P., & Hoff, C. (2013). Health, Trust, or “Just Understood”: Explicit and Implicit Condom Decision-Making Processes Among Black, White & Interracial Same-Sex Male Couples. *Archives of Sexual Behavior*. Advance online publication. doi: 10.1007/s10508-013-0146-5

**ABSTRACT**

Among gay and bisexual men, primary partners are a leading source of HIV infection. Trust, intimacy, and advancements in HIV treatment may impact same-sex male couples' decisions to engage in unprotected anal intercourse (UAI). This qualitative study explored how Black, White and interracial couples discussed, and made decisions regarding condoms. Qualitative interviews were conducted with 48 same-sex male couples in the New York and San Francisco metropolitan areas. Stratified purposive sampling was used to include Black (n = 16), White (n = 17), and interracial (Black-White) (n = 15) couples. Twenty-six couples were concordant HIV-negative and 22 were HIV-discordant. Interviews were recorded, transcribed, coded, and analyzed using a grounded theory approach. Some couples described *explicit processes*, which involved active discussion, while others described *implicit processes*, where condom-use decisions occurred without any explicit discussion. These processes also differed by race and HIV status. Black couples tended to report condom-use as "just understood." White, HIV-discordant couples decided not to use condoms, with some identifying the HIV-positive partner's suppressed viral load and high CD4 count as deciding factors. After an unplanned episode of UAI, White, HIV-negative couples tended to discontinue condom use while Black HIV-negative couples decided to revert to using condoms. HIV prevention efforts focused on same-sex, male couples must consider the explicit/implicit nature of condom decision-making processes. Understanding differences in these processes and considering relationship dynamics, across race and HIV status, can promote the development of innovative couple-level, HIV prevention interventions.

**KEY WORDS:** gay couples; Black MSM; HIV risk; safer sex; condom negotiation

## INTRODUCTION

Male-to-male sexual contact accounted for 64% of all new HIV infections in the United States in 2009 (CDC, 2012). White and Black men who have sex with men (MSM) accounted for the first and second highest number of incident infections, respectively, and in 2010, the CDC reported that MSM were the only risk group in the U.S. in which new infections had been steadily increasing since the early 1990s (CDC, 2010). Between 2006 and 2009, HIV infections among young Black MSM increased by 48% (CDC, 2011), though several research studies have found that Black MSM do not engage in more frequent risky sexual behavior than other MSM (Harawa et al., 2004; Millett, Peterson, Wolitski, & Stall, 2006; Millett, Flores, Peterson, & Bakeman, 2007).

Researchers and prevention experts have explored the factors driving the HIV epidemic among MSM. One area of recent and increasing investigation is risk within the context of primary, same-sex male (SSM) relationships (Beougher et al., 2012; Crawford, Rodden, Kippax, & Van de Ven, 2001; Davidovich, de Wit, & Stroebe, 2004; Harawa et al., 2004; Hoff et al., 2006; Hoff et al., 1997; Kippax et al., 2003; McNeal, 1997; Moreau-Gruet, Jeannin, Dubois-Arber, & Spencer, 2001; Prestage et al., 2006). While most HIV prevention efforts have been based on individual risk behavior, some data estimate that more than half of new infections may result from unprotected anal intercourse (UAI) with a primary partner (Sullivan, Salazar, Buchbinder, & Sanchez, 2009). These data indicate the need for HIV prevention efforts to consider the relational context in which risk behaviors occur for many MSM.

The field of HIV prevention has recently seen a pronounced shift, with greater emphasis on promising biomedical interventions, such as HIV treatment as prevention and pre-exposure prophylaxis (PrEP). Preliminary evidence indicates that this shift may have an impact on

attitudes about traditional HIV prevention methods such as condom use. Optimism about antiretroviral therapy (ART) (Holt, Ellard, & de Wit, 2011) and having an undetectable viral load (Prestage et al., 2009; Van de Ven et al., 2005) have been associated with a significantly increased likelihood of UAI among gay men in serodiscordant relationships. In one study, 36% of participants who were likely to use PrEP reported that they would reduce condom use while on PrEP (Golub, Kowalczyk, Weinberger, & Parsons, 2010). Crosby, Ricks, & Young (2012) suggested a need for additional research to explore the likelihood of condom migration—abandoning condoms for newer prevention strategies—in response to biomedical interventions.

Among SSM couples, various behavioral risk reduction strategies have been reported, including serosorting (Eaton et al., 2007), HIV testing (Crawford et al., 2001; Davidovich, de Wit, & Stroebe, 2000; Elford, Bolding, Maguire, & Sherr, 1999), and negotiated safety – a strategy where concordant, HIV-negative couples agree to engage in UAI within their relationship while negotiating an agreement about sex with outside partners (Hoff, 2005; Kippax et al., 1997; Moreau-Gruet et al., 2001). Research on negotiated safety has documented the ways in which men in relationships discuss condom use with primary and outside partners (Hoff, 2005; Kippax et al., 1997; Moreau-Gruet et al., 2001). In many cases, these negotiations lead to couples abandoning condoms within the primary relationship. While UAI is often assumed to be risky for HIV transmission, it may, in fact, be an objectively safe choice in some relationship contexts. For example, UAI within a monogamous relationship where both partners are HIV-negative carries low HIV transmission risk (Crawford, 2003). Indeed, data have indicated that UAI is more common among concordant HIV-negative couples than HIV-discordant couples (Crawford et al., 2001; Moreau-Gruet et al., 2001). Further, Adams and Neville (2009) found that some men perceived the transition to condomless sex, after discussing risks and benefits, as

part of the natural course of a relationship. Thus, among men who are in committed, trusting relationships, condom negotiation may lead to reductions, rather than increases, in condom use. When both partners are HIV negative and there are no outside partners, reduction or elimination of condom use may come with very little, if any, additional HIV risk. However, in the case of serodiscordant couples, this choice comes with increased risk of infection for the negative partner.

Perhaps more importantly, in the absence of a negotiation process, condom decisions may be the result of partners' tacit agreements with each other's desires or may happen in the heat of the moment. Research on the impact of sexual arousal on risk taking found that risk management in a loving relationship is more difficult than during casual encounters (Strong, Bancroft, Carnes, Davis, & Kennedy, 2005). Additionally, several researchers have distinguished between explicit (verbal) and implicit (nonverbal) sexual negotiations (Elwood, Greene, & Carter, 2003; McInnes, Bradley, & Prestage, 2011; Semple, Patterson, & Grant, 2000). However, we have found no studies that specifically distinguished between explicit and implicit condom negotiations among men in committed SSM relationships. Since condoms remain an essential tool in the prevention of sexual transmission of HIV (Crosby & Cates, 2012), it remains an important endeavor to examine the processes by which men in SSM relationships make decisions about condom use during anal sex.

### **Relationship Factors and Risk Behaviors**

While individual condom negotiation skills are a necessary point of intervention, additional interpersonal and intrapersonal factors impact the ways in which men employ these skills in the context of committed relationships. Research with SSM couples has shown various relational factors that impact HIV risk (Beougher et al., 2012; Crawford et al., 2001; Davidovich

et al., 2004; Harawa et al., 2004; Hoff et al., 2006; Hoff et al., 1997; Kippax et al., 2003; McNeal, 1997; Moreau-Gruet et al., 2001; Prestage et al., 2006). For example, love, trust, commitment, and interdependency have been found to be associated with HIV risk. Engaging in sex behaviors that are riskier for HIV transmission may be seen by some men as a way to show trust in their partner (Appleby, Miller, & Rothspan, 1999). Higher scores on various intimacy factors (e.g., excitement about one's relationship and relationship satisfaction) were associated with lower odds of condom use (McNeal, 1997). Additionally, perception of HIV risk, relationship length, fear of AIDS, and agreements about sex outside of the relationship have also been found to impact risk behavior, partner selection, and decision-making processes for MSM in primary relationships (Appleby et al., 1999; Davidovich et al., 2004; Frost, Stirratt, & Ouellette, 2008; Hoff & Beougher, 2010; Hoff, Beougher, Chakravarty, Darbes, & Neilands, 2010; McNeal, 1997; Theodore, Duran, Antoni, & Fernandez, 2004).

### **Impact of Race on HIV Prevention**

Research on MSM couples has increased in recent years. However, no HIV prevention studies have sought to understand how race influences relationship dynamics. In studies exploring racial preferences of MSM, data have suggested that Black men are less desired than other men and are considered "riskier" sex partners (Raymond & McFarland, 2009; Wilson et al., 2009). Undoubtedly, the plethora of data suggesting high HIV incidence and prevalence among Black MSM contributes to these perceptions. Yet, research has not examined the influence of these perceptions on risk behaviors within relationships.

Some data suggest potential differences in the ways that Black and White MSM negotiate HIV prevention strategies. For instance, research has found that HIV-negative, White MSM were more likely to engage in UAI and to endorse serosorting beliefs (Eaton, Kalichman, & Cherry,

2010). Other research highlights the need to consider cultural differences and experiences of racial, ethnic, sexual, and economic oppression on how Black MSM employ HIV prevention strategies (Nanín et al., 2009). Nanín et al.(2009) found that Black men in their sample expressed a need to take HIV more seriously and to take more responsibility for themselves and their communities. Thus, it is important to understand how social and cultural factors might impact the ways that Black MSM manage HIV risk in relationships. Further, studies have not explored the ways in which, within these social contexts, Black and White MSM form and negotiate same-race and interracial relationships. Our study explored the impact of racial makeup and HIV status on power and other relationship dynamics specifically among Black, White, and interracial (Black-White) couples. The current qualitative analysis examined narratives of both partners in SSM couples to further understand: how couples discuss and decide on condom use/non-use; whether couples revisit their condom agreements; the explicit and implicit processes of condom negotiation; and the prevention and risk implications of these processes.

## **METHOD**

### **Participants**

As part of a broader study investigating relationship power, race, and HIV risk, 48 SSM couples were recruited in the San Francisco and New York City metropolitan areas between March and November 2011. Stratified, purposive sampling was used to recruit 26 concordant HIV-negative couples and 22 HIV-discordant couples. Recruitment was also stratified by race, with Black, White, and interracial (Black-White) couples represented in the sample. Using both active and passive recruitment strategies, participants were recruited from venues frequented by MSM. Staff placed recruitment cards, flyers, and posters, as well as conducted active recruitment in community-based venues, such as bars, community centers, churches, and local businesses.

Advertisements were placed in local print media and online, and the research team reached out to specific staff members at community-based organizations and clinics who were willing to refer clients, patients, and members of their social and professional networks to participate in the study.

Participants were screened via telephone individually. Eligible participants had to: be at least 18 years old; have lived in the U.S. since age 7 or younger; know their own and partner's HIV status; and have been in their relationship for at least 6 months. Additionally, at least one partner in the relationship had to report engaging in anal sex within the previous three months. All participants had to identify as Black or White as their primary racial identity. Those who identified as multi-racial or mixed were asked a follow-up question to determine their primary racial identity. Couples in which either partner identified as transgender were not eligible for study participation nor were couples who provided discrepant reports of their partner's HIV status.

Of the 48 couples included in the sample, 26 were concordant HIV-negative and 22 were HIV-discordant (Table 1). There were 17 White, 16 Black, and 15 interracial (Black-White) couples in the sample. Approximately half of the couples were interviewed at each study site. Mean relationship length was 5.4 years (range: 6 months to 36 years). A one-way ANOVA found no significant differences in mean relationship lengths between any two groups ( $F(2, 47) = 1.07, p > .05$ ).

The mean age difference between partners in the sample was 5.6 years, with the most pronounced age differences among HIV-discordant couples (Table 2). Among HIV-discordant couples, the largest age gaps were among interracial couples ( $M = 11.33$  years; range: 1-25



years). A two-way ANOVA found no significant differences in mean age difference between any two groups ( $F(3, 47) = 2.58, p > .05$ ).

The mean age was 33.9 years (range: 18-66 years), with White men slightly older (35.9 years) than Black men (31.8 years) (Table 3). Among all HIV-positive men interviewed in the study, 14 were White and 8 were Black. A majority (70%) of White men reported having at least an associates-, bachelors-, or masters-level education, compared to 29% of Black men. Additionally, income and employment varied by race. Among Black men, 36% reported having full-time employment and 60% reported annual income under \$30,000, while half of White men reported having full-time employment and 46% reported income under \$30,000.

## **Procedure**

Six master's-level research assistants were trained in qualitative research methods, interviewing skills, and the ethics of human subjects research over a two-day period. Participants provided written informed consent prior to the interview. Members of the couple were interviewed separately and simultaneously to ensure confidentiality and to elicit sensitive information that may not otherwise have been revealed in the presence of the partner. Interviews were guided by a semi-structured, qualitative interview guide<sup>1</sup>, with interviews averaging 90 minutes in length. Interview domains included: relationship history; conflict; sexual relationship(s) and agreements; masculinity; condom use decision-making, experiences of racism and homophobia; and sexual health. The current analysis focused on the following domains: condom negotiation, condom use, sexual risk taking; and HIV risk reduction.

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<sup>1</sup> Interview questions are available from the corresponding author upon request.

Interviews were digitally recorded and transcribed verbatim, then checked for accuracy and grammatical errors. Using a grounded theory approach (Denzin & Lincoln, 2003; Lindlof & Taylor, 2002), members of the study team read and summarized 50% percent of the transcripts for use in the code development process. Upon codebook development, four 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. After each round of pilot coding, the codebook and code definitions were refined as needed. Once a codebook was finalized, transcripts were evenly divided between research assistants, who independently applied codes to the remaining interview transcripts using Transana qualitative analysis software (Woods & Fassnacht, 2007). To ensure reliability and consistency in coding, one quarter of the transcripts were coded by a second coder and verified by a third staff member. Interview data were analyzed by comparing the narratives of both partners of a couple, as well as by comparing themes between race and HIV status groups.

## **RESULTS**

In the results that follow, two overarching themes summarizing couples' condom negotiation patterns emerged. First, couples described condom negotiation occurring through *explicit processes*, conceptualized as engaging in an active discussion about whether they will use condoms in their relationship. These processes included: unplanned episodes of UAI followed by condom negotiation or renegotiation; among HIV-discordant couples, discussions of the positive partner's health status and testing as a precursor to engaging in regular UAI. Conversely, couples described *implicit processes*, where both partners assented to using or not using condoms, without any explicit discussion. These processes included defaulting to condoms without an overt discussion or negotiation. Implicit processes also included some unplanned

episodes of UAI. However, in these cases, experiences did not lead to an explicit negotiation process.

### **Explicit Decision-making Processes**

Many couples in our sample described explicit processes of decision-making around condom use. These couples' narratives indicated a conscious and participatory process in which both partners were able to express their own comforts, fears, and boundaries as they related to condom use and HIV risk. For some couples, these were proactive processes that occurred early on in relationships or prior to agreeing to have UAI; for others, these processes happened as a result of an unplanned "break" from their current condom agreement, such as having UAI "in the heat of the moment."

#### *Unplanned Episodes of UAI*

In our sample, most Black/negative (B/N) and Black/discordant (B/D) couples described condom use as a regular part of their sexual relationship. Of the 16 couples where both partners were Black, only three reported having regular UAI. Of the remaining 13, some couples reported having experienced at least one unplanned episode of UAI. While these experiences were not unique to Black couples, the subsequent negotiations that led to a return to condom use were. For most Black couples, unprotected UAI was followed by an explicit discussion and an agreement to revert to using condoms. For example, one participant described a sexual encounter with his partner when a condom was not used:

I guess the moment got pretty intense and the condom was not used there...Of course it felt better but the whole time I was, you know, just thinking all sorts of stuff... we actually had a test together twice after that situation and vowed never to be without a condom again. [Black/43/Negative/(B/N)]

His partner also acknowledged that they had had instances where they didn't use condoms but confirmed that they had agreed to always use condoms. Some couples reported multiple breaks in their condom usage but explicitly agreed to begin using condoms again.

About half of all White/negative (W/N) couples reported unplanned episodes of UAI. However, in contrast to the Black couples, these couples tended to continue having sex without condoms, regardless of timing of the episode. One participant who reported that he and his partner did not use condoms at the beginning of their relationship described:

...initially it happened really quick and we didn't from the beginning start with a condom, which was both recognized as a huge mistake and a huge risk. But then with conversation and understanding [we] agreed that we were okay and that we both wanted to be at that same place where we didn't need to use a condom.  
[32/White/Negative/(W/N)]

His partner similarly described their first sexual experience as a “mistake” that happened because they were “so into the moment.” Similar to the Black couples who had an episode of unplanned UAI, these experiences led to an explicit discussion about whether to use condoms in the future. However, as described above, the result of these decision-making processes was to continue having UAI.

#### *Discussing the Health of HIV-Positive Partners*

Among most White/discordant (W/D) and interracial/discordant (I/D) couples, the health of the HIV-positive partner was a key component of condom decision-making processes. Factors such as the positive partner's viral load, CD4 count, and ART adherence were considered, often resulting in couples deciding not to use condoms. One man described how recent research on transmission within HIV-discordant partnerships played a part in their discussion and ultimate decision to discontinue condom use:

Well he takes his medicine on time and when he needs to. And we actually looked into unsafe sex with positive men, negative partners and we actually found that there are a lot

of couples like that but the [negative] partner usually does not contract HIV from the [positive] partner. [24/Black/Negative/(I/D)]

His partner shared that he had always been honest about his dislike of condoms and that they were both mostly concerned with not having outside sexual partners to eliminate the risk of sexually transmitted infections. Similarly, another participant described his and his partner's decision-making process: "We don't use condoms, I'm on meds, I have no viral load, my T cells are high everything...But ultimately it was up to him and there was a long discussion over several weeks before we actually had sex" [White/36/Positive/(W/D)]. These couples believed that when the HIV-positive partner is healthy and virally suppressed, the risk of HIV transmission is low. Several of the HIV-positive members of these couples expressed concern and fear about the possibility of infecting their negative partners. For example, one participant initiated the agreement with his partner to have UAI because of his dislike of condoms. However, he expressed concern regarding his partner's status. He said, "It scares me because I don't want him to be positive and actually I fear it because I don't wish the disease on anybody" [White/27/Positive/(I/D)]. However, despite their fears, these couples perceived UAI with their partner as relatively safe because of their understanding of recent research, their personal knowledge about HIV risk, and/or advice from their doctors. In contrast, only one Black, HIV-discordant couple discussed the health of the positive partner. However, the positive partner's good health and suppressed viral load did not lead this couple to discontinue using condoms. While the HIV-positive partner described condom use as very important to preventing his partner from being exposed to HIV, his HIV-negative partner explained:

It's a discussion that we had because he's positive, I'm negative and so that was number one that we've always talked about but his numbers are so low, you know he's doing really, really well but we still just practice safe sex no matter what.  
[Black/47/Negative/(B/D)]

*HIV Testing as a Precursor to Ending Condom Use*

Across couple race, some concordant HIV-negative couples chose to get tested for HIV as a necessary step in their process of negotiating condom use. While there were subtle differences between these couples, in each of these cases, there was an expressed desire to discontinue condom use, whether to show trust, to satisfy a desire for UAI, or to address a dislike of condoms. Consequently, in each of these cases, the end result of the process was to discontinue condom use within the relationship. One man shared that he and his partner did not use condoms because they felt there was no need. His partner explained further, “We were both tested for HIV when we first got together and we were both negative and we you know committed to each other to be monogamous so we just didn't see any need to use condoms” [White/43/Negative/(W/N)]. This couple believed that UAI was an inherently “safe” decision, because of their trust in each other, their concordant HIV-negative status, and their monogamous agreement.

Another man described a process that first involved a year of regular condom use: “I think when we first started we used condoms and then once we got tested together and got our results together then we made the decision like probably a year into it that we'd stop using condoms” [White/45/Negative/(W/N)]. His partner further explained that they also have an open relationship and always use condoms with their outside sexual partners. Regular testing was a common theme among these couples, as were different condom use agreements for sex within and outside of the relationship.

Another couple shared their experience of testing at home prior to ending condom use in their relationship: “I brought a portable HIV testing kit and we tested each other. And that was where we benchmarked our status” [Black/34/Negative/(B/N)]. His partner’s narrative was consistent with this, adding that they waited until just before they got married to get tested and

stop using condoms. Prior to that point in their relationship, UAI wasn't something that they considered. This couple was the only one that chose to test in the privacy of their home.

### **Implicit Decision-Making Processes**

In contrast, discussion of condom use was absent from other couples' relationships. These couples' narratives described condom decision-making processes that relied heavily on assumptions and/or assent. For some of these couples, there was a feeling that there was no need to discuss condoms, as condoms are simply an understood part of having sex. Others felt comfortable enough with their partner and their perceived level of risk to discontinue condom use without having a discussion.

### *Unplanned Episodes of UAI*

For some couples, experiences of unplanned UAI led to decision-making processes that were more implicit than explicit. For many White and interracial couples, these experiences were followed by an unspoken agreement that having had UAI was tacit permission to continue doing so. For example, when asked if he and his partner ever discussed using condoms, one participant in an interracial/negative (I/N) relationship described, "No, I think it was just the first time we did it; the first time we did it we just fucked up and didn't use `em, and so we just kinda went with it you know" [Black/29/Negative/(I/N)]. His partner stated that he didn't even recall how they began having UAI. They both expressed the idea that engaging in UAI without planning may have been "a stupid decision." However, they both also expressed their trust for each other and because they both had been tested for HIV during their three-year relationship, they felt safe not using condoms. For some of these couples, the first instance of unplanned UAI led to regular UAI, while for others, the second or third break in their condom usage was the impetus for regular UAI.

*Default to Condoms (“Just Understood”)*

Defaulting to condom use without discussion was common among Black couples, regardless of couple HIV status. In contrast, this was true of none of the White couples and only a minority of the interracial couples. Of the 16 Black couples, 10 simply defaulted to condom usage in order to protect themselves from HIV risk. Several men described condom use as being “just understood.” This was true despite the fact that most of these couples reported that they had no outside sexual partners and, particularly for HIV-negative couples, at very low risk for HIV. For example, when asked if he and his partner had ever discussed condom use in their relationship, one participant explained:

It was just somethin' understood... So the first time when we decided to have sex I just snatched out the condom and he already knew what it's there for, so he agreed... he already know what it was, there was no discussion and he just put it on. [Black/30/Negative/(B/N)]

His partner explained that there was no need to discuss condoms because they both believe in safe sex. Another man described why sex without condoms was not an option in his relationship:

[Condoms are] very much involved because I'm positive, he's negative and I respect the fact that he would even consider being involved with someone positive. I mean, that means a lot to me because there's a lot of people that would run for the hills if they knew that the other person was positive... It's like, if you could respect me, I could respect you by giving a damn about you to make you protect yourself... It's just understood. [Black/31/Positive/(B/D)]

His HIV-negative partner acknowledged that they usually just used condoms without discussion, admitting that there were times when they slipped and had UAI. Most Black couples considered condoms a “natural” part of their sexual relationship. Some men suggested a personal connection to someone who was HIV-positive or high rates of HIV among Black men as possible motivations for this default. For example, one participant described:



I feel I'm cautious because the rate of African American men's status of being positive has risen so drastically in a short number of years that I don't want to contract it. And I think that plays a role in why we only have sex with condoms... you know statistics are statistics and it's almost like playing Russian roulette if you don't wear [a condom]. [Black/26/Negative/(B/N)]

## DISCUSSION

The current study sought to explore how couples discussed and decided on condom use/non-use; whether couples revisited their condom agreements; the explicit and implicit processes of condom negotiation; and the prevention and risk implications of these processes. Previous literature has largely focused on explicit condom negotiation. Here, we also include implicit processes, as both types of negotiation processes have implications for risk and may require different risk reduction strategies and interventions. While all couples described either explicit or implicit condom decision-making processes, those processes varied by couples' racial makeup and HIV status. Both concordant HIV-negative and -discordant Black couples tended to describe implicit agreements to default to condom use, with little or no discussion. While most of these couples described "slips" (instances of unplanned UAI), there was an implicit understanding that protected sex was "just understood." Black couples that did engage in explicit discussions around condom use usually did so only as a response to an unplanned episode of UAI. After these episodes, Black couples discussed the incident and/or received an HIV test, and agreed to return to using condoms. Some Black couples saw using condoms as a matter of respect for each other and taking responsibility for their own well-being. Others referenced the high prevalence and incidence among Black MSM in the U.S. and decided to take steps to ensure that they did not become "another statistic."

In contrast to Black couples, White couples generally discontinued condom use after an unplanned episode of UAI. This was true whether the unplanned UAI happened earlier or later in the relationship. For some couples, there were multiple occurrences of unplanned UAI. After the

first episode, some couples agreed to use condoms again, but after a second or third, they discontinued condom use. For others, the first episode of unplanned UAI was the impetus for continued UAI.

Some HIV-discordant White and interracial couples discussed the positive partner's "numbers" (i.e., viral load and CD4) when making decisions around condom use. For some couples, recent research and prevention information regarding "treatment as prevention" (Cohen & Gay, 2010) factored into their decision to begin engaging in regular UAI. That is, despite expressed concern about the possibility of the negative partner seroconverting, data suggesting that a suppressed viral load and a healthy CD4 count reduced transmission risk were sufficient evidence for these couples to decide that UAI was a worthwhile risk. In contrast, Black HIV-discordant couples decided that this risk was not worth taking, even when the positive partner was similarly healthy, and did not mention these biomedical approaches in their narratives.

Each of these condom decision-making processes can be described as protective in some ways and risky in other ways. The explicit processes highlighted the forthright communication that is needed to protect the health of both partners (Darbes, Chakravarty, Beougher, Neilands, & Hoff, 2012). It is important to note that while condom negotiation is often assumed to result in "safer sex," the explicit decision-making processes described by couples in this analysis, more often than not, resulted in the abandonment of condoms. However, explicit discussions can be protective, as they allow each partner to express his own concerns, boundaries, and level of comfort. During these discussions, couples were able to weigh the risks and benefits and come to agreement on whether condoms would be a part of their regular sexual relationship. Risks also arise from these explicit processes, particularly when decisions are made in the absence of important and/or accurate information. For example, only one HIV-negative couple had tested

and received results together, though others described being tested individually. Couples may benefit from HIV testing interventions that allow for partners to be tested and receive results together. Such couple-focused testing options may increase trust between partners, allow partners to support each other through the testing process, and provide concrete information that couples can use when making risk reduction decisions. HIV-discordant couples who discuss the health of the positive partner when deciding whether to use condoms may believe that suppressed viral load equals *no* risk rather than *low* risk. Low or undetectable viral load has been shown to reduce HIV transmission risk—mainly among heterosexual couples—although it has not been shown to be risk-free (Vernazza, Hirschel, Bernasconi, & Flepp, 2008). Couples using this information to inform their decisions may achieve a false level of security and safety (Wilson, Law, Grulich, Cooper, & Kaldor, 2008). While some couples' decisions may be guided by information from their doctor, it is important for HIV-discordant couples to have a clear understanding of the relationship between viral suppression and the risk of transmission during these decision-making processes.

In contrast, couples engaging in implicit processes did not experience the potential benefits from an explicit decision-making process itself. For Black couples, the implicit processes resulted in condom use, which is inherently safer than UAI (Varghese, Maher, Peterman, Branson, & Steketee, 2002). For those couples who had a “just understood” process and for those who began having UAI without discussion, the risks were rooted in the lack of discussion. By not engaging in important explicit communication about risks, benefits, and concerns, these couples operated with unclear understandings of the boundaries of their relationships and made decisions without a full picture of their partner's testing and sexual

history. There is also the potential that these couples may be missing a certain level of trust and emotional intimacy that can result from risk negotiation itself.

One interesting and important finding derived from this analysis was the difference in condom use by race. Our study contributes new data that examines HIV risk among Black men in SSM relationships. HIV-negative, Black couples in this sample overwhelmingly used condoms as a rule, simply defaulting to condoms despite the fact that many described being in monogamous relationships, placing them at low risk for HIV. Only a minority of Black negative and discordant couples made the decision not to use condoms. Even when faced with an unplanned episode of UAI, most of these couples responded by discussing the break in their regular condom usage, getting tested, and reverting to condom use. In contrast, both serodiscordant and concordant HIV-negative White couples discussed condom use in much more detail but did not use condoms. Evidence suggests that even if Black couples who described condom use as “just understood” had engaged in more explicit decision-making processes, they may not have made the decision to engage in UAI, as White couples did. Previous research has documented the belief among some Black MSM that safer sex discussions may lead partners to assume that they are HIV-positive and/or reveal an assumption that one’s partner is positive (Nanín et al., 2009). Also, research has documented the existence of distinctly different prevention needs resulting from communication chasms in the African American community (Mays, Cochran, & Zamudio, 2004). The differences in decision-making processes by race revealed in this analysis may reveal a need to better tailor HIV prevention messages regarding communication and safer sex strategies to reach minority men.

This is one of the few studies to qualitatively examine the narratives of both members of SSM couples. Because few studies include data from both members of the couple, the

opportunity to reveal the negotiation process that men actively create and constrain with one another is missed. Speaking to both members of the couple is critical in order to overcome limitations that exist when only the perspective of one partner is analyzed. While we made use of both partner's views, we interviewed the two members of the couple separately to allow each partner to speak freely from his own perspective without the presence of the other (Eisikovits & Koren, 2010). In an effort to respect confidentiality, we did not share quotes from both partners side by side. Additionally, while other studies have examined risk behaviors of MSM by race, ours is the first to specifically examine these among Black, White, and interracial (Black/White) couples. This gives us the novel ability to examine risk behaviors within the context of SSM relationships, while identifying differences based on the racial makeup of the couple.

There were some limitations to this study. First, all participants were recruited from the San Francisco Bay and New York Metropolitan Areas, both highly populated, progressive, metropolitan areas with large and visible lesbian, gay, bisexual, and transgender populations. Further, these areas have been highly impacted by the HIV/AIDS epidemic, resulting in MSM being inundated with public health messages. These results may not be generalizable to SSM couples in the United States more broadly, given that social context differs greatly by city and region, and public health messages have not been disseminated equally across the nation. We heavily recruited through gay venues, possibly limiting our recruitment of MSM who do not self-identify as gay. While some findings reflect important patterns for HIV-negative and -discordant couples, HIV status was self-reported and not verified. We did not conduct HIV testing, as this study was primarily focused on how men's perceptions of their own and partner's HIV status influenced sexual risk behavior. Additionally, our findings about condom use based on race were not derived from a larger sample and may reflect either the types of couples that we recruited or

simple sampling variability. As such, the findings may not reflect true differences between couples based on race, and caution should be taken when interpreting our findings.

Our data suggest that condom decision-making is a dynamic process, shaped by primary partners' interactions, partners' influences on each other, and perceptions of HIV risk. The results of this analysis should inform future research and intervention development focused on Black MSM in committed SSM relationships, given the high prevalence and incidence among Black MSM (CDC, 2010) and data suggesting that steady partners are a major source of HIV transmission (Davidovich et al., 2001; Sullivan et al., 2009). Future research should explore the extent to which Black MSM in the U.S. have internalized the realities of high HIV prevalence and incidence data. An analysis of these data indicated that Black MSM perceived an additional level of responsibility to protect themselves and bear a heightened fear of HIV infection, even in the context of a "safe" relationship (Grisham et al., 2012). Additional research should include an examination of the processes through which couples make sexual health decisions. Examining these processes may inform educational interventions to help men in committed relationships negotiate safety. These interventions should distinguish between explicit and implicit decision-making processes and consider the promises and pitfalls of each. Additional preventive interventions could include: tools for partners to discuss their HIV status; information regarding the benefits and risks of using HIV viral load in risk-reduction plans; and HIV risk management strategies with primary partners or potential partners. Given the importance of relational context to condom decision-making, developing interventions using information from both partners will contribute to the further reduction of HIV infections.

## **ACKNOWLEDGMENTS**

The authors extend their thanks to the participants for their time and effort and to the Research Assistants Carla Garcia, Sean Arayasirikul, H. Lenn Keller, Pamela Valera, Anthony Morgan, Allison Hamburg, and Terry Dyer for their work recruiting, scheduling, and interviewing participants. This research was supported by grant R01 #MH089276 from the National Institute of Mental Health

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**Table 1: Couple Characteristics (N=48)**

		White (n = 17)	Black (n = 16)	Interracial (n = 15)
		<b>% (n)</b>	<b>% (n)</b>	<b>% (n)</b>
Study Site	San Francisco	64.70 (11)	31.25 (5)	60.0 (9)
	New York City	35.29 (6)	68.75 (11)	40.0 (6)
Couple HIV Status	Concordant Negative	52.94 (9)	50.0 (8)	60.0 (9)
	Discordant	47.05 (8)	50.0 (8)	40.0 (6)
Relationship Length	M (Yrs)	6.64	3.49	3.78
	SD	8.58	5.67	5.11
	Range	6 mo-36 yrs	8 mo-20 yrs	6 mo-18 yrs

\*Based on ANOVA, no significant differences in mean relationship length by couple race.  $F(2, 47) = 1.07, p > .05$ .

**Table 2: Age Differences by Couple Race and HIV Status**

<i>Legend:</i>			
Mean; Std. Deviation; (Range)	White	Black	Interracial
HIV-negative	3.00; 3.25; (1 – 11)	2.38; 3.14; (0 – 10)	7.33; 9.36; (0 – 30)
HIV-discordant	6.25; 5.31; (0 – 14)	6.63; 8.87; (0 – 27)	11.33; 8.63; (1 – 25)

\*Based on ANOVA, no significant differences in mean age differences by couple race and HIV status.  $F(3, 47) = 2.58, p > .05$ .

**Table 3: Demographic Variables**

		White (n = 49)	Black (n = 47)
Participant Age	M (Yrs)	36.73	31.34
	SD	13.24	12.11
	Range	20-64	18-66
		<b>% (n)</b>	<b>% (n)</b>
Sexual Identity	Gay	97.96 (48)	78.72 (37)
	Bisexual	0 (0)	14.89 (7)
	Other	2.04 (1)	6.39 (3)
HIV Status	Positive	28.57 (14)	17.02 (8)
	Negative	71.42 (35)	82.98 (39)
Education	High School/GED or less	8.16(4)	42.55 (20)
	Some College	22.45 (11)	27.66 (13)
	Bachelors/AA	40.81 (20)	23.40 (11)
	Masters Degree	28.57 (14)	6.38 (3)
Employment	Employed Full Time	48.98 (24)	36.17 (17)
	Employed Part Time	14.29 (7)	17.02 (8)
	Unemployed	36.73 (18)	46.81 (22)
Income	<\$10,000	20.41 (10)	31.92 (15)
	\$10,000 – 19,999	14.29 (7)	17.02 (8)
	\$20,000 – 29,999	12.25 (6)	10.64 (5)
	\$30,000 – 39,999	14.29 (7)	14.89 (7)
	\$40,000 – 49,999	16.33 (8)	8.50 (4)
	\$50,000 – 59,999	0 (0)	0 (0)
	\$60,000 – 79,999	6.12 (3)	10.64 (5)
	\$80,000 – 99,999	8.16 (4)	4.26 (2)
	>\$100,000	8.16 (4)	2.13 (1)