African American Heterosexual Men’s Experiences of Emotionally and Sexually Intimate
Relationships with Women: Implications for Sexual HIV Risk and Protective Behaviors

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Dedications

This is dedicated to the memory of my friend, Dr. Shawn White, who conducted the majority of the interviews which I used for my dissertation. He was a hardworking man whose passion was to improve the health status of African American heterosexual men in Philadelphia. Your dedication to the REPRESENT study was exemplified in the conversations you had with these men.

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Table of Contents

LIST OF TABLES ...........................................................................................................viii
LIST OF FIGURES ......................................................................................................ix
ABSTRACT ......................................................................................................................x

CHAPTER 1: INTRODUCTION ......................................................................................1
   Background ...............................................................................................................1
   Literature Review .....................................................................................................2
   Study Goals ..............................................................................................................7
   Study Aims ...............................................................................................................7
   Operational Definitions ..........................................................................................7
   Summary of the Study ............................................................................................8
   Significance of the Study .......................................................................................9

CHAPTER 2: BACKGROUND AND LITERATURE REVIEW .....................................10
   HIV/AIDS among African American Men ..............................................................10
   Concurrent Sexual Partnerships ............................................................................12
   Relationship Context among African American Heterosexual Men .....................15
   Implications for African American Heterosexual Men’s Sexual Risk Behaviors ......18
   Implications for African American Heterosexual Men’s Protective Behaviors ......21
   Limits of Extant Literature ....................................................................................23
   Conceptual Framework .........................................................................................24
   Study Research Questions ....................................................................................25
CHAPTER 3: METHODS

Participants .................................................................................................................. 26
Recruitment strategies ............................................................................................... 26
Eligibility ..................................................................................................................... 27
Protection of human subjects .................................................................................... 27
Measures ..................................................................................................................... 27
Semi-structured interview .......................................................................................... 27
Procedures ................................................................................................................... 28
Analysis ....................................................................................................................... 28
Managing Interview Transcripts ................................................................................ 28
Coding ......................................................................................................................... 29
Open Coding ............................................................................................................... 29
Axial Coding .............................................................................................................. 29
Selective Coding ...................................................................................................... 30
Trustworthiness of Analysis ...................................................................................... 31

CHAPTER 4: RESULTS ............................................................................................... 34
Findings ....................................................................................................................... 35
Relationship Experiences Associated with Increased Sexual Risk ............................. 40
No Condom Use in Relationships Built on Trust ....................................................... 41
Trust ............................................................................................................................ 41
Trust and Length of Relationship with Main Sexual Partner(s) .................................. 44
No Condom Use with Partners Known for Significant Length of Time ..................... 45
No Condom Use in Relationships Developed Over Time and Involve Emotional Intimacy .......................................................... 47
Having Concurrent Sexual Partnerships………………………………………………50

Sexual Partner Concurrency…………………………………………………………50

Unprotected Sex with Multiple Partners in Concurrent Sexual Partnerships……51

No Condom Use during First Sex with Main Partners because of Low
Perception of Risk………………………………………………………………………55

Condom Use Symbolizes Infidelity………………………………………………….56

Relationship Experiences Associated with Protection against Sexual Risk……58

Having One Main Partner Only Protects against HIV/STIs………………………59

HIV/STI Testing in Committed Relationships……………………………………62

Condom Use with Casual Sexual Partners…………………………………………65

Condom Use with Casual Sexual Partners Only……………………………………65

Condom Use with Regular (Frequent) Casual Sexual Partners…………………..68

Condom Use with “Only Sex” Casual Sexual Partners…………………………69

Complying with Partner(s)’s Request/Demand to for Condom Use……………..71

Request by Partner(s) for Condom Use during First Sex………………………71

Request by Partner(s) for Condom Use throughout the Relationship……………72

Request by Partner(s) for Condom Use during Last Sex…………………………74

CHAPTER 5: DISCUSSION…………………………………………………………………78

Key Findings………………………………………………………………………………78

Key Findings that Address Relationship Experiences that May Increase Sexual
Risk…………………………………………………………………………………………78

Trust and Length of Association with Partner Influence Condom Use………..78

Concurrent Sexual Partnerships and Variant Condom Use across Main and
Casual Sexual Partners…………………………………………………………………80

Emotional Intimacy and Commitment Related to Non-Condom Use…………81
Key Findings that Address Relationship Experiences that May Protect Against Sexual Risk.................................................................83

Monogamy Regarded as HIV/STI Prevention........................................83

HIV/STI Screening with Committed Partner Viewed as Protective Behavior..................................................................................84

Partner Demand or Request for Condom Use Influenced by Infidelity or Change in Commitment Level.............................................85

Different Types of Casual Sexual Partners...........................................86

Limitations of the Study.......................................................................86

Secondary Analysis of Qualitative Data................................................86

Interview Guide Questions...................................................................87

Semi-structured Interviews..................................................................88

Relationship Experiences Based on Perception of Partners..................89

Conceptual Framework Implications....................................................90

Implications for HIV Prevention Research and Interventions...............92

Conclusion..........................................................................................94

BIBLIOGRAPHY.................................................................................95

Appendix A: Questionnaire.................................................................111

Appendix B: Phase I Interview Guide................................................116

Appendix C: Coding Matrix.................................................................124

Appendix D: Marital Status and Age of Participants............................126

Vita...................................................................................................128
List of Tables

Table 3.1 Demographic Characteristics of Interviewees…………………………..33

Table 4.1 Table of Key Themes Generated by Research Questions with Sample Quotes……………………………………………………………………………37
List of Figures

Figure 4.1 Model of Themes Associated with Increase in Sexual Risk…………………76

Figure 4.2 Model of Themes Associated with Protection against Sexual Risk…………77
Abstract

African American Heterosexual Men’s Experiences of Emotionally and Sexually Intimate Relationships with Women: Implications for Sexual HIV Risk and Protective Behaviors
Zupenda Malaika Imani Davis

Although HIV infection is relatively low among heterosexual men overall compared with other groups of men, HIV infection in heterosexual men is highest among African American heterosexual men. Research has demonstrated that intimate relationships with women among African American heterosexual men have influenced sexual risk behaviors, such as engaging in unprotected sex and having concurrent sexual partnerships; as well as protective behaviors, such as condom use. The Close Relationship Context was utilized to frame this study. This dissertation consisted of secondary data analysis of 30 semi-structured interviews conducted for the qualitative phase of REPRESENT, a mixed methods study conducted in Philadelphia (2007 – 2009). The REPRESENT study was conducted to examine the effects of gender role norms, sexual scripts and structural factors on sexual HIV risk behaviors of low-income African American heterosexual men who reside in Philadelphia. NVivo 10.0 software was used to code narratives stemming from the interviews relevant to sexually and emotionally intimate relationship experiences with women among this sample of men. The codes were subsequently refined to generate themes derived from the data. There were five dominant themes and two non-dominant themes related to relationship experiences that increased sexual risk, and four dominant themes related to relationship experiences protecting against sexual risk. Participants cited trust and length of relationship as reasons for non-condom use with main sexual partners, but cited length of association of sexual
partner as reasons for non-condom use with casual sexual partners. Participants cited relationships that have developed over time as reasons for non-condom use with both main and casual sexual partners. Participants identified monogamy and HIV/STI testing in committed relationships serving as protective sexual behaviors. They also cited that having sex with casual sexual partners and complying with partners’ requests and demands to use condoms as reasons to do so with their sexual partners.
CHAPTER 1: INTRODUCTION

Background

Currently, HIV is one of the 10 leading causes of death for African Americans (Centers for Disease Control and Prevention [CDC], 2010c). In 2009, African Americans comprised 14% of the United States population but accounted for 49% of all newly diagnosed AIDS cases (CDC, 2011c) and 44% of new HIV infections (CDC, 2011c). Since the early 1990s, the rates for new HIV infections among African Americans have remained relatively stable at high rates (CDC, 2010c). However, there was a 12% increase in estimated HIV diagnoses from 2005 to 2008 possibly stemming from an increase in HIV testing rates (CDC, 2010c). When compared to members of other races and ethnicities, African Americans comprised a higher proportion of cases from new infections to death (45% vs. 35% for Whites and 17% for Hispanics; CDC, 2008a, 2010c). In 2009, the overall rates of AIDS diagnoses among Blacks increased but were still higher than that of other races/ethnicities (CDC, 2011a). These rates were almost 2 times higher than that for Whites and almost 2.5 times higher than that for Latinos (CDC, 2011a).

African American men account for 39% and 35% of cumulative HIV and AIDS cases among men, respectively (CDC, 2010a, 2010b). Of these HIV and AIDS cases, heterosexual contact accounts for 13% and 11%, respectively (CDC, 2010a, 2010b). In 2009, Black men accounted for 70% of estimated new infections among Blacks (CDC, 2012). The new estimated HIV infection rates for Black men was more than 6.5 times

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1 Typically the term “Blacks” describes individuals who are African American, Afro-Caribbean, African-born, etc. For the purposes of this dissertation, “Blacks” will be used to represent “African Americans” only. Thus the terms “African American(s)” and “Black(s)” will be used interchangeably.
that of White men and 2.5 times that of Latino men or Black women. The primary mode of HIV transmission among Black men is sexual contact with other men (73%; CDC, 2012). Overall, the AIDS diagnosis rates for Black men are about eight times higher than those of White men (CDC, 2009).

In Philadelphia, African American men account for 44% of cumulative HIV/AIDS cases (Philadelphia Department of Public Health [PDPH], 2010). African American men account for 44% and 46% of the city’s newly diagnosed HIV and AIDS cases, respectively (PDPH, 2010). Of the city’s cumulative HIV/AIDS cases, 13% of African American men report heterosexual contact (PDPH, 2010). Of the city’s newly diagnosed HIV and AIDS cases, 20% and 19% African American men report heterosexual contact, respectively (PDPH, 2010).

**Literature Review**

Although these grim statistics exist, heterosexual men are almost virtually invisible in the HIV/AIDS social science literature (Bowleg & Raj, 2012; Raj & Bowleg, 2012). Most of the social science literature focuses on Black men who have sex with men or who are injection drug users (Bowleg & Raj, 2012; Raj & Bowleg, 2012). Focusing on both African American heterosexual men and women is equally important because of the emotionally and sexually intimate relationships that exist between them (Bowleg, 2004) and because HIV is more efficiently transmitted from males to females (Padian, Shiboski, Glass, & Vittinghoff, 1997). Historically, the lives of African American men and women have been linked (Bowleg, 2004) through shared experiences such as slavery, kinship, and relationships (Hecht, Jackson, & Ribeau, 2002; Waites, 2009). Many African American heterosexual men’s HIV risk behaviors (specifically
their injection drug use [IDU] and unprotected sex with multiple partners) influence the leading exposure categories for Black women’s HIV risk (CDC, 2010c). Higher efficiency of HIV transmission from male-to-female than female-to-male (Padian et al., 1997) explains why heterosexual transmission accounted for 85% of HIV cases among Black women but just 17% of HIV cases among Black men in 2009 (CDC, 2011c).

The aforementioned statistics dispel the myth that the rising HIV infection rates among Black women are caused by behaviorally bisexual Black men on the “down low” (Bond et al., 2009; Malebranche, 2003; Malebranche, Arriola, Jenkins, Dauria, & Patel, 2010; Millett, Malebranche, Mason, & Spikes, 2005). This implies that Black women are primarily infected with HIV by men who identify as heterosexual and were infected by having unprotected sex with other men. This assumption may promote a false sense of security among Black heterosexual men who may not perceive themselves to be at risk (Bowleg et al., 2011). Although there have been cases where bisexual Black men have infected African American women with HIV, the numbers reported are very small (2%; CDC, 2010d). Additionally, not all Black men who identify as being on the “down low” report having sex with women (Bond et al., 2009). Focusing more on Black heterosexual men in the context of HIV prevention efforts is crucial since HIV transmission from men to women is more efficient than from women to men (Glynn et al., 2001; Padian et al., 1997; Pettifor, Hudgens, Levandowski, Rees, & Cohen, 2007) and men, not women, are physically capable of wearing condoms (Bowleg & Raj, 2012; Wingood & DiClemente, 1998).

There are also higher prevalence rates of HIV in Black sexual networks, and African Americans tend to engage in sexual activities primarily with other African
Americans (Hallfors, Iritani, Miller, & Bauer, 2007). In light of research demonstrating that Black heterosexual men are more likely to have sex with Black women than women of other races/ethnicities, both Black men and women are more likely to encounter an infected partner due to the high prevalence of HIV in Black communities (Hallfors et al., 2007).

The gender ideology that men are socialized to have non-relational attitudes towards sex may influence African American heterosexual men’s sexual behavior with women (Bowleg et al., 2011; Carey, Senn, Seward, & Vanable, 2010; Corneille, Fife, Belgrave, & Sims, 2012; Corneille, Tademy, Reid, Belgrave, & Nasim, 2008; Epstein & Ward, 2007; Levant, 1997). However, there is a dearth of research focused on Black men’s relationships with women from the perspective of Black heterosexual men (Bowleg, 2004). Therefore it is important to examine the factors associated with Black heterosexual men’s relationship experiences with women and their reported sexual behaviors that may increase risk for HIV and other sexually transmitted infection (STI) risk for them and their sexual partners (Majors, 1989; Whitehead, 1997).

Historically, there has been an abundant social science literature about the role of intimate relationships in African American women’s lives and health, and the implications of intimate relationships on health from the perspective of African American women (Fullilove, Fullilove, Haynesa, & Grossa, February 1990; Kalichman, Williams, Cherry, Belcher, & Nachinson, 1998; Wingood & DiClemente, 1997). However, scholarly examinations of HIV from the perspective of African American heterosexual men are relatively rare (Gast & Peak, 2010; Ravenell, Whitaker, & Johnson, 2008; Sabo, 2000). One explanation for this oversight may be because the content of the literature
reflects the increasing rates of African American women acquiring HIV infection through high risk heterosexual sex (CDC, 2008b; Crepaz et al., 1999; El-Bassel, Gilbert, Witte, Wu, & Vinocur, 2010; Sobo, 1995; Stockman, Campbell, & Celentano, 2010). Another explanation may be because women, and not men, are socialized to be relational, and relationships are presumed to be more of a priority for women than men (Golden, 1996). African American women are contracting HIV primarily from infected heterosexual men. Therefore, it is imprudent not to focus on African American heterosexual men in HIV prevention research and practice (CDC, 2010c).

A significant part of the research on HIV and African American relationships focuses on issues related to relationship power (El-Bassel, Gilbert, Witte, Wu, & Vinocur, 2010; Pulerwitz, Gortmaker, & DeJong, 2000; Wingood & DiClemente, 1998), inequality in relationships (Amaro, 1995; Amaro & Raj, 2000; Sobo, 1995), and sexual coercion (Pulerwitz et al., 2000; Stockman et al., 2010). For example, women who experience violence or powerlessness in their relationships with men often face challenges negotiating safer sex behaviors such as condom use (Amaro, 1995; Amaro & Raj, 2000; Crepaz et al., 1999; El-Bassel, Gilbert, Witte, Wu, & Vinocur, 2010; Pulerwitz et al., 2000; Sobo, 1995; Stockman et al., 2010). Thus, HIV prevention-focused research has addressed these issues almost exclusively from the perspective of women, not men. (Amaro, 1995; Amaro & Raj, 2000; Crepaz et al., 1999; El-Bassel, Gilbert, Witte, Wu, & Vinocur, 2010; Pulerwitz et al., 2000; Sobo, 1995; Stockman et al., 2010). Considerable gaps exist about Black heterosexual men’s relationship experiences from the perspective of men, and how these experiences are associated with men’s HIV risk and protective behaviors (Bowleg, 2004).
HIV prevention research from women’s perspective documents that women are often at risk for HIV infection because of their male partners’ behaviors (Amaro, 1995; Amaro & Raj, 2000; El-Bassel, Gilbert, Witte, Wu, & Vinocur, 2010; Pulerwitz et al., 2000; Sobo, 1995; Stockman et al., 2010; Wingood & DiClemente, 1997, 1998; Wingood, Hunter-Gamble, & DiClemente, 1993). Moreover, HIV prevention research from women’s perspective implicitly makes women solely responsible for HIV prevention. It does not demonstrate men’s responsibility for HIV prevention, nor does it highlight intimate relationship dynamics that may increase Black heterosexual men’s risk for HIV (e.g., women partners who do not like to use condoms).

Research on masculinity ideology (Campbell, 1995; Levant & Majors, 1997; Levant, Majors, & Kelley, 1998; Noar & Morokoff, 2002; O'Sullivan, Hoffman, Harrison, & Dolezal, 2006; Pleck, Sonenstein, & Ku, 1993; Shearer, Hosterman, Gillen, & Lefkowitz, 2005) and gender attitudes in multi-ethnic heterosexual male adolescents (Pleck & O'Donnell, 2001) has demonstrated that there is a relationship between endorsing traditional male gender role norms and engaging in high risk sexual behaviors. Traditional male gender role norms dictate that it is normative for men to have non-relational, sex and that manhood is often defined as having multiple sex partners (Levant & Majors, 1997).

Therefore, research exploring African American heterosexual men’s intimate relationships from men’s perspective is necessary (Corbett, Dickson-Gómez, Hilario, & Weeks, 2009a). Understanding relationships and risk behaviors from Black heterosexual men’s perspectives may advance new knowledge about how their relationships with
women may be associated with their reported sexual behaviors that may increase their risk or protect them from HIV infection.

**Study Goals**

The study aimed to address gaps in the HIV prevention literature relevant to Black heterosexual men. Specifically, this study examined the relationship between African American heterosexual men’s experiences in emotionally and sexually intimate relationships with women and their reported sexual risk and protective behaviors. The study consisted of a secondary data analysis derived from qualitative individual interviews conducted with 30 self-identified African American heterosexual men who participated in the REPRESENT study. REPRESENT was a National Institutes of Health (NIH)-funded 3-year mixed methods study focused on the effects of structural factors, masculinity ideologies, sexual scripts and sexual risk behaviors for Black heterosexual men conducted in Philadelphia (2007 – 2009).

**Study Aims**

The overall aim of the study was to assess the implications of sexual risk and protective behaviors among a sample of African American heterosexual men through an examination of how African American heterosexual men’s experiences of emotionally and sexually intimate relationships with women are associated with their sexual HIV risk and protective behaviors.

**Operational Definitions**

The operational definition of intimate relationship used in the study is synonymous with that of a “close relationship” as defined by Castañeda (2000, p. 554). In this study of Latino heterosexual relationships in the context of HIV, Castañeda
researched two elements of a close relationship: intimacy (emotional closeness between partners), and commitment (stability of the relationship). For the study, I extended Castañeda’s definition of a close relationship as one consisting of intimacy and commitment, to include sexual as well as emotional intimacy. Throughout the dissertation, I use the terms “intimate relationship(s)” and “close relationship(s)” interchangeably to connote that intimate relationships include emotional and sexual intimacy and commitment. In this dissertation, I examined the levels of intimacy and commitment of relationships expressed by the African American heterosexual men of the parent study and implications for their reported sexual risk and protective behaviors in these relationships.

Summary of the Study

The goal of the study was to enhance the understanding of African American heterosexual men’s experiences of emotionally and sexually intimate relationships with women, and how these experiences may be associated with their reported protective and HIV risk behaviors. The study focused on sexual risk in the context of a relationship, and not just individual risk. The social science literature often highlights HIV risk as an element that is based solely on the behavior of an individual (Coker et al., 1994) without taking into much consideration the close relationship context (Castañeda, 2000; El-Bassel, Gilbert, Witte, Wu, Hunt, et al., 2010; El-Bassel, Gilbert, et al., 2011; El-Bassel et al., 2001; El-Bassel et al., 2003). A focus on relationships examines how intimacy and commitment in relationships are associated with engaging/negotiating safer sex behaviors (Castañeda, 2000). This focus also examined how love and trust in Black heterosexual
relationships may be associated with how Black heterosexual men engage and negotiate safer sex behaviors (Corbett et al., 2009a).

**Significance of the Study**

It is important for HIV researchers and prevention specialists to know how the intimate relationship context may be associated with Black heterosexual men’s sexual HIV risk and protective behaviors in order to develop effective interventions for this population. This study was poised to address critical gaps in the HIV prevention literature about how the intimate relationship context of a sample of Black heterosexual men’s lives is associated with their reported sexual HIV risk and protective behaviors. This study also sought to shape future interventions in order to improve African American men’s sexual health decisions (Ravenell et al., 2008; Sabo, 2000) by identifying and addressing barriers that African American heterosexual men may face when engaging in safer sex behaviors in the context of intimate relationships with women.
CHAPTER 2: BACKGROUND AND LITERATURE REVIEW

HIV/AIDS among African American Men

In 2009, African American men accounted for 70% of estimated new HIV infections among African Americans (CDC, 2012). The HIV incidence rate is higher among African American men than it is among other ethnic groups (the rate is more than 6.5 times that of White men and 2.5 times that of Latino men or African American women; CDC, 2012).

There are multifaceted factors associated with these grim statistics among African American men: low socioeconomic status (SES; Adimora, Schoenbach, & Doherty, 2006; Centers for Disease Control and Prevention, 2012); increased rates of sexually transmitted diseases (Adimora & Schoenbach, 2002; Doherty, Shiboski, Ellen, Adimora, & Padian, 2006; Koumans et al., 2001; Kraut-Becher & Aral, 2003; Lane, Rubin, & Keefe, 2004; Manhart, Aral, Holmes, & Foxman, 2002; Thomas, Levandowski, Isler, Torrone, & Wilson, 2008); injection drug use (Richardson, Myers, Bing, & Satz, 1997); high unemployment rates (Adimora & Schoenbach, 2002); partner concurrency (Adimora & Schoenbach, 2002; Adimora, Schoenbach, & Doherty, 2007; Adimora et al., 2003; Lane et al., 2004); and incarceration (Adimora & Schoenbach, 2002; Centers for Disease Control and Prevention, 2010e; Harawa, Greenland, Cochran, Cunningham, & Visscher, 2003; Lane et al., 2004).

A significant factor associated with the disproportionate rates of HIV among African Americans is the high prevalence of HIV in Black communities with low SES (Denning, DiNenno, & Wiegand, 2011). Even when sex and substance use patterns of Blacks were more normative (i.e., few partners and low use of alcohol, tobacco and other
drugs) than their White counterparts, the STI/HIV infection rates in Black communities were significantly higher because of the high concentration of HIV in their communities (Hallfors et al., 2007). Since there is a higher concentration of HIV in the African American population, members of this demographic group are exposed to this disease at a much higher rate than others (Adimora et al., 2007; Hallfors et al., 2007; Lane et al., 2004). Additionally, African Americans tend to date within their race so their chance of being exposed to someone infected with HIV is higher because they select their mates from a population that has a high concentration of HIV (Adimora et al., 2007; Hallfors et al., 2007; Lane et al., 2004).

For African American men, the primary modes of transmission are sex with men (CDC, 2012), injection drug use (IDU), and increasing evidence of high risk heterosexual contact (CDC, 2010c). Since the high risk behaviors of African American men are associated with the increasing rates of HIV infection in African American women, there is the need for more research focused on African American heterosexual men (Bowleg, 2004; Bowleg & Raj, 2012; Centers for Disease Control and Prevention, 2008b, 2010c).

Focusing on African American heterosexual men may advance new knowledge about aspects of their relationships with women that may be associated with their reported sexual risk and protective behaviors. Exploring Black heterosexual men’s perspective about their relationship experiences with women may also inform HIV prevention research and interventions about factors unique to Black heterosexual men, particularly those in intimate heterosexual relationships. More knowledge is needed on the barriers that Black heterosexual men may face when engaging in safer sex behaviors in the context of intimate relationships. This knowledge will help public health
practitioners to better target intimate relationship factors associated with African American heterosexual men engaging in high risk sexual behaviors.

In 2009, the CDC reported that more men were infected with HIV and diagnosed with AIDS due to heterosexual contact (followed by men who have sex with men [MSM]) than IDU or MSM and IDU combined (CDC, 2011a). HIV infection is relatively low among heterosexual men overall compared with other groups of men but HIV infection in heterosexual men is highest among African American heterosexual men (67% of new infections in 2009 vs. 18% and 15% in their Latino and White counterparts, respectively; CDC, 2011b).

HIV/AIDS rates for African American men in Philadelphia, the site of this study, mirror those nationally (PDPH, 2010). Black men who report heterosexual contact represent 13% of Philadelphia’s cumulative HIV/AIDS cases (N = 18,640); 20% of newly diagnosed HIV cases (N = 3,709); and 19% of newly diagnosed AIDS cases (N = 1982; PDPH, 2012).

These statistics demonstrate that HIV infection rates among Black men are increasing. Thus, there is a critical need for more HIV prevention research focused on Black heterosexual men, such as this study, to inform HIV prevention interventions addressing the needs of this population.

**Concurrent sexual partnerships.** Concurrent sexual partnerships are sexual partnerships that overlap in time (Morris & Kretzschmar, 1997). Traditional male gender role norms dictate that it is normative for men to have non-relational sex and that manhood is often defined as having multiple sex partners (Levant & Majors, 1997). An examination of data from four nationally representative surveys conducted with multi-
ethnic men and women ages 19 to 38 in the U. S. supported that concurrent sex partnerships may explain the disproportionate rates of HIV among African Americans (Morris, Kurth, Hamilton, Moody, & Wakefield, 2009).

The acceptance of concurrent sexual partnerships among many Black men may stem from the notion that having multiple sexual partners is normative (Bowleg et al., 2011; Carey et al., 2010; Darbes, Crepaz, Lyles, Kennedy, & Rutherford, 2008; McLellan-Lemal et al., 2012; Nunn, Dickman, et al., 2011). Qualitative research focused on Black heterosexual male STI clients further demonstrated that some Black heterosexual men felt that it is generally in a man’s nature to have multiple partners and that multiple partners fulfill different needs and make them feel like men (Carey et al., 2010). Additionally, these men often expressed that concurrent sexual partnerships are normative for men but not women.

Some theorists suggested that concurrent sexual partnerships among African Americans are linked to other sexual risk behaviors including having sex under the influence of drugs and alcohol, exchanging sex for money, and having a greater overall number of sexual partners (Adimora et al., 2007; Manhart et al., 2002). Concurrent sexual partnerships are also linked to HIV risk because individuals who engage in them often have sex with people who share the same networks (Hallfors et al., 2007). If there is a high prevalence of HIV in these networks, the likelihood of HIV transmission increases. Time frames are also key when discussing the concept of concurrent sexual partnerships (Kraut-Becher & Aral, 2003) and their link to HIV because the likelihood of HIV transmission between partners is contingent upon the timing of HIV infection and unprotected sex (Doherty, Schoenbach, & Adimora, 2009). HIV-positive individuals are
most infectious when newly infected because their viral loads are extremely high (Adimora et al., 2003; Ajzen, 1985; Morris & Kretzschmar, 1995, 1997).

Research has also documented that other factors linked to concurrent sexual partnerships among African American heterosexual men include the perceptions/suspicions of their partners’ sexual partner concurrent behavior (Paik, 2010), the proximity of partners’ residences (Gindi et al., 2011), and co-parenting concurrency (which involves engaging in sex intercourse with a co-parent while in another sexual partnership; Taylor et al., 2011).

Nationally, there is a low male-to-female sex ratio among African Americans suggesting that there are more Black women as compared to Black men (U. S. Census Bureau, 2005). Mays, Cochran and Zamudio (2004) hypothesized that disparities in HIV among African Americans are directly related to men having multiple sexual partners due to the low male-to-female ratio among African Americans in predominantly low, urban communities. However, a study by Senn and colleagues (2010), demonstrated no evidence that fewer African American men in a designated area was associated with having multiple sexual partners.

The study aimed to explore Black heterosexual men’s reported experiences in their intimate relationships with women. How Black heterosexual men express their experiences within concurrent sexual partnerships may be influential in informing HIV prevention researchers as they develop responsive strategies for Black men.
Relationship Context among African American Heterosexual Men

Research on concurrent sexual partnerships among men documented that concurrent sexual partnerships are higher among African American men (ages 20 to 38) than White men and men of other groups (Morris et al., 2009). A study on relationships in emerging adulthood among multi-ethnic populations demonstrated that 46% of the African American male respondents reported being less likely to commit to a single relationship because of the perceived low male-to-female ratio (Fishbein, 1995).

Quantitative research on heterosexual relationships has documented how African American heterosexual men’s intimate relationships with women increase or reduce condom use (Hock-Long et al., 2012; Walsh, Senn, Scott-Sheldon, Vanable, & Carey, 2012), discourage or encourage concurrent sexual partnerships (Kershaw, Arnold, Gordon, Magriples, & Niccolai, 2012), and improve or impair sexual communication (Kershaw et al., 2012). In a community venue-based study among African American and Puerto Rican males and females ages 18 to 25, condom use was higher with casual partners than with serious partners (Hock-Long et al., 2012). Condom use to avoid STI/pregnancy was the primary reason cited for condom use in casual relationships but pregnancy prevention alone was the primary reason given for serious relationships. Additionally, Walsh et al. (2012) documented that Black heterosexual men had a higher intention to use condoms consistently if they reported lower sexual risk behaviors after a sexual risk reduction intervention vis-a-vis their counterparts whose risk behavior did not change after said intervention.

Inconsistent or non-condom use among African American heterosexual men has also been linked to contraceptive status (i.e., use of a non-barrier contraceptive method)
and emotional intimacy with serious partners (Hock-Long et al., 2012); negative attitudes and efficacy towards condoms (Kershaw et al., 2012); maintaining high sexual risk behaviors (Walsh et al., 2012); and poor relationship functioning (Kershaw et al., 2012). Additionally, poor relationship functioning has also been linked to less intentions to be monogamous, more partner concurrency, and worse sex communication among African American heterosexual men (Kershaw et al., 2012).

These studies suggest that reasons for condom use and condom use frequency among Black heterosexual men was contingent upon their relationship status (casual vs. serious) and the stability of their relationships. These studies also underscore how relationships from men’s perspectives are an important, but under-researched aspect of HIV prevention for men.

There are additional studies that provide some insight on the relationship between intimate heterosexual relationships and HIV risk behaviors, but they are focused on primarily White (Agnew & Dove, 2011; Comer & Nemeroff, 2000; Mehrotra, Noar, Zimmerman, & Palmgreen, 2009; Vanderdrift, Lehmiller, & Kelly, 2012) or Latino (Warren, Harvey, & Agnew, 2012) heterosexual relationships or heterosexual women (Macaluso, Demanda, Artza, & Hook, 2000). It is important to note, however, that most of these studies suggest that individuals with a high level of commitment to their intimate relationships are more likely to have inconsistent or non-condom use (Macaluso et al., 2000; Vanderdrift et al., 2012).

Similarly, studies on risk perception of intimate partners have documented that individuals in committed relationships, tend to have a decreased perception of risk relative to their intimate partners (Agnew & Dove, 2011; Comer & Nemeroff, 2000),
were more specifically concerned about their casual partners (Mehrotra et al., 2009), especially relative to risk of pregnancy, followed by STIs, then HIV (Comer & Nemeroff, 2000).

Qualitative studies on African American heterosexual men’s intimate relationships have also suggested that there are various levels of casual and main/primary relationships (Corneille et al., 2008; Fishbein & Ajzen, 1975; Noar et al., 2012; Nunn, Dickman, et al., 2011). For example, various types of casual relationships have been expressed as one-night stands, that is, regular sexual relationships that are not committed or expected to be monogamous, or relationships involving a sexual and monetary/commodity exchange. Main/primary relationships have been expressed as committed/monogamous, but also as regular sexual relationships. They have also been defined as relationships in which a deep emotional connection is shared.

The research literature has also documented how African American heterosexual men view the lack of trust that exists between partners primarily due to the perception that multiple relationships are normative (Corneille et al., 2008; Fishbein & Ajzen, 1975; Krueger & Casey, 2009; Nunn, Dickman, et al., 2011; Tobin, German, Spikes, Patterson, & Latkin, 2011). For example, some African American heterosexual men exhibit unsafe sexual behaviors because of the pressure of cultural norms that relate manhood to non-relational sexual intercourse (Bowleg, 2004).

Another aspect of African American heterosexual relationships that has been studied is communication (verbal and nonverbal) about HIV/AIDS (Bowleg, Valera, Teti, & Tschann, 2010) and condoms (Bowleg et al., 2010; Noar, Carlyle, & Cole, 2006; Wingood et al., 1993). In a qualitative study of 27 Black men and women ages 22 to 50
focused on verbal and non-verbal communication about HIV/AIDS and condoms before first-time sex, more respondents reported communication about condom use than about HIV/AIDS (Bowleg et al., 2010). Women reported using verbal communication (i.e., requests and declarations) about condom use while men reported using non-verbal communication (i.e., presentation of condoms).

Some African American heterosexual men have described their relationships as involving their economic dependence on their intimate partner (Nunn, Dickman, et al., 2011). The aforementioned research denotes the importance of exploring how African American heterosexual men describe their experience of their intimate relationships with women to learn how these are associated with their reported protective and HIV sexual risk behaviors. This was an aim of this study.

**Implications for African American Heterosexual Men’s Sexual Risk Behaviors**

Perceived level of depth in a relationship appears to influence African American heterosexual men’s condom use and types of sexual behaviors. For example, Noar et al. (2012) reports an association of condom use with intimate relationship partner types among low-income African American heterosexual men. African American heterosexual men who participated in the study revealed that three intimate relationship partner types (one-night stands, regular “casual” partners and main partners) shaped their condom use and types of sexual behaviors. The study’s participants used condoms initially with their main partners but stopped doing so as trust and the relationship developed over time. Moreover, men reported having concurrent sexual partnerships as being normative, and that they used condoms primarily for pregnancy and STI prevention with their casual partners. Since the men perceived condom use in long-standing relationships as a sign of
infidelity, they felt that condom negotiation with casual partners was easier than with main partners. Additionally, the men felt that sexual experimentation (e.g., rough sex, anal sex) was reserved for casual partners and that making love and being emotionally intimate was more reserved for their main partners. The men also reported placing restrictions on oral sex, and only performed it with main partners since participating in that type of sexual behavior should be done only with a partner with whom there was an emotional connection. Men also discussed having a deep bond with women who are the mother of their children.

There are various factors that increase the risk of HIV among African American heterosexual men. Early introduction to sexual intercourse is associated with an increased risk of STIs. The age of onset of sexual intercourse among Black adolescent and adult males is significantly earlier than that of their White counterparts (Coker et al., 1994). In general, males are encouraged by other males and influenced by society to date and engage in sexual intercourse casually (Ballard & Morris, 1998; Ford & Norris, 1991; Pleck et al., 1993). This early onset of sexual intercourse is directly related to having more lifetime sexual partners as well as a higher number of current sexual partners (Dolcini et al., 1993; Smith et al., 2000). The combination of traditional masculinity ideology, ideological norms held by African American men, and media messaging may also influence African American heterosexual men’s sexual behaviors.

Research has also documented that African American heterosexual men who engage in risky sexual behaviors are more prone to have had an early debut of sexual intercourse than African American heterosexual men who delayed becoming sexually active (Levant, 1997; Levant & Majors, 1997; Levant et al., 1998). Black heterosexual
men, along with men who are young, less educated and unmarried, report that they live in communities where HIV rates were higher than average (Klepinger, Billy, Tanfer, & Grady, 1993). Although they reported that there is some risk for acquiring HIV infection in general, their risk perception about their own behaviors tends to be lower when examining their own personal risk (Bowleg, 2004; Thompson-Robinson et al., 2007). This lower perception of risk may be related to feeling unsusceptible to getting infected with HIV because they may feel that they do not fall under “high-risk” categories, including MSM, women and IDU (Bowleg et al., 2011; Flood, 2003). They may also be aware of the behaviors that put people at risk for HIV and may even engage in those same behaviors, but feel that the associated risk does not pertain to them because their sex partners are women, not men.

Research including African American heterosexual men has also documented that although the men generally are knowledgeable about HIV/AIDS and condom use, certain situations and their relationship status may influence whether or not they actually use condoms (Bazargan, Kelly, Stein, Husani, & Bazargan, 1997; J. A. Carter, McNair, Corbin, & Williams, 1999; Clark, Miller, Harrison, Kay, & Moore, 1996; Darbes et al., 2008). For example, Thompson-Robinson and colleagues (2007) found that some men recognize the importance of discontinuing engaging in sexual activities with women who are at risk for HIV. For example, African American heterosexual adult male respondents of several quantitative studies reported that inconsistent condom use was related to being more concerned about pregnancy prevention (in absence of non-barrier method) than STI/HIV prevention (Bazargan et al., 1997; J. A. Carter et al., 1999; Darbes et al., 2008; Flood, 2003; Ku et al., 1998); judgment impairment/lower inhibitions due to drugs and/or
alcohol use (Clark et al., 1996; Darbes et al., 2008; Rich, 2001; Thompson-Robinson et al., 2007); condom sensitivity (Flood, 2003; Thompson-Robinson et al., 2007); being in a monogamous relationship or in love (Flood, 2003; Thompson-Robinson et al., 2007) or being in the heat of the moment (Darbes et al., 2008; Flood, 2003; Thompson-Robinson et al., 2007). Theorists have also noted that inconsistent condom use among African American heterosexual men has also been linked to low perception of risk for HIV because they are heterosexual men (Flood, 2003), or because their partners are attractive symbolizing that they are not infected with an STI/HIV (Thompson-Robinson et al., 2007).

Sexual risk behaviors among African American heterosexual men have also been associated with relationship partner types (Darbes et al., 2008; Flood, 2003; Noar et al., 2012), masculinity ideologies (Ballard & Morris, 1998; J. A. Carter et al., 1999; Ford & Norris, 1991; Pleck et al., 1993), and risk perception for HIV (Bowleg, 2004; Bowleg et al., 2011; Clark et al., 1996; Flood, 2003; Thompson-Robinson et al., 2007). Building on these findings, this study assessed how African American heterosexual men’s experiences in their intimate relationships with women are associated with their reported sexual risk behaviors.

**Implications for African American Heterosexual Men’s Protective Behaviors**

Research studies have documented that African American heterosexual men report protective behaviors when engaging in sexual activities. For example, Black heterosexual men report the highest use of condoms among men across ethnic groups (Anderson, 2003; Anderson, Wilson, Doll, Jones, & Barker, 1999; Pleck et al., 1993), and that some Black heterosexual men use condoms for pregnancy prevention (when
engaging with main and casual sexual partnerships), as well as STI/HIV prevention in casual sexual partnerships (Corneille et al., 2008; Noar et al., 2012). Some Black heterosexual men expressed their desire to have children within the context of a stable relationship, and were concerned that an unplanned pregnancy would interfere with their future plans (Corneille et al., 2008). Others have acknowledged how drug and alcohol use can impair decision making about condom use (Corneille et al., 2008). Some Black heterosexual men engage in protective behaviors, such as non-verbal communication (i.e., presentation of condoms; Bowleg et al., 2010) and verbal communication (i.e., safer sex discussions with potential partners; Corneille et al., 2008) to reduce their sexual risk for HIV and STIs. Noar and others (2012) documented that some Black heterosexual men had less difficulty in condom negotiation with casual partners than main partners because they have more power in their casual intimate relationships.

These aforementioned studies would suggest that African American heterosexual men are capable and engage in protective behaviors associated with pregnancy and HIV/STI prevention, relationship type, and communication about safer sex among other factors. Therefore, it could be inferred that African American heterosexual men’s sexual decision-making is influenced, in part, by their intimate relationship experiences and interactions with their female sexual partners. Recognizing that intimate relationships play a crucial role in the engagement of not only sexual risk behaviors, but also in protective behaviors, influenced me to study and assess these in a cluster of African American heterosexual men in Philadelphia, PA, through the conduct of secondary analysis.
Limitations of Extant Literature

With regard to men’s intimate relationships and sexual HIV risk, at least three limitations appear to exist. First is that most of the empirical knowledge about men’s intimate relationships and risk is based on studies conducted with multi-ethnic male adolescents, not African American adult men (Pleck & O'Donnell, 2001; Pleck et al., 1993). Second, most of the social science research on African American heterosexual relationships and HIV is from the perspective of Black women, not Black men (Amaro, 1995; Amaro & Raj, 2000; Crepaz et al., 1999; El-Bassel, Gilbert, Witte, Wu, & Vinocur, 2010; Pulerwitz et al., 2000; Sobo, 1995; Stockman et al., 2010). Because women, and not men, are socialized to be relational and relationships are presumed to be a priority for women not men (Golden, 1996), it is no surprise that the Black male perspective of Black heterosexual relationships is scant in social science research. Third, HIV prevention research typically focuses on individual behavior without taking into consideration how the complexities of the relationship context (e.g., intimacy, commitment, HIV-related communication, partner’s reaction to suggested safer sex activities, and relationship maintenance) influence the individual’s sexual risk and protective behavior (Castañeda, 2000; Coker et al., 1994; El-Bassel, Gilbert, Witte, Wu, Hunt, et al., 2010; El-Bassel, Jemmott, et al., 2011; El-Bassel et al., 2001; El-Bassel et al., 2003). There is a dearth of research on adult men, African American heterosexual relationships from the perspective of Black men, and how the relationship context influences African American heterosexual men’s sexual risk and protective behavior.

In light of these gaps, this study assessed the implications of sexual risk and protective behaviors among a sample of African American heterosexual men in
Philadelphia. The study examined how African American heterosexual men’s experiences in their emotionally and sexually intimate relationships with women are associated with their sexual risk and protective behaviors.

**Conceptual Framework**

The Close Relationship Context (Castañeda, 2000) informed this study. The close relationship context comprises elements that exist at the relationship level and illustrate the nature of the relationship as perceived by participants. The close relationship context has been included in previous HIV-related risk behavior studies focused on close relationship factors, including power imbalance (El-Bassel, Gilbert, Witte, Wu, & Vinocur, 2010; Pulerwitz et al., 2000; Wingood & DiClemente, 1998), inequality in relationships (Amaro, 1995; Amaro & Raj, 2000; Sobo, 1995), trust (Pilkington, Kern, & Indest, 1994; Reisen & Poppen, 1995) and HIV-related communication (Bowleg et al., 2010).

Castañeda (2000) applied this social context to her research on Latino heterosexual relationships and HIV/AIDS risk reduction to explore the correlation between close relationship variables and HIV risk perception, condom use, and HIV-related communication. For this particular study, Castañeda (2000) focused on two elements of close relationships: intimacy, “the closeness between partners” (p. 554) and commitment, “the stability of the relationship” (p. 554).

This conceptual framework, with its HIV risk-specific emphasis on intimacy and commitment, appears to therefore serve as an appropriate theoretical foundation for this study’s focus on emotionally and sexually intimate relationship experiences with women among Black heterosexual men. While Castañeda (2000) researched emotional intimacy,
or closeness between partners, I have also included the element of sexual intimacy in my study. For the purpose of the study, I focused on two social constructs: intimacy and commitment. More specifically, I assessed how emotional and sexual intimacy and commitment among African American heterosexual men and their intimate relationships with women influence their protective and sexual risk behaviors.

**Study Research Questions**

I conducted this study to answer the following research questions:

1) What are the characteristics of emotionally and sexually intimate relationship experiences expressed by African American heterosexual men in this sample that may increase sexual risk?

2) What are the types of emotionally and sexually intimate relationship experiences expressed by African American heterosexual men in this sample that may protect against sexual risk?
CHAPTER 3: METHODS

This study consisted of secondary data analysis derived from 30 individual interviews, conducted as part of the qualitative phase of REPRESENT, a mixed methods study conducted in Philadelphia. The REPRESENT study, an R01 study funded by the National Institutes of Health, was led by Dr. Lisa Bowleg (Principal Investigator) to examine the effects of gender role norms, sexual scripts, and structural factors on sexual HIV risk behaviors of a cluster of low-income African American heterosexual men who reside in Philadelphia.

Participants

Participants were 30 self-identified African American heterosexual men who reported engaging in vaginal intercourse within the last two months. Participants’ ages ranged from 18 to 44 years (M = 31.47, SD = 8.41). The sample was predominantly lower income with a median income of $18,704; most had incomes below the median (62.9%, n = 17). Demographic characteristics of the participants are shown in Table 3.1. The demographic questionnaire (see Appendix A) included questions about HIV testing and HIV status. Nineteen of the 30 (63%) participants indicated that they had been tested for HIV. Almost three-quarters (73%, n = 22) of the participants reported being single, four indicated being married; two stated being engaged, and two noted being divorced.

Recruitment Strategies

Trained recruiters approached Black men from randomly selected venues (e.g., stores, barber shops, restaurants) in Philadelphia based on U.S. Census block sites with a Black population of at least 50%. The recruitment postcards invited Black/African American men to participate in a confidential study about the “health and sexual
experiences of Black men.” The postcards encouraged prospective participants to call a local telephone number, to undergo further screening to ensure that they met the study’s eligibility criteria.

**Eligibility**

To participate, respondents had to be male, self-identify as Black or African American and heterosexual, between the ages of 18 and 44, and have had heterosexual sex (i.e., vaginal or anal sex with a woman) within the last two months.

**Protection of Human Subjects**

The study’s sampling plan included interviews with a total of 30 participants. Participants received an informed consent form explaining the study and a $50 cash incentive, and after their participation, a resource sheet of local community-based medical, mental health and social services. The Drexel University’s Institutional Review Board approved all study procedures in 2008.

**Measures**

**Semi-structured interview.** The study’s interview guide (see Appendix B) included questions designed to elicit rich descriptions about respondents’ lives, their perceptions of societal expectations; intimate relationships; and condom use. The researchers asked specific questions about first and last sexual experiences, condom use and types of sexual activities. The semi-structured interview format allowed participants to answer questions freely and gave them flexibility to discuss other relevant topics. Sample interview questions included: “Tell me about the first time you and [partner’s name] had sex. What happened?” and “Did you use condoms the first time?.”
Procedures

Three trained interviewers, all Black men, conducted face-to-face, digitally-recorded individual interviews in Philadelphia, PA. Interviews ranged in length from 45 to 90 minutes, followed by completion of the questionnaire. Digitally-recorded interview data were professionally transcribed verbatim and edited to remove identifiers. The names of the participants were changed to maintain confidentiality.

Analysis

NVivo 10.0, a qualitative data analysis software package (QSR International, 2012) was used to code narratives relevant to intimate relationship experiences (e.g., emotional involvement), sex (e.g., types of sexual activity), sexual risk (e.g., unprotected sexual intercourse), and protective behaviors (e.g., consistent condom use). Coding these narratives helped me to assess the characteristics of emotionally and sexually intimate relationship experiences expressed by African American heterosexual men that increase and protect against sexual risk.

Managing Interview Transcripts. The transcribed interviews were imported into NVivo 10.0 for coding and analysis. Transcripts were reviewed multiple times to become intimately familiar with the data (Ulin, Robinson, & Tolley, 2005), while simultaneously writing my ideas (or impressions about the interviews) in memos as I read each transcript (Richards & Morse, 2007). I wrote memos about documents (one memo for each transcript) to keep all observations on one particular transcript in one place. I wrote a memo for each of the following themes: types/characteristics of relationships; emotional aspects of relationships; sexual aspects of relationships; sexual risk behaviors;
and protective behaviors. I also wrote memos about emerging ideas to record potential themes, or interesting ideas that emerged while reading the transcripts (Richards, 2007).

**Coding.** For the analysis, I utilized three types of coding: open coding, axial coding and selective coding (Strauss & Corbin, 1990). Open coding consists of identifying categories or concepts from narrative text (Strauss & Corbin, 1990). I utilized open coding to examine the characteristics of relationships (i.e., emotional and sexual), the types of relationships (e.g., sexual, financial, long-term), sex-related items (e.g., types of sexual activity), condom use, risky sexual behaviors, and protective behaviors that were described in the interview transcripts.

**Open coding.** For open coding I developed broad labels (“nodes” in NVivo) and assigned them to different portions of text (e.g., an entire paragraph, a few sentences, short phrases) that reflected key themes (e.g., relationships, sex). As coding progressed, I developed more refined hierarchical codes (“trees” in NVivo) which I branched out into descriptions of the hierarchical codes. For example, a sample “tree” hierarchical code, “condom use” included “branches” such as “communication,” “barriers,” and “facilitators.” The list of codes was then compiled into a final list of codes. I then utilized the final list of codes to code relevant text.

**Axial coding.** Axial coding consists of exploring how the categories and concepts are related and confirming that they accurately represent interview responses (Strauss & Corbin, 1990). For axial coding I examined the similarities and differences in emotional and sexual relationships, and how they were associated with HIV risk and protective behaviors.
**Selective coding.** Selective coding involves selecting a main category and then relating it to the other categories (Strauss & Corbin, 1990). With selective coding I examined the core category that provided the storyline, or participant narrative, of the data and other related categories that are centered on that storyline (Creswell, 2009). For example, my main category was “type of relationship” and other related categories included “trust,” and “partner known for a significant amount of time.”

During the coding process, I wrote copious notes and memos about how I arrived at the broad labels and hierarchical codes (Richards, 2007; Richards & Morse, 2007). I also developed coding matrices for data reduction (Ulin et al., 2005). The data reduction process involves condensing the data to make evident the most important concepts and relationships. One approach to data reduction is to develop a table, or matrix for each code which will allow for the identification of key phrases (from participant responses) and comparisons of these phrases. This process is very helpful in separating the data that is important to the study from that which is not.

I also wrote analytical notes and memos throughout all phases of coding to highlight key questions about relationships (relevant to my research questions) derived from the data (Richards, 2007; Richards & Morse, 2007). I then utilized the coding matrices, which highlighted codes per interviewee, to allow me to assess the depth and breadth of codes across the entire sample. This process is essential to distinguishing central and secondary themes.

After reviewing the codes, I integrated them into selective codes that addressed the two research questions used to organize this study (see Coding Matrix, Appendix C). This coding matrix highlights how the open codes were developed and refined to arrive at
selective codes, which I subsequently utilized to assess pre-set codes based on my research questions.

My analysis assessed the implications for HIV prevention for African American heterosexual men through an examination of their experiences in intimate relationships with women, and how those experiences are associated with African American heterosexual men’s protective and HIV risk behaviors. Lastly, I used modeling (Richards, 2007) to create a diagram that displays themes derived from the data (see Figure 4.1 and Figure 4.2).

Trustworthiness of analysis

My analysis demonstrated three criteria of trustworthiness: credibility, confirmability and transferability (Merrick, 1999). Credibility encompasses the use of methods to increase the likelihood that interpretations about the data are consistent with it (Merrick, 1999). For credibility, I used the technique known as prolonged engagement, (or investing sufficient time for persistent observation) to increase the likelihood that credible findings and interpretations will be produced (Merrick, 1999). My prolonged engagement with the data involved multiple reviews of the transcripts, approximately 4 months devoted to intensive coding, and revision of codes.

Additionally, I assessed for negative cases for my findings; tested rival explanations; and sought explanations for inconsistencies arising from triangulation of respondents, methods theories, or that found among researchers (Merrick, 1999; Patton, 1999). Lastly, I devoted approximately three months to the writing and revision of analyses to ensure that they reflected the experiences reported by all of the respondents.
Confirmability involves maintaining the distinction between my ideas and that of the interviewees (Ulin et al., 2005). To establish confirmability, I developed an audit trail describing methods, procedures, process of data collection and analyses, and conclusion of my research to ensure accuracy of my findings (Merrick, 1999; Richards & Morse, 2007). I have provided brief quotes from the sample of respondents in the Results section to give validation to assertions made about the data (Richards & Morse, 2007), and to support conclusions drawn (Richards, 2007).

Transferability is the process by which researchers can infer if their research findings are transferable to other populations (Ulin et al., 2005). For transferability, I assessed convergence and divergence of my research findings to determine whether conclusions drawn from my proposed research can be compared or contrasted (Richards, 2007; Richards & Morse, 2007) with other samples or theories relevant to the relationship context (Merrick, 1999). I also ensured that the data supported any conclusions drawn (Ulin et al., 2005). Additionally, I described the research context and the characteristics of the study participants so that others can decide how transferable the findings are to other contexts (Ulin et al., 2005).
<table>
<thead>
<tr>
<th>Characteristic</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
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<td></td>
</tr>
<tr>
<td>18 – 24</td>
<td>8</td>
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</tr>
<tr>
<td>25 – 34</td>
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<td>(30%)</td>
</tr>
<tr>
<td>35 – 44</td>
<td>13</td>
<td>(43%)</td>
</tr>
<tr>
<td><strong>Annual income range</strong></td>
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</tr>
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<td>Less than $9,999</td>
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</tr>
<tr>
<td>$10,000 to $19,999</td>
<td>2</td>
<td>(7%)</td>
</tr>
<tr>
<td>$20,000 to $39,999</td>
<td>5</td>
<td>(19%)</td>
</tr>
<tr>
<td>$40,000 to $59,999</td>
<td>5</td>
<td>(19%)</td>
</tr>
<tr>
<td><strong>Employment status</strong></td>
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<td></td>
</tr>
<tr>
<td>Work full-time</td>
<td>11</td>
<td>(37%)</td>
</tr>
<tr>
<td>Work part-time</td>
<td>2</td>
<td>(7%)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>16</td>
<td>(53%)</td>
</tr>
<tr>
<td>Disability</td>
<td>1</td>
<td>(3%)</td>
</tr>
<tr>
<td><strong>Highest level of education</strong></td>
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<td></td>
</tr>
<tr>
<td>Some high school</td>
<td>7</td>
<td>(23%)</td>
</tr>
<tr>
<td>High school graduate/GED</td>
<td>13</td>
<td>(43%)</td>
</tr>
<tr>
<td>Some college/professional</td>
<td>8</td>
<td>(27%)</td>
</tr>
<tr>
<td>Professional training</td>
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<td></td>
</tr>
<tr>
<td>College degree</td>
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<td>(3%)</td>
</tr>
<tr>
<td>Master’s degree</td>
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<td>(3%)</td>
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<td><strong>Marital status</strong></td>
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<tr>
<td>Engaged</td>
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<td>(7%)</td>
</tr>
<tr>
<td>Married</td>
<td>4</td>
<td>(13%)</td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
<td>(7%)</td>
</tr>
</tbody>
</table>
CHAPTER 4: RESULTS

I conducted a secondary data analysis of a cluster of African American heterosexual men in Philadelphia to explore the association of African American heterosexual men’s intimate relationships with women and the men’s reported protective and sexual risk behaviors. Subsequently, I selected quotes to illustrate my findings described below. This chapter provides a description of this study’s findings, accompanied by examples of the interviewees’ own words to support my conclusions.

All of the interviewees were asked if they had main and casual sexual partners. The marital status, age group and type of sexual partners (main and casual) of the interviewees are outlined in Appendix D. Interviewees were also asked to describe their experiences of the first and last time they had sex with their main (and casual) sexual partners. Eleven of the 30 interviewees reported that they had one main sexual partner only, and no casual sexual partners in the last six months. Nineteen of the 30 interviewees reported that they had one main sexual partner, and at least one casual sexual partner in the last six months. Although the interviewees were asked to specifically report sexual experiences with main and casual sexual partners that occurred during the last six months, approximately three interviewees provided additional information about their sexual experiences with sexual partners that were outside of the six-month timeframe. In my analysis, I included any information given that was relevant to my research questions. Whenever interviewees discussed experiences related to a partner who was outside of the six-month timeframe, I highlighted this stipulation in parentheses upon first mention of the partner’s name or associated experience.
Findings

The purpose of this study was to explore how Black heterosexual men’s sexually and emotionally intimate relationships with women are associated with their protective and sexual risk behaviors. Results derived from this dissertation addressed the two research questions guiding this study: 1) What are the characteristics of emotionally and sexually intimate relationship experiences expressed by African American heterosexual men in this sample that may increase sexual risk?; and 2) What are the types of emotionally and sexually intimate relationship experiences expressed by African American heterosexual men in this sample that may protect against sexual risk? When the selective coding was completed (out of the 22 initial open codes in which nine categories emerged; see Appendix C.), nine dominant themes and two non-dominant themes emerged. The dominant themes related to relationship experiences that increased sexual risk were: 1) No Condom Use in Relationships Built on Trust; 2) No Condom Use in Relationships Developed over Time and Involve Emotional Intimacy; 3) No Condom Use with Partners Known for Significant Amount of Time; 4) Having Concurrent Sexual Partnerships; and 5) Unprotected Sex with Multiple Partners in Concurrent Sexual Partnerships. Two non-dominant themes that emerged from the data were: 1) No Condom Use during First Time Sex with Main Partners because of Low Perception of Risk and 2) Condom Use Symbolizes Infidelity.

The dominant themes related to relationship experiences that appear to protect against sexual risk were: 1) Having One Main Partner Only Protects against HIV/STIs; 2) HIV/STI Testing in Committed Relationships; 3) Condom Use with Casual Sexual Partners; and 4) Complying with Partner(s)’s Request/Demand to Use Condoms. A
summary of these emergent themes with relevant interviewee quotes can be found in Table 4.1
Table 4.1

*Key Themes Generated by Research Questions with Sample Quotes*

**Q1. What are the characteristics of emotionally and sexually intimate relationship experiences expressed by African American heterosexual men in this sample that may increase sexual risk?**

<table>
<thead>
<tr>
<th>Category and descriptions</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>No condom use in relationships built on trust</td>
<td>7/30</td>
</tr>
<tr>
<td>No condom use in relationships built on trust</td>
<td>4/30</td>
</tr>
<tr>
<td>“I don’t know who she’s been with in that regard…but I trust. So that would be the really reason [to not use a condom]”</td>
<td></td>
</tr>
<tr>
<td>No condom use in relationships built on trust and length of relationship with main sexual partner</td>
<td>3/30</td>
</tr>
<tr>
<td>“I didn’t use a condom the last time…’cause we may have been together for like a year and I kind of trust her not being with nobody else.”</td>
<td></td>
</tr>
<tr>
<td>No condom use with partners known for a significant amount of time</td>
<td>4/30</td>
</tr>
<tr>
<td>“There’s people that have been…around my life for so long that I look at them [and] go past the thought of contracting a disease.”</td>
<td></td>
</tr>
<tr>
<td>No condom use in relationships developed over time and involve emotional intimacy</td>
<td>3/30</td>
</tr>
<tr>
<td>“…So we just decided one day like…well you want to try no condom one day…after that we always liked it.”</td>
<td></td>
</tr>
<tr>
<td>Having concurrent sexual partnerships (CSPs)</td>
<td>19/30</td>
</tr>
<tr>
<td>“She’s number one…and she’s] the go to…the jump off.”</td>
<td></td>
</tr>
<tr>
<td>Having unprotected sex with multiple partners in CSPs</td>
<td>6/30</td>
</tr>
<tr>
<td>“With the other partners, I become so habitually used to not using a condom with my main partner, to me, having sex doesn’t include using condoms.”</td>
<td></td>
</tr>
</tbody>
</table>
Table 4.1 (continued)

**Q1. What are the characteristics of emotionally and sexually intimate relationship experiences expressed by African American heterosexual men in this sample that may increase sexual risk?**

<table>
<thead>
<tr>
<th>Category and descriptions</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>No condom use first time having sex with main sexual partners because of low perception of risk</td>
<td>3/30</td>
</tr>
<tr>
<td>“I didn’t use a condom because of her age. And when I met her, she was messin’ with one dude. And—prior to that one dude, it was only another one.”</td>
<td></td>
</tr>
<tr>
<td>Condom use symbolizes infidelity</td>
<td>3/30</td>
</tr>
<tr>
<td>“Now she probably would look at me if I use a condom now, like, ‘You got somethin’ now? Who was you messin’ with?’”</td>
<td></td>
</tr>
</tbody>
</table>

**Q2. What are the types of emotionally and sexually intimate relationship experiences expressed by African American heterosexual men in this sample that may protect against sexual risk?**

<table>
<thead>
<tr>
<th>Category and descriptions</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having one main partner only protects against HIV/STIs</td>
<td>4/30</td>
</tr>
<tr>
<td>“I can go home an’ be happy, an’ I don’t have to worry about if I’m gonna have somethin’.”</td>
<td></td>
</tr>
<tr>
<td>HIV/STI testing in committed relationships</td>
<td>4/30</td>
</tr>
<tr>
<td>“When we found out that it was going to be something long term, I think that’s when we got comfortable with the point we going to go have the test done together.”</td>
<td></td>
</tr>
</tbody>
</table>
Table 4.1 (continued)

Q2. What are the types of emotionally and sexually intimate relationship experiences expressed by African American heterosexual men in this sample that may protect against sexual risk?

<table>
<thead>
<tr>
<th>Category and descriptions</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom use with casual sexual partners</td>
<td>10/30</td>
</tr>
<tr>
<td>Condom use with casual sexual partners only</td>
<td>3/30</td>
</tr>
<tr>
<td>“I use condoms [with] every girl I been with, 'cept that main jawn. She’s the only one.”</td>
<td></td>
</tr>
<tr>
<td>Condom use with regular (frequent) casual sexual partners</td>
<td>4*/30</td>
</tr>
<tr>
<td>“We seem to get together once every six months… I always make sure I have some protection.”</td>
<td></td>
</tr>
<tr>
<td>“Only sex” casual sexual partners</td>
<td>5*/30</td>
</tr>
<tr>
<td>“Yeah we did use condoms. We only did it one time. I was just hitting it.”</td>
<td></td>
</tr>
<tr>
<td>Complying with partner request/demand for condom use</td>
<td>18/30</td>
</tr>
<tr>
<td>Partner(s)’ request/demand for condom use first sex</td>
<td>13/30</td>
</tr>
<tr>
<td>“She said, ‘Cuz if you don’t have no condoms, we ain’t doin’ anything.’”</td>
<td></td>
</tr>
<tr>
<td>Request by partner(s) for condom use throughout relationship</td>
<td>3/30</td>
</tr>
<tr>
<td>“…she knows I’m out there doing something and she is going to demand that I wear a condom or she is not going to let me touch her until I do.”</td>
<td></td>
</tr>
<tr>
<td>Request by partner(s) for condom use last sex</td>
<td>3*/30</td>
</tr>
<tr>
<td>“We don’t know where each other been…since we not to go on the same tip that we was on before, let’s use these condoms.”</td>
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</table>
At the conclusion of this chapter, models that demonstrate how Black heterosexual men’s intimate relationship experiences may be associated with their protective and sexual risk behaviors are presented.

**Relationship Experiences Associated with Increased Sexual Risk**

According to the CDC, unprotected vaginal and anal sex are high sexual risk behaviors (2013b). The risk increases if unprotected sexual behavior takes place with a partner whose HIV/STI status is unknown, or if the partner is HIV positive or has an STI. The risk diminishes when the person is in a mutual monogamous relationship with a partner who is uninfected. Eleven interviewees reported being in monogamous relationships; 19 reported having casual sexual partners. Some of the men who reported to be in monogamous relationships and who also reported seeking STI screening with their main partners regarded this behavior as one that is protective in nature. Some of the men who reported to be in monogamous relationships did not indicate being screened for HIV/STI with their main sexual partners. For these men, along with others who reported having casual partners, unprotected sex is a sexual risk behavior.

Five prominent themes that appeared to emerge from the relationship experiences that increased sexual risk in this sample included: 1) No Condom Use in Relationships Built on Trust; 2) No Condom Use in Relationships Developed over Time; 3) No Condom Use with Casual Partners Known for Significant Amount of Time; 4) Having Concurrent Sexual Partnerships; and 5) Unprotected Sex with Multiple Partners in Concurrent Partnerships. On the other hand, two non-prominent themes were: 1) No Condom Use during First Time Sex with Main Partners because of Low Perception of Risk and 2) Condom Use Symbolizes Infidelity.
No Condom Use in Relationships Built on Trust. Seven interviewees indicated that trust in their main sexual partners was the primary reason they chose to engage in unprotected sex with them. Three of these seven interviewees indicated that in addition to trust, the length of time they have known their main sexual partners also influenced their decision to have unprotected sex with them. Therefore, when coding, I developed a subset of the trust theme to encompass the combination of trust and length of time the interviewees have known their sexual partners.

Trust. Four interviewees, Ronald, Corey, Steve and Donovan, indicated that trust in their main sexual partners alone was the primary reason they chose to engage in unprotected sex with their main sexual partners. Two of these four men, Ronald and Corey, who reported that they had a main sexual partner only in the last six months, discussed how they felt safe engaging in unprotected sex with their main sexual partners because they trusted them.

Ronald, a 27 year-old engaged man, explained that his reason for engaging in unprotected sex with his fiancée, Donna was mutual trust, as he stated “I trust her and she trusts me…at this point I don’t have any reason to think anything otherwise”.

Similarly, Corey, a 44 year-old single man, discussed that he also engaged in unprotected sex with Melody, his main sexual partner and girlfriend of three years, because he trusted her. He recognized that although he could never be too sure if Melody was having sex with other people, he still trusted her. Corey explained it in this way, “I don’t know who she’s been with in that regard. You never really know. But I trust. So that would be the really, really reason [to not use a condom].”
Two interviewees (Donovan, a 28 year-old single man, and Steve, a 23 year-old single man) who reported having both main and casual sexual partners, also discussed how trust in their sexual partners had influenced their decisions to engage in unprotected sex with them. Donovan discussed how trusting his sexual partners influenced his condom use when talking about his main sexual partner, Tamika, and one of his casual sexual partners, Debbie, when he stated, “If the relationship is good [presumably in good standing]…like I mentioned with the first two women [referring to Tamika and Debbie], that’s maybe the second time you may not use a condom because the dynamics are different. The trust level is different”.

The accounts from the four aforementioned men demonstrated how a man’s trust in his main (and casual) sexual partners can influence his decision to engage in unprotected sex with her (them). For Donovan, his experience with trust in his sexual partners also included one of his casual sexual partners and his trust was related to how good the relationship was.

Engaging in sexual risk behaviors influenced by trust can cause complex situations, as was the case for Steve, a 23 year-old single man, and his main sexual partner, Karen – his girlfriend of one year. Steve and Karen got tested for HIV/STIs prior to discontinuing condom use. At some point after they had stopped using condoms, Karen informed Steve that he had infected her with an STI which led to their breakup. Steve talked about their breakup and his feelings as he described the experience in this manner:

I feel she hurt me. She said I had burned her, I don’t think so but I mean she came over one day like, “I just came from the doctor. I’ve got chlamydia.” So I’m like,
“I ain’t fucking nobody else. If I did, I used a condom.” So we just wind up breaking up.

Steve described in greater detail how this incident affected his ability to trust others. He expressed that “it made me feel like I can’t really trust nobody. I still don’t trust nobody.” In addition to this experience affecting his trust for Karen, it also changed the dynamic of their relationship. Some time after they both got treated for chlamydia, Steve and Karen had sex again. When asked how his last time having sex with Karen differed from the first time he had sex with her, he described the difference as “the courtesy wasn’t there no more so we were like before we go our separate ways one last time.” Steve’s approach to sex during their last sexual encounter (which was protected by condom use) was different as well. He explained, “I really wasn’t into it. I mean it was all right but I wasn’t into it like I wasn’t giving it my all and so I just got my nut off…she got hers off…”

Steve’s account demonstrated how his trust in Karen influenced his decision to discontinue condom use with her, which resulted in him being blamed for infecting Karen with an STI. In turn, Steve’s STI diagnosis negatively impacted how he felt about Karen and his ability to trust her as well as future sexual partners. It is important to note that Steve reported that he also had two casual sexual partners (Latoya and Vanessa) during this time but he did not feel that he gave Karen chlamydia.

The accounts given by these four men demonstrated how trust-established relationships are associated with an increase in sexual risk behaviors, unprotected sex, more specifically. Steve’s account in particular demonstrated how engaging in
unprotected sex with a trusted partner could still result in an STI diagnosis, presumably because of his non-monogamy.

*Trust and length of relationship with main sexual partner(s).* Three interviewees reported that they did not use condoms with their main sexual partners because they trusted them, and had known their partners for a significant amount of time. Jamie, Roger and Marc discussed that trust in their main sexual partners and the length of time they had been in relationships with their respective main sexual partners were their reasons for not using a condom the last time they had sex with them.

The last time Jamie, a 42 year-old single man, had sex with his main sexual partner, Valerie, he noted, “I didn’t use a condom the last time…‘cause we may have been together for like a year and I kind of like trust her…not being with nobody else.”; and Roger, a 37 year-old married man, echoed Jamie’s sentiments, “‘cause, I trust her and that’s my wife. We’ve been together for 14 years,” when he talked about why he did not use condoms the last time he had sex with his wife, Yvette.

Similarly, when Marc, a 34 year-old single man, discussed his sexual experience with his main sexual partner, Stephanie, he stated that his reasons for not using condoms the last time they had sex was because “I know her. We’ve been together for eight years or more.” It is important to note that one factor that was common with these three accounts was in addition to the significant amount of time the men have known or dated their partners, they also indicated that they trusted them or knew them.

These three accounts indicated that trust, and the length of time the interviewees have known their main sexual partners were associated with their decisions to engage in unprotected sex with their partners. Jamie recognized that having unprotected sex with
Valerie was possibly putting him at risk for an STI or HIV, but his trust in her combined with him knowing her for a year influenced him to not use condoms the last time he had sex with her. Jamie indicated this by noting:

I should have still used [a condom] regardless, not knowing [for sure if she had sexual partnerships outside of their relationship], but she seemed like she was all right [was monogamous], seemed well or whatever. I’ve never had no kind of problems [suspicion or evidence of infidelity] with her since I’ve been dealing with her so I pray that everything was all right [regarding their relationship].

**No condom use with partners known for significant length of time.** In the previous section, I specified that the combination of trust and length of time that some of the interviewees knew their sexual partners was a subset of the trust theme. However, it seems important to note that the length of time that some of the men had known their main and casual sexual partners, irrespective of trust, was also associated with increased sexual HIV risk behaviors.

Four interviewees, who reported that they had casual sexual partners over the last six months, expressed that they did not use condoms with their casual sexual partners and that their non-condom use was associated with knowing their partners for a considerable length of time. Paul, a 33 year-old divorced man, explained that he had inconsistent condom use with Tonya, his casual sexual partner and ex-wife. He described the situation in this manner:

We got divorced [in] 2002; we didn’t have sex for a couple years after we got divorced. So after 2004, we would have sex every now an’ again. An’ there would
always be a condom. But I guess over the last nine months—we’ve only had sex six times. So, of those six times, we used condoms, like, four times.

When asked why Anthony, a 29 year-old single man, chose to have unprotected sex with two women, Linda and Kelly, with whom he had previously had sex (outside of the six-month timeframe), he responded, “It’s just that I’ve got to [meaning he had the opportunity to] know them for a long time.”

Karl, a 43 year-old single man, associated the length of time (30 years) he had known his casual sexual partner, Anita, with not using condoms with her the last time they had sex. He explained, “There’s people that have been in and around my life for so long that I look at them [and] go past the thought of contracting a disease.”

Dave, a 35 year-old single man, reported non-condom use during the last time he had sex with his casual sexual partner, Gina, whom he has known for 17 years. He explained it this way:

…she’s someone I have known for a long time, a very long time. Since—I’d say at least 17 years. So our relationship is very up front. It’s no hidin’ behind any bells or anything, so…with her and I, it’s like, if I wanna have sex, or if she wants to have sex, we just, just articulate…I don’t remember the details. I mean, it’s just a very smooth compliant experience on both parts...

Sean, a 37 year-old single man, reported non-condom use during the last time he had sex with his casual sexual partner, Zoe. Sean did not provide reasons for having unprotected sex the last time he had sex with her. Although he did not indicate that the length of time he knew Zoe was his reason for not using condoms with her, it seems important to note that Sean reported that he had known Zoe for 7 years.
These four accounts indicated that the length of time the interviewees knew their casual sexual partners was associated with their decisions to engage in unprotected sex with them. Conversely, two interviewees, Malcolm, a 30 year-old single man, and Greg, a 32 year-old single man, reported that they used condoms the first and last time they had sex with their respective casual sexual partners although they knew them for a significant amount of time. For example, Malcolm, who reported that he and his casual sexual partner, Michelle had been having sex for three years, indicated that he used condoms with her throughout their sexual relationship because of their open relationship. The first time he had sex with Michelle he explained his reasons for condom use as, “We fucking. I know you fuck with a lot of niggers and shit and I’m fucking with a lot of bitches, we got to be safe. Fuck that”.

The accounts from Paul, Anthony, Karl, and Dave demonstrated that some of the interviewees gauged their sexual partner’s risk for HIV/STIs by how well they knew their partners based on the length of time that they knew them, which influenced them to have unprotected sex with them. Meanwhile, Malcolm and Greg, who also indicated that they knew their casual sexual partners for a significant amount of time, reported condom use the first and last time they had sex with their respective casual sexual partners.

**No condom use in relationships developed over time and involve emotional intimacy.** Three interviewees reported that their reasons for having unprotected sex with their main sexual partners were due to both the developing time and emotional intimacy in the relationship. These themes allude to the comfort level the interviewees had with their main sexual partners, and how this comfort influenced their condom use with them.
Anthony, Steve, and Wayne discussed how their close relationships with their main partners influenced their decisions to engage in unprotected sex or discontinue condom use (Wayne only). Anthony, a 29 year-old single man, was asked if he had ever had unprotected sex where he pulled out before ejaculating with his main sexual partner, Faith. He stated that he did that with Faith “because the relationship was getting real close [meaning emotionally intimate].”

As Steve and Karen’s relationship became more emotionally intimate, they began to get curious about unprotected sex and wanted to see what it was like. Steve described, “We talked about it and she said she never did that before. So we just decided one day like…well you want to try no condom one day…after that we always liked it.”

Wayne, a 26 year-old single man, described that there was some emotional intimacy in his relationship with his main sexual partner, Nicole. Although Wayne reported that he used condoms the first and last time he had sex with Nicole, there were times that he and Nicole had unprotected sex. Wayne’s description of the intimacy in his relationship with Nicole was somewhat complex as it defined his feelings for her, which he did not believe were mutual. Wayne described that Nicole “might be the closest that can develop into that [referring to a deep bond].” He further explained, “I’m trying to get there with her because she’s attractive but I don’t think she feel the same way that I feel about her. We don’t have that thing that I can say somebody can be girlfriend and boyfriend.”

Anthony also discussed how his comfort level with one of his past sexual partners (outside of the six-month timeframe) was associated with his decision to not use condoms when having sex with her. He explained why he chose not to use condoms in this way:
And the other girl I met her in ’05 while I was dealing with my girl and we just got real cool like she knew about my girlfriend and everything and I knew about her and her baby father and everything…we just got so cool we just started going and having unprotected sex, oral sex, all that…almost every night.

Conversely, Donovan, a 28 year-old single man, when describing his experience with his casual sexual partner, Debbie, demonstrated an opposite trend where emotional intimacy in a relationship did not translate into unprotected sex. Donovan reported no condom use the first time he had sex with Debbie, but reported condom use the last time he had sex with her. When discussing what made their last sexual experience different from the first one, he talked about how their last sexual experience was much more meaningful than the first. He described it in the following manner:

That was…a lot of discussion…but we used condoms this time it was real. It was sex as society would like to call…love making. It was more on that tip…real passionate. Real deep, she said that she loved me and…so it was more so on that level…so it wasn’t no real wild and crazy sex but it was real passionate… it was a very passionate, slow sex that time…with a condom. And it was different from times before because of the exposure of her feelings for me.

It is important to note that when asked what made this last experience different that influenced Donovan to use condoms with Debbie, he discussed that he used a condom to protect her from his herpes infection.

Anthony and Steve reported emotional intimacy as a reason for discontinuing condom use with their respective main sexual partners, whereas Wayne described his close feelings for his main sexual partner, Nicole, but reported inconsistent condom use
(they used condoms primarily, however). These narratives could possibly suggest that the more the men felt mutual closeness in an intimate relationship, the greater the likelihood that it would influence them to discontinue condom use with their main sexual partners. Among the men who stated that feelings of emotional intimacy were one-sided and not reciprocal, it may have been more likely for them to use condoms inconsistently. On the other hand, Donovan’s account about his sexual relationship experience with Debbie may possibly speak more to feelings of emotional intimacy in the relationship and its association with characteristics of sexual activity than condom use.

**Having concurrent sexual partnerships.** I divided the theme of “having concurrent sexual partnerships” into two sub-themes: “sexual partner concurrency” and “unprotected sex with multiple partners within sexual concurrent partnerships.”

**Sexual partner concurrency.** As I indicated earlier, 19 interviewees reported having both main and casual sexual partners in the last six months. These interviewees also reported having between one to 20 casual sexual partners in the last six months, but did not provide information about their sexual experiences with all of them.

When asked how many sexual partners these interviewees had in the last six months, they all provided a number, specified if the sexual partners were their main or casual partners, and specific information about their sexual experiences with them. While discussing these experiences some of the men labeled their sexual partners to characterize the type of relationship that they had. For example, when asked how many sexual partners Donovan, a 26 year-old single man, had, he responded, “I have four sex partners. In the last six months. That’s including Tamika [main sexual partner], the second [Debbie, casual sexual partner] and the two strays [laughter].” Likewise, Wayne,
a 26 year-old single man, clarified whom his main and casual sexual partners were in the following way: “Yeah. She’s number one [referring to his main sexual partner, Nicole]” while Jamice, one of his casual sexual partners was “the go to…the jump off [a regular casual sexual partner].”

Two interviewees, who both reported having had one main sexual partner, discussed concurrent sexual partnerships as these related to their present monogamous relationships. Ronald, a 27 year-old engaged man, mentioned his concurrent sexual partnership experiences (outside of the six-month timeframe) that he had prior to meeting his fiancée, Donna. He explained, “Before I met her, man, I was just out there. I ain’t even going to lie; I was out there trying to tag everything I could tag. So I really can’t say I was just having sex with one person.” Conversely, Ricky, a 40-year old married man, talked about his desire of wanting to have sex with someone else besides his wife Monique. He explained:

I want to fuck somebody else. If I wanted to, I could be with someone else. I guess I really don’t want to…They know what I want to do, but I am afraid because things have been going okay. I don’t want the Devil to have his victory by me going outside of this relationship I’d say I’m committed to.

Donovan and Wayne’s accounts and labeling of their main and casual sexual partners suggest variant levels of emotional and sexual intimacy with their partners.

Unprotected sex with multiple partners in concurrent partnerships. Six interviewees, Paul, Sean, Karl, Donovan, Dave, and Steve reported that they had concurrent sexual partnerships in which they engaged in unprotected sex with more than one of their sexual partners in the last six months. Karl, a 43 year-old single man,
reported that he had approximately five (one main and four casual) sexual partners. When asked if he engaged in unprotected sex with all of his partners, he answered, “All except maybe two”. When asked what determined whether or not he used condoms with his sexual partners, he discussed the stability of two of his casual sexual partners as a factor in his decisions. He rationalized it in this fashion:

The stability. Are they stable? Like Anita…she lives with a man, so I would look at her as being a little more stable other than say Heather who doesn’t live with anyone, she lives with her mother but you know the streets are an option to her. With Heather, she don’t have an option of the streets because she is more or less with a man and her children. So I would say the chances of me contracting something…it’s greater with Heather and it’s lesser than Anita. It’s greater with Heather because she is in the street [referring to her being on crack cocaine and often leaving his house at very odd hours to be outside]. I could say out of maybe out of the ten times I’ve had sex with at least four I may have had protected sex with Heather.

Karl’s description of how his condom use was contingent upon his view of his partners’ stability indicated that his decision to use condoms was more related to the perceived sexual behaviors of his partners.

When asked why he did not use condoms, Dave, a 35 year-old single man, initially responded by discussing that his comfort level with his main sexual partner, Yolanda, had influenced him to engage in unprotected sex with her, “Well, with my main partner, it’s because I feel comfortable and safe not using a condom”. However, when Dave provided reasons why he engaged in unprotected sex with his casual sexual
partners, he contradicted his earlier statement bringing an interesting perspective about routine condom use and sex. Dave explained:

As crazy as it may seem, when you consider how many other women I’m not using condoms with. With the other partners, I become so habitually used to not using a condom with my main partner, to me, having sex doesn’t include using condoms.

These two accounts demonstrated how Karl and Dave’s relationship experiences within their concurrent sexual partnerships influenced them to engage in unprotected sex with more than one sexual partner.

Only one interviewee who reported having both main and casual sexual partners stated having more than five sexual partners in the last six months. When asked if he had any other casual sexual partners aside from his main sex partner Dionne and his casual sex partner, Juanita, Rasheed, an 18 year-old single man, revealed that, “Most o’ the partners I don’t even know their name. I had to have at least about 20 partners in the last six months. Most of ‘em been, like, one-night stands, or hit twice then I’m out with three.”

Rasheed discussed that he consistently used condoms when he had sex. He explained, “I always have condoms. Always went into the free condom people. Or I—get at somebody for a condom when I think the time is right. An’ if I don’t, you can get none [no sex from him].” When Rasheed was asked if he used condoms every time, he contradicted this statement when he answered, “If you have sex multiple times and get to know person there would be plenty of times where you might not use a condom.”

Although Rasheed provided condom use information specific to his main sexual partner
of 15 months, Dionne and his two casual sexual partners, Juanita and Blanca, he did not provide condom use information specific to each of his sexual partners. Therefore I was not able to assess his overall condom use during the six-month timeframe.

Rasheed reported that he did not use condoms the last time he had sex with Dionne, because the sex was unexpected. He also indicated that he used condoms the first and last time he had sex with Juanita. Meanwhile when discussing his sexual experiences with Blanca, he was uncertain if he used a condom the first time he had sex with her. He believed that he used one based on seeing a condom that was out the wrapper the next morning. He explained, “I know I put a condom on because I seen…the condom when we woke up”. When asked how many times he had sex that time he answered, “I guess once because I seen the one condom [outside of the wrapper] there”. When asked if there was a possibility that he had had sex without the condom, Rasheed demonstrated even more uncertainty as he answered, “I’m hopin’ that I didn’t. I don’t think so. It might be, but I don’t think so. ‘Cause at that time, oh well, she didn’t pop up pregnant or nothin’ like that.” Rasheed’s accounts of his sexual experiences with Dionne, Juanita and Blanca suggested variable condom use across partners because of various factors indirectly related to relationships (e.g., unexpected sex).

In Steve’s account about his casual sexual partner, Latoya, he reported that he had never used condoms with her because she was allergic to latex condoms. It is unclear if Steve contracted chlamydia from Latoya and infected Karen, or if Karen contracted chlamydia from someone else and infected Steve. What is known is that contracting an STI can occur from engaging in unprotected sex with an infected partner,
and uncertainty about whom is the source of the infection increases when engaging in unprotected sex with more than one person in a six-month timeframe.

The five aforementioned accounts suggest the variant condom use behavior that can exist in concurrent sexual partnerships, and how the complexity of relationship experiences influences condom use. Only one interviewee, Greg, a 32 year-old single man, reported that he had concurrent sexual partnerships but used condoms with his main and casual sexual partners the first and last time that he had had sex with them. Having concurrent sexual partnerships is a sexual risk behavior; having unprotected sex with multiple sexual partners within these concurrent sexual partners makes this sexual behavior even more risky.

No condom use first time having sex with main partners because of low perception of risk. Three interviewees, James, Trevor, and Ronald indicated that they engaged in unprotected sex the first time they had sex with their respective main sexual partners because of their low perception of risk for contracting HIV/STI from them. My analyses of James and Trevor’s narratives show that their low perception of risk was based on the lack of or limited sexual experience their partners had prior to the first time they had sex with them. Ronald’s low perception of risk for contracting an HIV/STI from a sexual partner (outside of the six-month timeframe), who was his main sexual partner at the time, was based on his knowledge of her having been tested for HIV.

James, an 18 year-old single man, reported that he had not used condoms the first time he had sex with his main partner, Portia, because she was a virgin. Although he thought that having unprotected sex was risky because he had a casual sexual partner at
the time, James decided to not use condoms because he said that he felt confident that neither he nor Portia had any STIs/HIV.

Trevor, a 36 year-old married man, reported that he had not used condoms the first time he had sex with his main partner, his wife, Jennifer, because of her age and sexual inexperience. He explained it this way:

I didn’t use a condom because of her age. And when I met her, she was messin’ with one dude. And—prior to that one dude, it was only another one. So I think that’s probably why I didn’t use a condom. And plus she had just turned 18 [presuming that her young age eliminates her risk for having an STI/HIV].

Ronald discussed why he did not use condoms the first time he had sex with his ex-wife, Marlene (a previous sexual partner who was outside of the six-month timeframe), who was his main sexual partner at the time. Ronald and Marlene were in the military together. He perceived his risk as low because she had just completed boot camp, which provided HIV/STI testing. He discussed the rationale for his perception of low risk for contracting HIV/STI as:

She just got out of boot camp. They just gave you an HIV test…and…you just got all of your blood work done up; complete physical, …so they did the works on you so I figure trust me, when I say if you had something in boot camp your ass was out of there or if you had something and they needed to give you some medication for it they’re going to give it to you. We definitely knew who had what [STIs].

**Condom use symbolizes infidelity.** Both Trevor, a 36 year-old married man, and James, an 18 year-old single man, reported that they did not use condoms the first nor the
last time they had sex with their main sexual partners. In the preceding section, I discussed that both did not use condoms the first time they had sex with their main sexual partners because of the sexual inexperience and age of their main sexual partners. When asked why they did not use condoms the last time they had sex with their main partners, Trevor and James discussed how introducing a condom to their main sexual partners would have indicated infidelity.

Trevor explained, “Because if she was doin’ anything else, with anybody else or if she felt as though I was doin’ somethin’ with somebody else she’ll say use a condom.” Similarly, James stated, “Because if the first time we didn’t use it, why now am I gonna use it? Now she probably would look at me if I use a condom now, like, ‘You got somethin’ now? Who was you messin’ with?’” In James’s explanation, he discussed how introducing a condom later on in the relationship may cause his main sexual partner to not only suspect that he was having sex with someone else, but also that maybe he had an STI.

Donovan, a 28 year-old single man, discussed the importance of using condoms when having sex with casual sexual partners for self-protection and to protect main sexual partners from an STI. He also discussed how doing so would avoid introducing a condom in a serious relationship, which may cause his main sexual partner to become suspicious. Donovan explained:

Because if you are in a serious relationship with your woman you know she’s going to say, “Why are you using that [condom]?” So you make sure that you stay protected…when you stepping out on your lady because you don’t want to bring nothing [STIs] home to her...
There appear to be several relationship factors that influenced most of the interviewees to engage in sexual risk behaviors, such as having concurrent sexual partnerships, and having unprotected sex with sexual partners. My research findings also highlighted relationship factors that influenced interviewees to participate in protective behaviors.

**Relationship Experiences Associated with Protection against Sexual Risk**

My second research question focused on the types of relationship experiences that protect against sexual risk. Generally sexual risk is defined as: unprotected vaginal, anal or oral sex with a partner or partners with unknown HIV/STI status or diagnosed HIV/STI (CDC, 2013a). Although unprotected oral sex is technically a sexual risk behavior, it poses the lowest risk for HIV/STI transmission (CDC, 2013a). In this study, I focused solely on unprotected vaginal and anal sex as sexual risk behaviors.

The types of relationship experiences that protected against sexual risk in this sample included those that influenced the interviewees to engage in safer sex activities, such as monogamy, abstinence if no condom was available, and condom use and STI/HIV screening. Some of these safer sex activities were reported across the various relationship types that were discussed: monogamous relationships, committed/long-term relationships, and casual sex relationships.

Some of the men mentioned these types of relationships when describing their sexual experiences with their main (and casual) sexual partners. Monogamous relationships were those characterized by the men having only one main sexual partner during the last six months. Committed/long-term relationships were relationships characterized by the men having an agreement with their partners to date and have sex,
but may not include sexual exclusivity. Casual sex relationships included those characterized by the men having primarily a sexually intimate relationship with their sexual partners. Some of these casual sex relationships had emotionally intimate and sexually intimate components.

Relationship experiences that increased protective behaviors in this sample were associated with HIV screening and variant condom use across relationship types. Four prominent themes of the relationship experiences that increased protective behavior in this sample were: 1) Having Only One Partner Protects against HIV/STIs; 2) HIV/STI Testing in Committed Relationships; 3) Condom Use with Casual Sexual Partners Only; and 4) Complying with Partner(s)’s Request/Demand for Condom Use.

**Having one main partner only protects against HIV/STIs.** The monogamous relationships in this sample were represented by the 11 interviewees who reported one main sexual partner only and no casual sexual partners in the last six months. Four interviewees who reported that they had only main sexual partners expressed that their monogamous relationships had protected them from sexual risk. When asked if they had any casual sexual partners, Kareem and Erik expressed that they currently had one sexual partner only and that this decision was based on wanting to be protected from contracting an STI/HIV. Kareem, a 35 year-old engaged man, talked about how having only one main sexual partner – his fiancée Renee – protected him being at risk for HIV/STIs. He explained:

There’s just been that one person. ‘Cause I believe once I’m dealin’ with one person, I’m not gonna multi-task. And I know I don’t like to really use condoms like that —so I’m not gonna put myself in jeopardy of bein’ in the heat of the
moment an’ be like, ‘Nah [no], I’m just gonna go straight at it.’ No. So, I’d rather have, just have one partner, an’ just do it like that.

Similarly, Erik, a 20 year-old single man, discussed that STI/HIV was the primary reason for not having any casual sexual partners and that he was “scared to do it to other girls cuz, the rate goin’ up rapidly with diseases”.

Two interviewees, Rob and Tommy, reported other ways in which monogamy protected them from HIV/STIs. Rob, a 40 year-old married man, explained that he stopped having sex with casual partners because of the risk of STI/HIV associated with having sex with them. Rob said that he had had a casual sexual partner over a year ago but had “stopped because it’s too dangerous out there. [Then, I] just wanted to be out there screwin.’ Not no more. [I] put all that to the side.” Tommy, a 38 year-old married man, described a situation when two women propositioned him to have sex with them while they were at a picnic. He declined the proposition and told the women, “No, I’m not goin’.” He also acknowledged that he was protected from HIV/STIs by his being faithful to his wife, Bernice and told the women, “…I can go home an’ be happy, an’ I don’t have to worry about if I’m gonna have somethin’ [STI].”

Kareem, Erik, Rob, and Tommy demonstrated that their decision to either stop having sex with casual sexual partners, or not have casual sexual partners at all was associated with decreasing their risk from contracting an STI/HIV. For these four men, reporting having had one main sexual partner only in the last six months appears to have been associated with being protected against HIV/STI because they were not having sex with casual sexual partners.
One interviewee, Zack, a 43 year-old single man, who also reported having one main sexual partner only in the last six months, disclosed that his partner of six years, Raquel, was HIV-positive. For Zack, his monogamous (but not committed) relationship with Raquel was not associated with being protected against HIV/STI. Because of Raquel’s HIV diagnosis, Zack was at an increased risk for contracting HIV. Although Zack was aware of Raquel’s HIV diagnosis, there were times that he engaged in unprotected sex with her. When asked how he felt after he had unprotected sex with Raquel, Zack seemed to be uncertain about his experience the first time he had unprotected sex with her. On one hand, he was excited about how it would feel to have sex with Raquel without a condom. Zack recounted, “I was lustfully wanting to see what she felt like without wearing one of them condoms and I wanted to…see what it really felt like.” On the other hand, he was somewhat regretful because he realized that he put himself at risk for contracting HIV, and acknowledged that he needed to engage in safer sex activities if he was going to have sex with Raquel. He stated, “…I can’t be having Russian roulette like that…if this is what I want to do I know there are precautions need to be involved in this. This ain’t no game you know, this is something serious.”

Zack’s account of having unprotected sex with Raquel suggested his ambivalence with wanting to be sexually intimate with her without using a condom, while acknowledging that he was putting himself at risk for contracting HIV. He also said that he had thought about how being infected with HIV could impact him and his family long term. He realized that if he was going to be in a relationship with Raquel, he needed to make sure that he took the necessary precautions to protect himself from contracting HIV.
The noted interviewees discussed in this section associated having one main sexual partner only with some level of protection from contracting HIV/STIs. Conversely, having one main sexual partner only who is HIV-positive diminishes this protective factor. It is important to note however that this protective factor presumably existed with the four interviewees since I did not know their HIV/STI status, or that of their main sexual partners. I will discuss this in more detail in my Discussion section.

**HIV/STI testing in committed relationships.** Four interviewees discussed how the significance of the relationships they had with their main sexual partners had influenced them to get tested for HIV/STIs with their sexual partners. Three of the four men, Ronald, Steve and Paul, reported that they waited to get tested prior to discontinuing condom use with their main sexual partners.

Ronald, a 27 year-old engaged man, reported that he did not use condoms the last time he had sex with his fiancée Donna. He explained that their commitment prompted them to get screened for HIV/STIs (prior to this last time) as:

I think that must have been at a point when we kind of got the inkling that we were actually going to be dealing with each other, like seriously like that. When we found out that it was going to be something long term, I think that’s when we got comfortable with the point we going to go have the test done together and if we’re going to be together, we might as well know [our HIV status].

Ronald further explained that he had used condoms until they got tested. He stated, “If she’s my girl and we been together for four years…definitely we went together…got tested…until it’s safe…you both know it’s safe. No? That thing [condom]
is coming on, I’m not going out that way [having sex without a condom prior to knowing HIV status].”

When Ronald discussed his former relationship with his ex-wife, Marlene, he talked about how he used condoms to prevent both HIV/STI infection and pregnancy. He explained:

We rarely used condoms; the only time we probably used a condom is like if she was off of birth control or something or like she’s afraid she must have missed a pill or something like that...We were all in the medical field so...once she began working in the hospital, we were always being checked for Hepatitis or HIV or Herpes or stuff like that.

Steve, a 23 year-old single man and Paul, a 33 year-old divorced man, both responded affirmatively to getting tested for HIV/STIs with their main sexual partners (Karen and Violet, respectively) before discontinuing condom use.

Lastly, although Rasheed, an 18 year-old man, did not report getting tested for HIV/STIs with his main sexual partner, Dionne, he described his past experiences with partners (outside of the six-month timeframe) where they got tested together as:

…in the past, we went down to the free clinic an’ got checked for HIV. It’s even a time went I took a girl to my—we had the same pediatrician [he was younger than 18 at the time]. We got the same appointment on the same day. An’ they allowed us to view our test results with each other. ‘Cause, well, we had to say that we were in a relationship.

In addition to getting screened for HIV/STIs to determine it was safe to have sex without using a condom with their main sexual partners, two of the interviewees,
Malcolm and Tommy, discussed regular HIV/STI screening with their respective main sexual partners.

Malcolm, a 30 year-old single man, reported that he and his main sexual partner, Felicia, got screened for HIV/STIs regularly, but separately. He expressed, “I go to the clinic every three months and get my body checked out. And the one thing that I can say about her, she get her shit checked out so I know that there ain’t nothing coming [no STI infection from her] back.”

Tommy, a 38 year-old married man, noted that he and his wife Bernice chose to discontinue condoms after the condom broke during the first time they had sex. Tommy recounted the conversation he had with Bernice as, “An’ then, after the condom broke, she said, ‘Well, it already did it. So now we don’t have to use ‘em anymore.’ So we both keep our doctors’ appointment—every six months [possibly implying HIV/STI testing].”

Ronald, Steve and Paul said that they regarded HIV/STI testing with their sexual partners as a way to assess disease status but also as a prevention mechanism. They wanted to discontinue condom use but wanted to ensure the safety of themselves and their partners by getting tested first. Malcolm discussed regular screening as his method of disease prevention. Whether the men got tested for HIV/STI with their partners together or separately, they recognized the importance of testing for HIV/STI as a means for disease prevention.

It is important to note here that although HIV/STI screening is a protective behavior, the men often discussed that after being screened with their partners they discontinued condom use. So, in essence, the protective behavior of HIV/STI screening
did not appear to reduce risk behaviors, such as engaging in unprotected sex. This limitation will be discussed in more detail in my Discussion section.

In addition to engaging in protective behaviors with main sexual partners, some of the interviewees discussed how relationship experiences they had with their casual sexual partners influenced them to engage in protective behaviors, such as condom use, which I will discuss in the next section.

**Condom use with casual sexual partners.** Ten interviewees who reported having casual sexual partners in the last six months indicated that they used condoms when having sex with them. The stated prominent reason for condom use with casual sexual partners was because they were unaware of their sexual partners’ HIV or STI status. Other reasons given included protecting themselves and their sexual main partners from contracting HIV or an STI infection, as well as concealing their infidelity from their main sexual partners. I classified the sub-categories under this theme as: 1) condom use with casual sexual partners only; 2) condom use with regular (frequent) casual sexual partners; and 3) condom use with “only sex” sexual partners (no emotional attachment and only one sex encounter).

**Condom use with casual sexual partners only.** Three interviewees, Marc, Tony, and Malcolm, indicated that although they had unprotected sex with their main sexual partners, they used condoms when having sex with their casual sexual partners.

Marc, a 34-year old single man, reported that he did not use condoms with his main sexual partner, Stephanie, but used them with his casual sexual partners, Leslie and Koren, for disease prevention. He expressed, “I always use a condom, other than with my
main girl. With my casual partners, I don’t know exactly who they’d be with, or they got anything. I don’t know too much about ‘em, so it’s better safe than sorry.”

Tony echoed Marc’s sentiments when he stated, “I use condoms [with] every girl I been with, ‘cept that main jawn. She’s the only one [I use condoms with].”

When Malcolm, a 30 year-old single man, was asked about his condom use with his main sexual partner, Felicia, and that of his casual sexual partners, he explained that he did not use condoms with Felicia “Cause that’s my bitch, that’s my girl”. He further explained that he used condoms with his casual sexual partners to ensure that he does not transmit an STI to his main sexual partner: “Like the women that I do be fucking with around on the side. Yeah, I use rubbers for them. I don’t bring no trouble [STIs] home.” He also discussed how using condoms with his casual sexual partner, Michelle, helps “more so to keep things on the low [conceal his infidelity].”

Dave, a 35 year-old single man, talked about how his feeling of safety is the primary reason why he had unprotected sex with his main sexual partner, Yolanda. He explained, “Well, with my main partner, it’s because I feel comfortable and safe not using a condom.” Unlike Marc, Tony, and Malcolm, who reported engaging in unprotected sex with their main sexual partners but used condoms with their casual sexual partners, Dave reported that he also engaged in unprotected sex with his casual sexual partners as well, which contradicted his earlier statement. He explained,

As crazy as it may seem, when you consider how many other women I’m not using condoms with. With the other partners, I become so habitually used to not using a condom with my main partner, to me, having sex doesn’t include using condoms.
Dave further explained that he used condoms with some of his casual sexual partners, and how he engaged in oral sex as sexual risk reduction strategy.

He noted:

I do use condoms with some of them periodically. Or, with them, a lot of the times, it’s just strictly oral. And, for whatever reason in my head, oral places you at less risk when you’re being intimate, than dealin’ with someone anally or, um, vaginally.

Donovan, a 26 year-old single man, reported that he did not use a condom the last time he had sex with his main sexual partner, Tamika but used one the last time he had sex with his casual sexual partner, Debbie. In addition to trust, he noted that his variability in condom use across partners was also associated with the disclosure of his herpes diagnosis to his sexual partners. Donovan indicated that disclosing his herpes diagnosis to his sexual partners was difficult. He disclosed to Tamika because she is a medical doctor and knows her risk for contracting an STI infection. He explained that although Tamika understood her risk, her perception should not have justified their decision to have unprotected sex. He noted, “…so, it doesn’t make it right but she’s well aware of if she doesn’t want a condom…she’s well aware of what she’s doing [having unprotected sex although she knows she is at some risk for an STI infection].”

When asked what made Donovan use condoms the last time he had sex with Debbie, his casual sexual partner, he explained, “What made the difference is, I don’t want to put anyone body…in harm’s way, so that was more…so for the reason…of me getting the condom.”
So although Donovan did not explicitly state that he used condoms only with his casual sexual partners, I thought it was important to note that he reported variable condom use across his sexual partners and how his condom use was associated with his disclosure of his STI status.

**Condom use with regular (frequent) casual sexual partners.** Four interviewees, Greg, Rasheed, Malcolm, and Paul, described their sexual relationships with their casual sexual partners as experiences that occurred regularly, or frequently. Greg, Rasheed and Malcolm reported that they used condoms the last time they had sex with their respective regular casual sexual partners. When reflecting on the most recent time Greg, a 32 year-old single man, had had sex with his casual sexual partner, Imani – his children’s mother, he discussed that the last time he had sex with her was, “About six months ago. We seem to get together once every six months, somethin’ like that. Might be longer than that. But, on average, once every six months.” When asked if he had used condoms the last time he had sex with Imani, Greg answered, “And, right before we did it, I always make sure I have some protection.”

Rasheed, an 18 year-old single man, indicated that his relationship with his casual sexual partner, Juanita, was a regular casual sex relationship. He explained that, “We had sex, like, on occasions.” When asked if he used a condom the last time he had sex with Juanita, Rasheed answered, “Yeah. It’s an automatic must. It’s like a mutual agreement on both parts.”

Malcolm, a 30 year-old single man, reported that he had four sexual partners (one main and three casual). When asked if any of the three (outside of his main sexual partner) were regular sex partners, Malcolm answered:
“Regular come throughs? When I want them to be, or when they want me to be. I mean like they smut [use me for sexual gratification] me too, I ain’t gonna front like they ain’t smut me too. The way I be smutting, they be smutting me. That mean they just call me when they want to fuck.”

Malcolm reported condom use with his regular casual sexual partner, Michelle.

Although Paul, a 33 year-old divorced man, used the word “exclusive” to describe his relationship with his main sexual partner, Violet, he soon contradicted the definition of this and disclosed his regular casual sex partnership with Tonya, his ex-wife. Paul remarked, “An’ since this the only person I been with, we been exclusive with each other. Except for when I had sex with my ex-wife.” Paul reported inconsistent condom use with Tonya and noted, “I guess over the last maybe nine months—I mean we’ve only had sex…really six times in, like, the last nine months. Not even. Like, in the last year. So, of those six times, we used condoms, like, four times.”

Paul’s account suggested that Tonya was his regular casual sexual partner, but it did not reflect the same theme of consistently using condoms with casual sexual partners that was present in the accounts provided by Greg, Rasheed and Malcolm.

**Condom use with “only sex” casual sexual partners.** Five interviewees reported that they had “only sex” casual sexual partners. These “only sex” casual sexual partners included those with whom the interviewees had only one sexual encounter. These five interviewees, Steve, Sean, Marc, James and Donovan reported using condoms with their respective casual sexual partners, with whom they only had sex with once. As Steve, a 23 year-old single man, discussed his sexual experience with his casual sexual partner, Vanessa, he mentioned, “Yeah we did use condoms. We only did it one time. I was just
Sean, a 37 year-old single man, echoed Steve’s sentiments as he discussed his sexual experience with his casual sexual partner, Kia:

I pulled a condom out, she got on top o’ me, an’ now, I see her. She calls me still. It’s been like about six months ago. She wants some more [to have sex again]. I ain’t gettin’ myself in between that [having sex with her again]. I did it once an’ that was it for that.

Similarly, Marc, a 34 year-old single man, discussed that his relationships with his two casual sexual partners, Leslie and Koren, were sexual only and that he had sex with them only once. He described his first (and only) time having sex with Leslie as, “She already knew what I was comin’ for. She was already naked. Came in, took my clothes off, put the condom on, an’ we had sex. It was straight sex. That was my only time with her.” Marc used condoms the first (and only) time he had sex with Koren and described his sexual encounter (and relationship) with her as, “An’ we already knew what it was [laughing], so basically—it’s always about sex. With my main jawn, that’s like my girl, but anybody else I deal with is strictly sex.”

When asked at what point in his relationships he decided to not use condoms, Donovan, a 26 year-old single man, explained that he discontinued condom use when his main relationship was good [presumably in good standing] but would continue condom use if his sexual partner was casual. He noted, “The interaction is just different. With my little hood honey it might be just sex. Maybe a movie here and there but the other women are something that you have a little more interest in.”

There were three other interviewees (Lamont, Wayne and Anthony) who reported having sex once with a casual sexual partner because the opportunity to have sex with
them again did not happen by the time they were interviewed for this study. Lamont, a 23 year-old single man, reported that he and Tyra had sex only one time because the opportunity to have sex again did not happen by the time of the interview. Wayne, a 26 year-old single man, reported that he had sex with Dee Dee once only because his first time having sex with her was very recent. Anthony reported that he had sex with Bridget once only, and that they did not have a recent time when they had sex. He did not give a reason, however.

One relationship factor that just one of the interviewees reported centered on the exchange of sex for money. When Wayne described his first (and only) sexual experience with his other casual sexual partner, Dee Dee, he also mentioned her request for money. He explained that Dee Dee, a tenant in the apartment building that he owned, would often ask him for money. When Dee Dee asked him for $100, he stated that he would give it to her if she had sex with him. After coming to an agreement, she requested a condom and they had protected sex. He illustrated this money/sex exchange in detail:

I’m like, “Man, I ain’t got no hundred dollars.” She’s like, “Um well you ain’t getting no cock.” I’m like, “Come on…I got you any way. Let me get some of that.” She was like, “Yeah all right.” She’s like, “You got condoms?” I’m like, “Yeah.”

**Complying with partner(s)’s request/demand for condom use.** Complying with partners’ request or demand for condom use is a factor that 18 interviewees said had influenced their decision to use condoms with their partners. Some of the partners’ condom use requests were made during the first time they had sex, some throughout the relationship, and some during the last time they had sex.
Request by partner(s) for condom use during first sex. Thirteen interviewees reported that their sexual partners requested that they use condoms the first time they had sex with them. Two of these interviewees, Paul and Tommy, reported that their sexual partners demanded that they use condoms the first time they had sex with them. For example, Paul, a 33 year-old divorced man, described the first time he had sex with his casual sexual partner, Tonya (his ex-wife). He discussed how Tonya was adamant about him using condoms, and that she would not have sex with him unless they used condoms. He noted Tonya’s demand for condoms as, “’Cause if you don’t have no condoms, we ain’t doin’ anything’.”

Similarly, Tommy, a 34 year-old married man, discussed that his wife, Bernice, requested condom use during the first time they had sex. Tommy’s account demonstrated that she requested condoms at various times: before they were physical, closer to the time they were going to have sex and then again right before the first time they had sex. Tommy described what happened as, “Well, she’d say, ‘Well, when it do happen, let’s be patient. We gonna use a condom.’” During the morning they were going to have sex for the first time, Tommy explained that Bernice requested a condom again, “Well, she said, ‘Did you bring some up? Because I have some in the drawer’.” Right before they had sex she reinforced condom use again. Tommy noted, “An’ then she just—she felt aroun’ because I had the condoms on the side. An’ she passed it in my hands. ‘So, are you ready?’ she said.”

Request by partner(s) for condom use throughout the relationship. Three interviewees, Karl, Zack and Trevor, discussed their sexual partners’ requests for condom use throughout the relationship. For Karl and Trevor, this request was based on their main
sexual partners’ knowledge/suspicion of their infidelity. For Zack, his main sexual partner’s request was associated with preventing him from becoming infected with HIV.

When asked how his main sexual partner, Crystal, felt about not using condoms throughout their relationship, Karl, a 43 year-olds single man, explained that she had occasionally demanded condom use when she suspected that he was being unfaithful.

He stated:

Well, she knows what type of person I am. Sometimes when she feels that I been in the street a lot, she demands that I wear a condom. But, if she sees me around the house a lot and doing what I am supposed to do, working and lounging and doing housework and stuff like that, she’ll be all right with it. If I’m out that late, she knows I’m out there doing something and she is going to demand that I wear a condom or she is not going to let me touch her until I do.

Karl also discussed condom use demands from his casual sexual partner, Anita, who was also aware that he had multiple sexual partners. Anita’s demand for condom use was for Karl to use condoms with his other casual sexual partners but not her.

Karl explained:

Well she knows I have a lot of sexual partners and she demands it; she doesn’t really say anything about a condom. She tells me more so about other people that I mess with that I need to wear condoms more so than herself, ‘well, you better start using condoms fucking all them girls’ is what she will say as opposed to, ‘you better use one with me.’ She will tell me I need to use them with them, fucking them, than with her.
Karl’s account about Crystal’s condom request was based on her suspicion of his infidelity. This suspicion appeared to be based on past experiences in her relationship with Karl. His account about Anita’s condom request was based on Anita’s knowledge of his other sexual partners. Her demand for condoms was unique in that it was not for Karl to use condoms with her per se, but with his other sexual partners.

**Request by partner(s) for condom use during last sex.** Three interviewees, Tony, Paul, and Wayne, reported that their sexual partners requested condoms the last time they had sex with them. Tony, a 22 year-old single man, discussed how changes in his relationship (from the first time they had sex to the last time they had sex) with his main sexual partner, Wanda, was associated with his decision to use condoms with her the last time they had sex. Tony reported that they no longer had a boyfriend/girlfriend relationship established but that they were still having sex. He explained how Wanda’s request for condom use had influenced his decision to use condoms. He described the situation as:

…we definitely use condoms now because we know we not in that type relationship together. So, we use condoms for sure. Well the first time we talked about usin’ condoms, cuz we didn’t use condoms for two and a half years, almost. But we, we had separated for a minute, an’ then when we hooked back up, we was like, “We don’t know where each other been, but—I’m sure we clean, but, you know, just, just since we not to go on the same tip that we was on before, let’s use these condoms.” She brought it up to me.

Paul, a 33 year-old divorced man, reported that his casual sexual partner, Juanita, had requested he use a condom the last time they had sex. He admitted that he penetrated
her first without a condom prior to her request. Paul stated that even after Juanita’s request for a condom, he had tried to convince her that they did not need to use one. He reported that they did use a condom, however. Paul detailed the incident as:

I’m not even going to lie, I slipped up. I put it in for a few strokes without a condom. Then that’s when she said, ‘Get the condom out right here.’ So, I said you don’t even need that condom over there.

Wayne, a 26 year-old single man, reported that his casual sexual partner, Nicole, requested a condom the last time they had sex. He said that he had agreed that they should use condoms because he had suspected that she may have been having sex with some of the men that she often bragged about to him.

Karl, a 43 year-old single man, provided a unique perspective regarding relationship factors and condom use. His knowledge about his casual sexual partners and their sexual partners, played a role in his decision to use condoms when having sex with them. He described that their perceived stability, defined by their living situations and relationships with their partners, influenced his decisions to use condoms with them.

Eighteen interviewees reported that their sexual partners requested or demanded condom use during the course of their relationships. The timing of these requests/demands differed according to the dynamics of the relationship experiences with both the main and casual sexual partners. These relationship experiences included first sex; knowledge/suspicion of infidelity; partners’ awareness of other casual sexual partners; change in relationship status (from committed to uncommitted, but still sexual); and perceived stability of casual sexual partners.
Figure 4.1: Model of Themes Associated with Increase in Sexual Risk
Figure 4.2 Model of Themes Associated with Protection against Sexual Risk
CHAPTER 5: DISCUSSION

My dissertation examined emotionally and sexually intimate relationship experiences with women and their implications for protective and sexual risk behaviors among a sample of 30 African American heterosexual men.

Key Findings

Key findings addressing relationship experiences associated with increased sexual risk. This study highlighted three key findings that address emotionally and sexually intimate relationship experiences, as expressed by African American heterosexual men in this sample that may increase sexual risk. These key findings are summarized below.

Trust and length of association with partners influence condom use. The majority of interviewees cited trust as their reason for engaging in unprotected sex with their main sexual partners and, in some cases, their casual sexual partners as well. This finding mirrored that of other HIV prevention research suggesting non-condom use with main sexual partners was related to partner trust among young African American and Puerto Rican heterosexual men (Hock-Long et al., 2012); the level of trust in the relationship among African American heterosexual men (Corneille et al., 2008) and, more specifically, trust and being in a monogamous relationship among Australian men ages 18-26 (Flood, 2003).

Additionally, interviewees cited the length of their relationships with their main sexual partners, and length of association with their casual partners as reasons for non-condom use. This length of relationship finding was similar to that reported in a qualitative study conducted by Corneille and colleagues (2008) suggesting that
relationship status influenced African American heterosexual men’s decision not to use condoms. One of the most interesting findings in my study was that the men reported having had emotionally intimate relationships with their casual sexual partners and, in some instances, knew their casual sexual partners better than their main sexual partners. Although some of the interviewees reported that they had been with their main sexual partners from six to 14 years, many of the men had known their casual sexual partners for the same amount of time and at times even longer. Such was the case for Karl who knew his casual sexual partner, Anita for 30 years, and Dave who knew his casual sexual partner, Gina for 17 years. In contrast, a study among 123 male STI clinic patients demonstrated that the proportion of men who knew their main partner for at least a year was significantly higher than the proportion who knew their side partner for that length of time (Lansky, Thomas, & Earp, 1998).

Some of the interviewees reported that their first time sexual encounters with their casual sexual partners occurred prior to that of their main sexual partners, or prior to meeting their main sexual partners. Interviewees cited that they had past emotionally intimate relationships with their casual sexual partners who were ex-wives, ex-girlfriends or the mother of their children. Others were neighbors, friends, or women with whom they had regular platonic encounters that eventually became sexual encounters. This finding is similar to what Noar and colleagues (2012) found in their study on partner types among African American heterosexual men. These specific partners would fall under what they consider regular casual partners, where interactions are primarily devoted to sex. However, in my study, these sex-focused interactions did not always
translate into condom use as has been reported in other research (Chatterjee, Hosain, & Williams, 2006; Corneille et al., 2008; Hock-Long et al., 2012; Noar et al., 2012).

Interviewees cited length of association with partner only as a reason for non-condom use with their casual sexual partners, but cited trust and length of association as reasons for non-condom use with their main sexual partners. It appears that having familiarity and comfort with these casual sexual partners influenced their perceptions of their casual sexual partners to not have any risk for HIV/STIs. The findings of a study on partner-specific relationship characteristics among young people with STIs (Katz, Fortenberry, Zimet, Blythe, & Orr, 2000) are also consistent with my own. This infers that not all men perceive their sexual relationships with casual sex partners as riskier than with their main partners as respondents reported in a qualitative study about concurrent partnerships among African American heterosexual men in Philadelphia (Nunn, Dickman, et al., 2011). Another possible explanation for this low-risk perception relative to their casual sexual partners is that for interviewees whose casual sexual partners had a main sexual partner, the fact that they were in a committed relationship seemed to reduce the potential for risk for HIV/STI transmission possibly because these men may see their partners’ risk similar to their own (Harman, O’Grady, & Wilson, 2009).

**Concurrent sexual partnerships and variant condom use across main and casual sexual partners.** Most of the interviewees reported that they had casual sexual partners as well as main sexual partners in the last six months. Although some reported variant condom use with their partners (i.e., condom use with casual sexual partners only), their risk for HIV transmission is increased because of their engagement in concurrent sexual partnerships. The six-month timeframe and spacing of multiple sexual
partners within this timeframe promotes increased HIV transmission risks more than having numerous serial monogamous sexual partnerships (Adimora & Schoenbach, 2005). Reports of engaging in unprotected sex with main sexual partners, but using condoms with casual sexual partners may suggest that the interviewees believe that their casual sexual partners are more risky than their main sexual partners. This finding is consistent with that of other studies of African American heterosexual men (Chatterjee et al., 2006; Corneille et al., 2008; Nunn, Dickman, et al., 2011), and findings derived from a study of African American and Puerto Rican males and females ages 18 to 25 (Hock-Long et al., 2012) where condom use was reported to be higher with casual partners than with serious partners. Some interviewees, for example, Malcolm cited STI/HIV protection for themselves and their main sexual partners and concealing their infidelity from their main sexual partners as reasons for condom use with their casual sexual partners. However, for some of the interviewees who discussed having had unprotected sex with multiple partners within their concurrent sexual partnerships, it appears that they do not believe that their casual sexual partners are risky because of other aforementioned factors, such as length of association with partner.

*Emotional intimacy and commitment related to non-condom use.* Some interviewees cited trust as their reason for non-condom use. Although non-condom use is a sexual risk behavior, it is important to note that not all unprotected sex is risky. For example, if a mutual monogamous couple comprises two HIV/STI-negative people, then their unprotected sex is not risky at all.

Interviewees also cited relationships that developed over time and involved emotional intimacy as their reason for non-condom use. This finding suggests that as
sexual relationships mature, condom use declines (Crosby, Yarber, & Meyerson, 2000; Ku, Sonenstein, & Pleck, 1994; Manning, Flanigan, Giordano, & Longmore, 2009).

It appears that mutual emotional intimacy influenced discontinued condom use whereas non-reciprocal emotional intimacy influenced inconsistent condom use, as was the case with Wayne and his main sexual partner, Nicole, who was not his girlfriend.

My findings suggest that commitment within main sexual partnerships also influenced non-condom use with main sexual partners in this sample. This was demonstrated by interviewees who discussed that introducing a condom in a serious relationship would have indicated infidelity. Other research has demonstrated that negotiating condom use with main partners is extremely difficult, and that asking a main partner to use a condom has a negative impact on the relationship (Noar et al., 2012). Since interviewees cited that condom use in main sexual partnerships symbolizes infidelity, it can be inferred that unprotected sex symbolizes fidelity and possibly commitment to the relationship for the men in this sample. This was demonstrated by Tony’s account which highlighted condom initiation by Wanda during last sex because although their relationship involved sexual intimacy, it no longer had the same element of emotional intimacy or commitment that existed when their relationship had a boyfriend/girlfriend status. Because condom initiation in relationships where the couple never used condoms or discontinued condom use after some time in their relationships symbolizes infidelity, men like Trevor and James, may have decided to engage in unprotected sex with their main sexual partners to avoid jeopardizing their relationships for being accused of being unfaithful or having an STI as a result of being unfaithful.
However, commitment in relationships does not always translate to monogamy, and partner expectations may differ. For example, Steve’s hurt feelings influenced his ability to trust Karen (and others) when she blamed him for her chlamydia infection. I have a few possible explanations for Steve’s mistrust. One possibility could be that Steve thought that Karen was being unfaithful to their relationship and contracted an STI as a result of her infidelity. In this hypothetical scenario Steve’s mistrust of Karen may be associated with her presumed infidelity, or her presumed infidelity coupled with bringing an STI to their relationship. In this particular proposed circumstance, it appears that there is a double standard since he noted having casual sexual partners, one of whom he never used condoms with. This may suggest that Steve believes that it is normative for men to have concurrent sexual partnerships but that it is unacceptable for women to do so. Another possible reason for Steve’s mistrust is because Karen did not trust that he was being faithful to the relationship. Although Steve was not monogamous and had casual sexual partners, he appeared that he wanted to be committed in his relationship with Karen.

**Key findings that address relationship experiences associated with protection against sexual risk.** My dissertation highlighted four key findings that address emotionally and sexually intimate relationship experiences expressed by African American heterosexual men in this sample that may protect against sexual risk. These key findings are outlined below.

*Monogamy regarded as HIV/STI prevention.* Interviewees cited HIV/STI infection as a motivation for having one sex partner only. Although some of the interviewees chose to have one main sexual partner only in order to decrease their risk for
HIV/STIs, this protective factor presumably exists with these interviewees because I do not know their HIV/STI status or that of their main sexual partners. It is important to note that having one partner only does not guarantee no risk for HIV/STI infection for these men particularly if their main sexual partner is not monogamous or is already infected with HIV as was the case with Zack whose main sexual partner, Raquel, was HIV-positive. His contrasting account demonstrated how having one sexual partner only who is infected with HIV significantly increased his risk for infection especially since he reported that he had had unprotected sex with her. This finding mirrors that of a study among 28 African American men, ages 18-35 that indicated that these men did not perceive themselves at risk in monogamous relationships (Corneille et al., 2008).

Although monogamy can be effective in reducing/eliminating HIV/STI risk, being in a mutual monogamous relationship where neither person in the dyad is infected with HIV or an STI reduces this risk significantly.

**HIV/STI screening with committed partners viewed as protective behavior.**

HIV/STI testing in couples is regarded as a protective behavior as demonstrated by Ronald, Steve and Paul who waited to get tested prior to discontinuing condom use with their main sexual partners. This finding is similar to what was found in a study of 25 high-risk heterosexual couples where HIV testing in monogamous relationships was a reason given for not using condoms (Corbett, Dickson-Gómez, Hilario, & Weeks, 2009b). It is also in accord with findings of an ethnographic study of African American and Puerto Rican adults ages 18-25 that indicated that participants utilized HIV/STI screening to establish trust and baseline STI/HIV of their partners and also to make the transition from protected sex to having sex without a condom (Abraham, Macauda,
Although getting tested to know one’s HIV/STI status is important in STI prevention, this protective behavior does not reduce risk behaviors, such as engaging in unprotected sex. HIV/STI testing is a prevention method that aids in reducing transmission because it comprises STI diagnosis and treatment (if infected), but does not prevent future infections, especially if condoms are not being used. Therefore, interpreting HIV/STI screening with committed partners as a protective behavior is a limitation. This limitation was demonstrated in Steve’s narrative about his relationship with Karen. They got tested together prior to discontinuing condoms, and an STI diagnosis in their relationship caused their one-year relationship to end. This example suggests that generally HIV/STI screening is not necessarily useful in reducing risk behaviors; it is more of a method of documenting that the men and their sexual partners do not have any diseases at the time of testing.

Some interviewees discussed regular testing for HIV/STIs within their relationships with their main sexual partners as protective behaviors. This was the case with Tommy and his wife Bernice, and Malcolm and his main sexual partner Felicia. Continued testing (every six months) is not a prevention strategy because it is serving more as a check-up particularly because it does not reduce risk behaviors. Their accounts seem to indicate that their regular testing is more of a strategy to determine if risk behaviors, such as engaging in unprotected sex with their main sexual partners, have resulted in an HIV/STI infection.

*Partner demand or request for condom use influenced by infidelity or change in commitment level.* For interviewees who reported condom use demands from their main sexual partners throughout their relationships, it appears that these may not only suggest
their desire for disease prevention, but also may symbolize their disapproval of the infidelity or suspicion of infidelity. For example, Crystal’s demands for condom use based on her suspicion of Karl’s infidelity suggested that. I presume that this particular account emphasizes that when Karl’s behavior (i.e., being more around the house) is more acceptable to Crystal, she is fine with having sex unprotected.

Some interviewees cited a partner’s request for condom use due to change in commitment level of relationship as motivation to use condoms. It appears that once the relationship status changed from one of commitment to one of being just friends, it impacted the emotional intimacy but not the sexual intimacy. This was demonstrated by Tony and Wanda who continued to have a sexual relationship after they broke up.

**Different types of casual sexual partners.** Some interviewees who reported condom use with their casual sexual partners categorized their partners, possibly indicating variant levels of emotional and sexual intimacy. My findings suggest that condom use was part of a mutual agreement between the men and their regular (frequent) casual sexual partners and was more of an unwritten rule for the men who had sex with their “only sex” casual sexual partners. Condom use decisions based on the distinction among partner types is not new and has been noted in previous research (Lescano, Vazquez, Brown, Litvin, & Pugatch, 2006; Misovich, Fisher, & Fisher, 1997; Rosengard et al., 2005).

**Limitations of the Study**

**Secondary analysis of qualitative data.** First, a limitation to conducting a secondary analysis of qualitative data is the inability to ask the interviewees new questions (Boslaugh, 2007). Although the interviewees provided information regarding
their relationship experiences and how these were associated with protective and sexual risk behaviors, the participants were not asked direct questions about such experiences and these particular associations. Rather, the questions examined the effects of gender role norms, sexual scripts and structural factors on sexual HIV risk behaviors of low-income African American heterosexual men who reside in Philadelphia. Moreover, the questions were not developed to examine relationship experiences on their sexual HIV risk behaviors.

If I had the opportunity to develop new questions, I would have queried their current relationships with women (e.g., “How would you describe your current relationship(s)?”, “How does/do your relationship(s) affect your condom use?”, “How do your relationships differ?”, “How are they the same?”); how they viewed commitment (e.g., “What does commitment mean to you?”, “Are you in a committed relationship?”, “Why or why not?”); monogamy (e.g., “What does monogamy mean to you?”, “Are you in a monogamous relationship?”, “Why or why not?”); sexual and emotional intimacy with women whom they have a relationship (e.g., “Would you say that your relationship(s) is/are primarily sexually intimate, primarily emotionally intimate or a combination of both and why?”, “How do you feel about your partner(s)?”); and how this may differ based on partner type (e.g., “How does your type of intimacy and/or level of intimacy differ based on your main sexual partner and your casual sexual partners?”).

Additionally I would have asked questions to assess the men’s attitudes about concurrent sexual partnerships (e.g., “Do you think engaging in concurrent sexual partnerships is normative?”, “What do you think are the advantages and disadvantages of
engaging in concurrent sexual partnerships?”, “What characteristics in relationships influence men to move from monogamous relationships?”.

**Interview guide questions.** Second, the interview guide’s questions asking participants to discuss first and last sexual experiences with their main (and casual) partners only may have prompted participants to respond in terms of specific sexual contexts, thereby obscuring other key relationship contexts (e.g., love, trust, commitment or status of relationship) that may be associated with sexual risk and protective behaviors. If I had the opportunity to design the interview guide questions, I would have asked questions that focused on defining the concepts of “love”, “trust”, and “commitment” and personal feelings about these concepts (e.g., “How do you define love/trust/commitment?”, “How does love/trust/commitment relate to your relationship with Partner X?”). Other questions I would ask would focus on the men’s relationship statuses (e.g., “How would you rate your relationship with Partner X?”, “Why did you give your relationship with Partner X that particular rating?”, “What makes the relationship good or bad or [other adjectives provided by the interviewee]?”).

**Semi-structured interviews.** Third, a limitation found in conducting semi-structured interviews is that not all of the participants are asked the exact same questions due to the “interviewer flexibility in sequencing and wording questions” (Ulin et al., 2005, p. 43). For example, the majority of the men were asked for reasons that they either engaged in protected sex or unprotected sex with their main (and casual) sexual partners. At least four of the men (Corey, Kareem, Lamont and Justin) were not asked these questions nor was the information given (per partner) so I had difficulty assessing if their reasons were directly influenced by their relationships, or relationship experiences with
their sexual partners. If I had the opportunity to design the study de novo, I would have included a question in the study guide that directly asked the interviewees their reasons for engaging in protected sex or unprotected sex with their main (and casual) sexual partners (e.g., “What are some reasons you chose to (not) use a condom with Partner X?”). Another option would be to add an instruction to probe when an interviewee answers the question about condom use or mentions engaging in protected sex or unprotected sex (e.g., “Why did you use a condom?”, “How come you chose to not use a condom?”).

**Relationship experiences based on perception of partners.** My research was based on assessing the association of relationship experiences on protective and sexual risk behaviors by utilizing interview data of a cluster of Black heterosexual men only. One of the purposes of my research was to examine how social interactions influence individual behavior. The men’s responses dictating what their partners said or did are just a representation of their perception. Their responses do not provide a complete dyad perspective of the interactions and circumstances that occur in relationships since only one half of the dyad was interviewed. If I had the opportunity to re-design the study, I would have either recruited couples and interviewed the male and female parts of the dyad separately, or conducted interviews with the men and then recruited their sexual partners (main and casual) by asking the men to refer them for participation in the study. Inclusion of the men’s sexual partners would have provided their perspective on the various relationship context factors: relationship status; love, trust, monogamy and commitment in the relationship; and how these factors are associated with their protective and sexual risk behaviors.
These limitations nevertheless, my study highlights at least three noteworthy implications for HIV prevention interventions for African American heterosexual men. First, I will discuss the utility of the Relationship Context conceptual framework to my study; followed by the implications for HIV prevention research, and the future design of HIV/STI prevention interventions for Black heterosexual men.

**Conceptual Framework Implications**

Despite the aforementioned limitations, my study has important implications for applying the Close Relationship Context conceptual framework to research and interventions involving Black heterosexual men. The most apparent conceptual framework implication of my study is that assessing how close relationship factors are associated with HIV risk perception, condom use, concurrent sexual partnerships and HIV/STI screening are instrumental factors in HIV prevention research focused on Black heterosexual men. The complexities of the relationship context (e.g., trust, commitment, relationship status, perceived partner stability) expressed by the men interviewed were associated with and influenced their individual sexual risk and protective behavior. There is a dearth of research on Black heterosexual intimate relationships focused on men’s perspectives (Bowleg & Raj, 2012; Raj & Bowleg, 2012), and most research on sexual risk behavior is exclusively individualistically-focused and ignores the relationship context (Castañeda, 2000; Coker et al., 1994; El-Bassel, Gilbert, Witte, Wu, Hunt, et al., 2010; El-Bassel, Jemmott, et al., 2010; El-Bassel et al., 2001; El-Bassel et al., 2003). Thus, utilizing the Close Relationship Context to assess social factors that may influence Black heterosexual men’s sexual risk and protective behavior addresses these shortcomings.
One particular relationship context factor not addressed in my study was that of power and inequality. It is important to mention this because previous research on African American heterosexual women has demonstrated how having power in an intimate relationship is directly related to increase in and consistent condom use (El-Bassel, Gilbert, Witte, Wu, & Vinocur, 2010; Pulerwitz et al., 2000; Wingood & DiClemente, 1998). Moreover, inequality in intimate relationships is directly related to low rates of condom use and challenges in negotiating condoms (Amaro, 1995; Amaro & Raj, 2000; Sobo, 1995).

Additionally, research on power (Theresa E. Senn, Carey, Vanable, & Seward, 2009) and intimate personal violence (Decker et al., 2009) from the perspective of Black men has also demonstrated the impact that power and inequality may have on Black men’s sexual risk behavior. For example, a study about Black men’s perceptions of power in intimate relationships conducted by Senn and colleagues (2009) showed that men more frequently cited money and sexual decision making (i.e., refusal of sex) as sources of power in relationships. The majority of the men indicated that individuals able to contribute money or withhold sex had more power in the relationship. In instances where a man chose to withhold sex from his female partner, he could still have sex with a casual partner while his main partner was deprived of sexual satisfaction. If the man perceived the woman to have more power (i.e., income, stability of residence) in the relationship, he may feel that sexual power is the only type of power that he possesses (Whitehead, 1997) which can either lead to engaging in unprotected sex or having concurrent sexual partnerships.
Meanwhile, a study on intimate partner violence (IPV) perpetration, and STI/HIV risk behavior and STI/HIV diagnosis among a clinic-based sample of over 1500 heterosexual men (majority Black) suggested that men who were IPV perpetrators were more than likely to engage in anal sex and sexual infidelity and reported STI/HIV diagnosis across the lifetime than their non-abusive counterparts (Decker et al., 2009). Additional factors associated with lifetime STI/HIV diagnosis were sexual infidelity, anger in response to condom request and transactional sex. It is important to note the tremendous impact that power and IPV may have on Black heterosexual men’s sexual risk behavior thereby increasing their risk for STI/HIV infection.

**Implications for HIV Prevention Research and Interventions**

Multiple efforts to eliminate and reduce the burden of social barriers to HIV prevention in Black heterosexual men via research, intervention development and implementation have been made to address their disproportionate rates of HIV/STI infection (Baker et al., 2012; Bowleg et al., 2011; Carey et al., 2010; M. Carter, Henry-Moss, Hock-Long, Bergdall, & Andes, 2010; Cohen, Dent, MacKinnon, & Hahn, 1992; Crosby, DiClemente, Charnigo, Snow, & Troutman, 2009; El-Bassel et al., 2003; Flood, 2003; Jemmott, Jemmott, & Fong, 1992; Kalichman et al., 2005; Kamb et al., 1998; Maher, Peterman, Osewe, Odusanya, & Scerba, 2003; Morris et al., 2009; Noar, Crosby, Benac, Snow, & Troutman, 2011; Nunn, Zaller, et al., 2011; Whitehead, 1997). Findings from my study suggest that HIV prevention research and interventions informed through the lens of Black heterosexual men’s perspectives would have to include and address their HIV risk perception, understanding of monogamy, condom use heuristics, and HIV/STI testing behaviors. The first implication of this study is to ensure that future HIV
risk perception education focuses more on the behavior of Black heterosexual men and not the partner.

The second implication of the study is to provide additional information when discussing the role of monogamy in HIV prevention interventions for Black heterosexual men. The information should focus on the realism that monogamy does not guarantee HIV/STI prevention. The information should also highlight that although a casual partner may be one with whom there is a history, his engaging in a concurrent sexual partnership obviates the fact that he only has one main exclusive sexual partner.

A third implication is making condom use sexy, and relating its use to manhood and being a protector of one’s lady, woman or main partner. The focus of condom use should also center on love and protection for one another and not as a measurement of fidelity or infidelity.

Lastly, HIV testing behaviors should be promoted as a venue for ensuring the healthy status of self and partners, but does not in itself guarantee one being risk-only when adding consistent condom use.

My study’s findings have contributed to the existing work focused on the association of intimate heterosexual relationships and sexual risk and preventive behaviors, and provided additional research from the perspective of Black heterosexual men. It therefore has the potential to further inform the work of future HIV prevention interventions for African American heterosexual men, in order to more comprehensively address the complex relationship factors that influence the motivation of Black heterosexual men to engage in preventive behaviors.
Conclusion

Human relationships are often complex, and my study has documented the multi-faceted factors identified in a cluster of main and casual sexual relationships involving Black heterosexual men (Corneille et al., 2008; Fishbein & Ajzen, 1975; Noar et al., 2012; Nunn, Dickman, et al., 2011). My study uncovered additional nuances of casual sexual partners, suggesting that future research must take into account the context that casual sexual relationships can encompass friendships, past intimate relationships, and also “only sex” relationships among others. Acknowledging these nuances is essential as HIV prevention researchers continue to discover the multiple layers that exist in heterosexual intimate relationships among Black heterosexual men.
BIBLIOGRAPHY


Appendix A: Questionnaire

Please read all of the questions and responses thoroughly and then check the box that best describes your answer.

Some of the questions may be similar to the ones that the interviewer asked you during the interview, but we would like you to answer all of the questions as accurately as possible. To keep your answers as private as possible, please do not put your name or any other identifying information on this questionnaire.

All information that you provide on this questionnaire is confidential and will not be shared with anyone other than members of research team.

1. How old are you? ________________

2. What is your work/employment status? Please check one response.
   □ 1 I work full-time (40 hours or more per week)
   □ 2 I work part-time (20 hours per week or less)
   □ 3 I don’t have a job/ am unemployed
   □ 4 I’m on disability
   □ 5 Other (please describe): ________________________________
3. What is the **highest** level of school that you finished? *Please check one response.*

   □ 1  Some high school
   □ 2  High school graduate or GED
   □ 3  Some college or professional training
   □ 4  Bachelor’s degree/College graduate
   □ 5  Some graduate work
   □ 6  Master’s degree
   □ 7  PhD, MD, JD degree

4. What is **your** personal annual income (that is, the amount of money that you, yourself earn each year)?

   □ 1  Less than $9,999
   □ 2  $10,000 to $19,999
   □ 3  $20,000 to $39,999
   □ 4  $40,000 to $59,999
   □ 5  $60,000 to $79,999
   □ 6  $80,000 or $99,999
   □ 7  $100,000 or more

5. Which of the following best describes how you identify:

   □ 1  Heterosexual/Straight
   □ 2  Bisexual
   □ 3  Gay
   □ 4  Other (please describe): ____________________________________________
6. Do you have a main partner? By main partner, we mean a person that you have an emotional relationship and have sex with?

☐ 1  Yes
☐ 2  No

7. If you have a main partner, is this a:

☐ 1  I do not have a main partner
☐ 2  A woman
☐ 3  A man

8. How often do you use condoms with your main partner?

☐ 1  I do not have a main partner
☐ 2  Never
☐ 3  Sometimes
☐ 4  Most of the time
☐ 5  Every time

9. How many people have you had sex with during the last 6 months (including your main partner if you have one)?

☐ 1  1
☐ 2  2 to 5
☐ 3  6 to 9
☐ 4  10 or more
10. How often did you use condoms with the person (or people) you had sex with in the last 6 months?

□ 1  Never
□ 2  Sometimes
□ 3  Most of the time
□ 4  Every time

11. Which of the following sexual experiences have you had in the past 6 months? Please check all that apply.

□  I had vaginal sex with a woman (penis in vagina sex)
□  I had oral sex with a woman (your mouth on a woman’s vagina)
□  I had oral sex with a woman (her mouth on your penis)
□  I had anal sex with a woman (your penis in a woman’s anus or butt)
□  I had oral sex with a man (your penis in a man’s mouth or his penis in your mouth)
□  I had anal sex with a man and put my penis in his anus/butt
□  I had anal sex with a man who put his penis in my anus/butt

12. Have you been tested for HIV in the past year?

□ 1  Yes
□ 2  No
□ 3  Don’t Know

13. What was the result of the HIV test?

□ 1  Positive
□ 2  Negative
□ 3  Don’t know
14. (Optional). Is there anything you would like to share with us about this questionnaire or your participation in the REPRESENT study? ____________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

THANK YOU FOR YOUR PARTICIPATION IN THE REPRESENT STUDY
Appendix B: Phase I Interview Guide

INTRODUCTION

I’d like to begin by thanking you for your willingness to be interviewed. I will be asking you some questions about your experiences as a Black man, the role of religion and spirituality in your life. I will also be asking you some very personal and detailed questions about your sexual experiences.

The reason we’re interested in what you have to say and your experiences is because there are so few studies about the health and sexual experiences of Black men. I would like you to answer these questions as honestly and accurately as possible. All of the information that you give during this interview will be strictly confidential, which means that we will never use your name when we summarize these results. Do you have any questions before we begin?

TURN ON DIGITAL RECORDER

WARM UP QUESTION

In general, how would you describe what it’s like for you as a Black man? You personally, not Black men in general.

GENDER ROLE NORMS

1. Now, I’d like you to tell me some of the expectations that people have for you as a Black man.

   (PROBE): As with focus groups, probe for positive + negative expectations.
2. Now I’d like to ask you to tell me some of the expectations that you are not supposed to be as a Black man.

GENDER ROLE STRAIN

3. So thinking back on what we just talked about, what’s it like to live with these expectations of what a Black man is supposed to be?

4. What sorts of things do you do when you feel like you’re not meeting these expectations?

RELIGIOSITY & SPIRITUALITY

5. Tell me how you think your religion or spirituality helps you during stressful or hard times.

6. Now I’d like you to tell me about any times that you have had when your religion or spirituality didn’t help you or even seemed like it was doing more harm than good?

GENDER ROLE NORMS & SEXUAL RELATIONSHIPS

I’d like to focus a little more on this topic, and ask you some specific questions about your sexual relationships with women.

7. How do you define having sex?

   a. (PROBE): Do you think of oral sex as sex? What about anal sex?

   b. (PROBE): Some people we’ve spoken to say that they count sex as sex only if its penis-vagina sex with a woman, and so they might not count things that they might do with another man (e.g., oral or anal sex) as sex. Based on sexual experiences that you may have had with women and/or men, how do you see it?

SEXUAL SCRIPTS

Now I want to ask you some very personal questions about the things that happened the first and last (the most recent) time you had sex with your main partner and/or other partners. I’m going to ask you to be as detailed with your answers as possible in telling me about your sexual activities. I’ll also be asking you lots of
questions about the order things happen in, who says and does what, and stuff like that, to make sure that I’m getting as many of the details as possible, okay?

I know that these questions are pretty personal, but they are really important to helping us learn more about Black men’s health and sexual experiences. So, I want to remind you that everything you tell me is going to be strictly confidential; we won’t use your name when we summarize these results. So I hope you feel free to be as honest and detailed as possible.

8. Okay, so first I’d like to get a little information about your **main** sexual partner. Do you have a person that you consider to be your main partner, someone that you are in a relationship with and/or have sex with the most? (IF NO), So then I would like you to think about the last main partner you had. How long ago was that?

   a. Can you tell me this person’s first name or make up a name? Sometimes names can be either a man or woman’s name, so can you tell me the gender of their person (i.e., whether they are a man, woman, or transgender)?

**First Time Sex with Main Partner**

9. So pretend I’m not a researcher, but I’m one of your boys, one of your friends.

   a. Who started it? (PROBE: How did that person start it? What did they do? What did they say?)

   b. And what kinds of things did you do sexually? (PROBE): Kissing, caressing, oral sex, vaginal sex, anal sex? Who did what to whom? What order did these things happen in?

   c. Where did you have sex?

10. Some people use alcohol and drugs before they have sex, others don’t. Were either of you under the influence of anything when you had sex the first time? (PROBE: What substance? Both partners?)

11. Some people don’t use condoms the first time they have sex; other people use condoms. Did you happen to use condoms the first time you had sex with [main partner’s name]? If no, go to Question 12.

   a. (If yes). I’d like you to tell me about what happened right up until you (or the partner if main partner is a man) put the condom on.
b. Did you talk about using condoms before you (or he) put it on?  
(PROBES): At what stage did you talk about it (e.g., before clothes were removed? Before kissing? After? Before oral sex? During sex?) Who brought up the topic? How? Who said what?

c. Was there any nonverbal communication or communication without words about condoms (e.g., actions, gestures, etc.)? (PROBES: Who did what?)

d. What happened in terms of putting on the condom? (PROBE: Did he put it on? Did partner do it? Did they both do it?)

e. So thinking about the first time you had sex, tell me about how many times you had intercourse (vaginal, anal) that time?

f. And would you say that you used a condom for each of those times?

**Last Sex with Main Partners**

12. So we’ve talked in detail about what happened the first time you had sex with (main partner’s name). Now, I’d like you to tell me what happened the last time. When was the last time you had sex with (main partner’s name)? {Lots of PROBES of, “And then what happened?”}

a. Who started it? {PROBE: How did that person start it? What did they do? What did they say?}

b. And what kinds of things did you do sexually? (PROBE): Kissing, caressing, oral sex, vaginal sex, anal sex? Who did what to whom? What order did these things happen in?

c. Where did you have sex?

13. Some people use alcohol and drugs before they have sex, others don’t. Were either of you under the influence of anything when you had sex the last time? (PROBE: What substance? Both partners?)

14. Did you happen to use condoms the last time you had sex with [main partner’s name]? If no, go to Question 15.

a. (If yes). I’d like you to tell me about what happened right up until you (or the partner if main partner is a man) put the condom on.
b. Did you talk about using condoms before you (or he) put it on? 
(PROBES: At what stage did you talk about it (e.g., before clothes were removed? Before kissing? After? Before oral sex? During sex?) Who brought up the topic? How? Who said what?

c. Was there any nonverbal communication or communication without words about condoms (e.g., actions, gestures, etc.)? (PROBES: Who did what?)

d. What happened in terms of putting on the condom? (PROBE: Did he put it on? Did partner do it? Did they both do it?)

e. So thinking about the last time you had sex, tell me about how many times you had intercourse (vaginal, anal) that time?

f. And would you say that you used a condom for each of those times?

_Interviewer:_ Thank you so much for your detailed answers. Okay, we have just two more sections to go and then we’re done. How you doin’?

**Other Sex Partners**

15. So we’ve talked about what happens when you have sex with [name of main partner]. Now I’d like you to tell me about anyone (other than main partner’s name) that you’ve had sex with during the last 6 months.

_[Notes to interviewer: If no other sex partner, then go to closing comments]_

_[Note to interviewer: If more than one sex partner, then ask about the most recent other partner and then repeat questions for each as much as time allows]_

**First time sex with other sex partner 1:**

16. Okay, so can you tell me this person’s (or people’s) first name or you can make up a name. Sometimes names can be either a man or woman’s name, so can you tell me the gender of their person (i.e., whether they are a man, woman, or transgender)? Okay, so tell me what happened the first time you had sex with [other sex partner’s person’s name]. {Lots of PROBES of, “And then what happened?”}

a. Who started it? {PROBE: How did that person start it? What did they do? What did they say?)
b. And what kinds of things did you do sexually? (PROBE): Kissing, caressing, oral sex, vaginal sex, anal sex? Who did what to whom? What order did these things happen in?

c. Where did you have sex?

17. Some people use alcohol and drugs before they have sex, others don’t. Were either of you under the influence of anything when you had sex the first time? (PROBE: What substance? Both partners?)

18. Some people don’t use condoms the first time they have sex; other people use condoms. Did you happen to use condoms the first time you had sex with [other partner’s name]? If no, go to Question 19.

a. (If yes). I’d like you to tell me about what happened right up until you (or the partner if other partner is a man) put the condom on.

b. Did you talk about using condoms before you (or he) put it on? (PROBES): At what stage did you talk about it (e.g., before clothes were removed? Before kissing? After? Before oral sex? During sex?) Who brought up the topic? How? Who said what?

c. Was there any nonverbal communication or communication without words about condoms (e.g., actions, gestures, etc.)? (PROBES: Who did what?)

d. What happened in terms of putting on the condom? (PROBE: Did he put it on? Did partner do it? Did they both do it?)

e. So thinking about the first time you had sex, tell me about how many times you had intercourse (vaginal, anal) that time?

f. And would you say that you used a condom for each of those times?

Last sex with other sex partner 1:

19. So we’ve talked in detail about what happened the first time you had sex with (other partner’s name). Now, I’d like you to tell me what happened the last time. When was the last time you had sex with (other partner’s name)? {Lots of PROBES of, “And then what happened?”}

a. Who started it? {PROBE: How did that person start it? What did they do? What did they say?}
b. And what kinds of things did you do sexually? (PROBE): Kissing, caressing, oral sex, vaginal sex, anal sex? Who did what to whom? What order did these things happen in?

c. Where did you have sex?

20. Some people use alcohol and drugs before they have sex, others don’t. Were either of you under the influence of anything when you had sex the last time? (PROBE: What substance? Both partners?)

21. Did you happen to use condoms the last time you had sex with [other partner’s name]? If no, go to Question 22.

a. (If yes). I’d like you to tell me about what happened right up until you (or the partner if other partner is a man) put the condom on.

b. Did you talk about using condoms before you (or he) put it on? (PROBES): At what stage did you talk about it (e.g., before clothes were removed? Before kissing? After? Before oral sex? During sex?) Who brought up the topic? How? Who said what?

c. Was there any nonverbal communication or communication without words about condoms (e.g., actions, gestures, etc.)? (PROBES: Who did what?)

d. What happened in terms of putting on the condom? (PROBE: Did he put it on? Did partner do it? Did they both do it?)

e. So thinking about the last time you had sex, tell me about how many times you had intercourse (vaginal, anal) that time?

f. And would you say that you used a condom for each of those times?

First time sex with other sex partner 2:

22. Okay, so can you tell me this person’s (or people’s) first name or you can make up a name. Sometimes names can be either a man or woman’s name, so can you tell me the gender of their person (i.e., whether they are a man, woman, or transgender)? Okay, so tell me what happened the first time you had sex with [other sex partner’s person’s name]. {Lots of PROBES of, “And then what happened?”}

a. Repeat questions 16-18.
**Last sex with other sex partner 2:**

23. Okay, so now think back to the **last** time you had sex with (other sex partner’s name). Tell me what happened that last time.

   a. Repeat questions 19-21.

**Interviewer:** Alright, we’re almost done. We’re reached the last section.

**CLOSING COMMENTS**

Well, that’s it. We’re done. I know that that was a long interview and I asked you lots of questions. I want to thank you for your patience and for taking the time to give such detailed information. There’s so little information on Black men’s sexual experiences and so this information is really important to our study.

Before we close though, I wanted to ask, is there anything else that you’d like to tell me about any of the topics that we covered in the interview?

24. Are there questions that I didn’t ask you but should have?

Again, thank you so much for your information and your time.
Appendix C: Coding Matrix

Adapted from Anfara, Brown & Mangione (2002)

<table>
<thead>
<tr>
<th>Research Questions</th>
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<tbody>
<tr>
<td>What are the characteristics of emotionally and sexually intimate relationship experiences expressed by African American heterosexual men in this sample that may increase sexual risk?</td>
<td>What are the types of emotionally and sexually intimate relationship experiences expressed by African American heterosexual men in this sample that may protect against sexual risk?</td>
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<tr>
<td>Relationships Built on Trust</td>
<td>Low Perception of Risk</td>
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<tr>
<td>Relationships Developed Over Time</td>
<td>Condom Use Symbolizes Infidelity</td>
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<tr>
<td>Partners Known for Significant Amount of Time</td>
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<tr>
<td>Concurrent Sexual Partnerships (CSPs)</td>
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<tr>
<td>Unprotected Sex with CSPs</td>
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</tr>
<tr>
<td><strong>Dominant Codes</strong></td>
<td><strong>Non-Dominant Codes</strong></td>
</tr>
<tr>
<td>Monogamous Relationships</td>
<td>Low Perception of Risk</td>
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<tr>
<td>HIV/STI Testing</td>
<td>Condom Use Symbolizes Infidelity</td>
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<td>Condom Use with Casual Sexual Partners</td>
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<td>Partner’s Request/Demand for Condom Use</td>
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<td>Prevent HIV/STIs</td>
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<td>Number of Partners</td>
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<td>Reasons for Using Condoms based on Partner Behavior</td>
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<td>Conversation about Sex Prior to Having Sex</td>
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<td>Conversation about Sex Prior to Having Sex</td>
<td>Protective Behaviors- condom use</td>
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Appendix D: Marital Status and Age of Participants

Marital Status and Age of Participants who reported Main Sexual Partners & Main and Casual Sexual Partners

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Marital Status and Age of Participants who reported Main Partners Only (N = 11)

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<td>35 – 44</td>
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Marital Status and Age of Participants who reported Casual Sexual Partners \((N = 19)\)

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