

The Risk Ecology Framework: A Socioecological Analysis of HIV Risk Perception among Black and Latino Men who have Sex with Men.

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ABSTRACT

The Risk Ecology Framework: A Socioecological Analysis of HIV Risk Perception among Black and Latino Men who have Sex with Men.

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This dissertation examines how Black and Latino men who have sex with men (MSM) are making sense of the contemporary HIV/AIDS epidemic and their relation to it. Black and Latino MSM in the United States are disproportionately impacted by HIV. Interdisciplinary scholarship on the matter has conceptualized risk as an intrinsic facet of HIV. However, this research has paid little attention to the process by which Black and Latino MSM form their HIV risk perceptions. In this dissertation, I advance the “risk ecology framework” as a novel socioecological approach for understanding risk perception. This framework conceives of HIV risk perception as emerging from individuals’ relationship to HIV as shaped by the intersecting influences of the broader social environment. I base my analysis on 40 in-depth semi-structured interviews with HIV-negative Black and Latino MSM in New York City, as well as a year of participant-observation with a health advocacy group that serves this community. I find respondents form their risk perceptions by reflecting on HIV vis-à-vis their respective and distinctive social locations. The intersections of race, class, and sexuality come to be associated with HIV risk across the ecological levels of an individual’s lived experience, revealing a *risk ecology*, or a set of interrelated potential threats posed by HIV. I find this risk ecology to be reflected in Black and Latino MSM’s framing of HIV as a risk to their bodily health and social wellbeing, on the one hand. Or, its framing as personally irrelevant, on the other. Relationships and interactions with family, friends, and romantic/sexual partners inform what Black and Latino MSM understand HIV to potentially threaten. Respondents and the people in their lives draw

upon culturally-available discourses, rhetoric, and beliefs concerning HIV that reflect how the institutionalization of racial, social, and sexual inequalities structure risk perception. With respect to health-relevant behaviors, I demonstrate how the analysis of risk perception formation clarifies the ways in which Black and Latino MSM make use of preventative tools and construct meanings about sex. I conclude with a discussion of the broader implications of the risk ecology framework for future health policy and further sociological research. By interrogating what it means to be at-risk, this dissertation lends crucial insight into the persistence of the HIV epidemic at a time when the means to end it are available, and also enriches sociological understandings of risk both within and beyond the public health domain.

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For my parents, who taught me to dream.

CHAPTER I

Immeasurable Risks / Incalculable Uncertainties: The Risk Ecology Framework

He had fallen / and the passing ceremonies / marking his death / did not stop the war.

— “When My Brother Fell,” Essex Hemphill

Shortly after I began recruiting respondents for my study, I spoke with an individual who expressed interest in participating and seemed surprisingly enthusiastic to talk about HIV. During our initial screening conversation, he relayed that he was HIV-negative and fit the other eligibility criteria for my study. While we planned to meet the following week, work obligations and other constraints demanded that we continued to reschedule the interview for some time. When we finally sat face to face, I sensed that his initial eagerness had come to be replaced with solemnity. During the course of the interview, I asked him to describe to me the actions he would take were a friend to test positive for HIV, only for him to share that he himself had recently been diagnosed with the virus. As I had not designed this study for HIV-positive individuals, I informed him of our inability to continue our discussion and concluded the interview shortly thereafter. After thanking him for taking the time to meet with me, I began my walk to the subway home, taking a few moments to reflect on what I had just heard, and what else I may come to learn throughout the year of interviews and fieldwork that lay before me. How many more men are there like him? What social factors influence the ways they confront and navigate the illness today? When knowledge and awareness about HIV prevention are at an all-time high, in a city where resources are remarkably available to those who desire them, how can someone continue to be exposed to the virus in spite of it all?

It is now widely known that HIV infection rates in the United States, while steadily declining across the general population, continue to disproportionately impact Black and Latino communities. Black and Latino men who have sex with men (MSM), in particular, comprise the majority of new infections, with rates of transmission increasing among young and adult cohorts (CDC 2019)¹. The dominant orientation of interdisciplinary scholarship on the matter has been to conceptualize risk as an intrinsic facet of HIV. The literature in public health identifies Black and Latino MSM and other heavily impacted groups as being “at-risk” of HIV infection due to overwhelming disparities in access to, affordability of, and awareness about prevention and care options (D’Aquila et al. 1989; Garofalo et al. 2010; Lanier and Sutton 2013; Sullivan et al. 2015). Sociological research alternately views HIV risk as a product of structural barriers to care, experiences of social oppression like racialized homophobia, and individual behaviors driven by socioeconomic and cultural constraints (Diaz et al. 2004; Hirsch et al. 2010; Ayala et al. 2012; Mizuno et al. 2012; Watkins-Hayes 2014; Parker et al. 2017). More recently, this body of work has demonstrated that social location affects people’s motivations for and capacity to navigate a changing global HIV disease landscape that remains static in its disproportionate impact on underserved communities (Mojola 2014; Carrillo 2018; Frye and Gheihman 2018; Watkins-Hayes 2019).

Sociocultural approaches to risk perception have contributed to this discussion by highlighting how an individual’s risk perceptions are impacted by external forces in their social environment (Renn 1995; Taylor-Gooby and Zinn 2006). Through its consideration of the interactions between the perceiver, their sociocultural context, and the “risk” itself, this

¹ HIV diagnoses have increased among Latino MSM Latino between 2010 and 2016, especially those among those age 25 to 34. Diagnoses have remained relatively stable for Black MSM overall but there was a noted 42% increase between 2010 and 2017 within the same age cohort as Latino MSM.

scholarship has demonstrated how risk perceptions reflect the social organization surrounding an individual (Douglas and Wildavsky 1983). Mary Douglas (1992), for example, documented how HIV risk perceptions varied due to differences in culture, knowledge, and beliefs in the social groups to which people belonged. This analysis of risk perception also evinces how HIV risk can be discursively mobilized, embodied, and negotiated, such as in the case of Malawians for whom condom use presents a risk to the “sweetness of sex” that outweighs the risk of HIV infection (Tavory and Swidler 2009).

Nevertheless, current sociological research has paid little attention to *the process* by which individuals form their risk perceptions (Lupton 2006; Zinn 2009). Risk perception formation has mainly been a point of inquiry for psychology, health communications, and environmental studies, and has traditionally been treated as relating to assessments of the “riskiness” of certain hazards like disease and natural disasters (Andersson and Lundborg 2007; Fung, Namkoong, and Brossard 2011; Ferrer and Klein 2015; Yu, Cruz, and Hokugo 2017). There has been a lack of sociological attention devoted to examining the social dimensions of this process.

Examining HIV risk perception formation among Black and Latino MSM is particularly urgent given recent reports projecting that 50% of Black MSM and 25% of Latino MSM will acquire HIV in their lifetime (CDC 2016). I focus specifically on this demographic because, while Black and Latino MSM comprise a small portion of the greater US population, they account for the largest number of HIV diagnoses. Despite advances in treatment and prevention technologies allowing HIV-positive people to lead full and healthy lives, Black and Latino MSM are not afforded the same life chances. For instance, the development of pre-exposure prophylaxis (PrEP) for HIV, typically administered as a once-a-day pill, has been proven to be an

effective means of preventing transmission, but uptake is significantly lower among Black and Latino MSM in comparison to their White MSM peers due to disparities in health insurance and affordability of care (Murnane et al. 2013; Lelutiu-Weinberger and Golub 2017; Kay and Pinto 2020; Guilamo-Ramos et al. 2020). Expanding our understanding of Black and Latino MSM's various risk perceptions can lend insight into the persistence of HIV disparities at a time when the means to address them are available but unequally distributed.

How, then, do individuals form their risk perceptions about an illness they have been deemed to be at-risk of? What does an examination of Black and Latino MSM's HIV risk perception formation tell us about how people conceptualize and confront uncertainty? Beyond human agency, what social forces influence how a person behaves with respect to their risk perceptions? In this dissertation, I advance the "risk ecology framework" (REF) as a novel socioecological approach for the analysis of risk perception formation. Taking HIV as a case study, this framework conceives of risk perception formation as sensemaking about one's relationship to disease, against the backdrop of the broader influences of the social ecology. I develop this framework through the analysis of forty in-depth semi-structured interviews with HIV-negative Black and Latino MSM in New York City, as well as a year of participant-observation at a health advocacy group.

I contend that Black and Latino MSM form their HIV risk perceptions at the interface of their lived experience, their social locations, and their knowledge of this infectious disease. Race, class, and sexuality arise as important factors in this process. Specifically, respondents' incorporate associations between a range of individual, relational, and structural factors that, taken together, constitute an ecological understanding of HIV risk. Relational interactions between an individual and the people in their lives, along with certain cultural influences, shape

how individuals draw these associations. As a result, I argue, Black and Latino MSM's perceptions reflect a framing of HIV as a risk to (1) individual bodily health, (2) to social welfare, and/or as (3) personally irrelevant altogether. These findings suggest that risk is not a singular fixed quality of HIV, but instead arises as a perceived potentiality with varied manifestations situated across the ecological levels of an individual's experience.

In this introduction, I begin with a review of the pertinent literature on risk to highlight the need for sociological scholarship on risk perception formation that extends beyond individual assessments of riskiness. I then introduce the risk ecology framework, the socioecological approach I advance as a response to this gap in the literature. I describe the qualitative methodology I employed for this study before moving onto an overview of the dissertation. I make use of the REF, a scalar approach that helps to comprehensively demonstrate the depth of insight to be gained from its use. I also articulate how the REF can deepen comprehension of health-relevant behaviors and contribute to broader sociological research on risk and health policy.

The Role of Risk in Health & Illness

Risk is an inescapable dimension of human life that captures the thoughts, motives, and emotions that drive action in the face of an unforeseeable future. While the exact origin of risk as an epistemic object is often debated, the study of risk in academic circles can be traced back to 17th-century probability theory and statistical sampling methods (Bernstein 1998). From these conceptualizations arose a method for humans to calculate and quantify risk as a means of reconciling with uncertainty. In time, economists and policymakers alike developed their own mathematical representations of risk to estimate possible outcomes and evaluate the potential

performance of markets, policy interventions, and other aspects of the socioeconomic fabric of society. Such a statistical interpretation has been both practical and useful in this regard, though it is not completely representative of the role of risk in the society. While mathematical approaches fashion risk as an objective metric for uncertainty, scholars of risk soon began to consider the breadth of social forces that shape how people identify, define, and perceive what a “risk” is. What arose from this was a troubling duality of objectivism and constructivism in interpretations of risk. Objectivist definitions view risk as natural phenomena existing independent of social context, while constructivist perspectives view risk as cultural phenomena that exist within specific social contexts.

Sociologists of risk argue that strict adherence to either the objectivist or constructivist perspective yields myopic analyses that cannot adequately reflect the reality of the problems they seek to answer. As such, some sociologists such as Wynne (2002) make use of a constructivist-realist perspective that views risks as hybrid phenomena of nature and culture that are inaccessible without social interpretation. This perspective allows for the consideration of risks as epistemic objects that “should be scrutinized in relation to their social functions and effects” (Zinn 2004) rather than as objective “descriptions of reality.” The value of this stance is made clear in Wynne’s examination of Cumbrian sheep farmers in the wake of the Chernobyl nuclear radiation disaster (Wynne 1992; Wynne 1996). Wynne finds that scientists conducted “technical risk assessments” of soil radiation in order to give advice to farmers about selling their sheep, but their failure to consider the farmer’s local knowledge about their land and potential risks of contaminated soil led to economic instability within this community. As this example suggests, the conventional sociological approach to risk encourages an investigation of *who* gets to define risk and *how*, a perspective that can reveal socially constructed realities that “[broaden] the scope

of undesirable effects, include other ways to express possibilities...and expand the horizon of risk outcomes” (Renn 1998).

With regard to issues of health, risk is unique in that it exists at the intellectual juncture of both the life and social sciences. In public health, for example, risk is established by the Center for Disease Control as a probability that some event will occur within a certain time, often one that is described to be undesirable such as illness or death (CDC 2016). Risk appears in several other forms, such as “relative risk” when comparing health-related events in two groups, or “risk factor” as a behavior or trait that is linked to increased occurrence of disease. Risk is also implicitly incorporated into other quantitative measures of health, such as morbidity rate data that is used to determine the degree of risk of disease a certain population possesses. In all of these cases, risk is equated with probability and, as such, is used as a metric in many epidemiological analyses (Jekel et al. 2007).

Sociologists have endeavored to move beyond a singular understanding of risk as a kind of metric for uncertainty because these approaches, while efficacious in a narrow sense, do not elucidate how the social construction of risk can impact experiences of and responses to disease. Though the risk-related work of public health professionals has provided useful measures that are necessary for the creation of health interventions, it is the sociologist’s task to understand the formulation of these metrics and their adequacy given the contexts within which they will be deployed. This is important because while epidemiological research offers understandings of how to slow or stop the spread of infectious disease among susceptible populations, it cannot account for the breadth of related social problems that may persist or even be further complicated by the adoption of suggested preventative measures. Focusing on risk perception formation can bring these social problems to the fore. The epistemological constructivism at the heart of

sociological research on risk has provided nuanced perspectives that can be used to improve interventions aiming to attenuate both the biological and socioeconomic impact of epidemics. Even so, certain scholars hold that present sociological study of risk is not without its faults. Perhaps the most salient critique is that risk has become more of a popular key term rather than a useful intellectual tool in studies of health inequality and illness experience (Green 2009). Similar criticisms of the ubiquity of “risk” sans any perceivable empirical utility exist with relation to medical journals and other biomedical scholarship (Skolbekken 1995). At the same time, there are some who believe risk still has its merits and only needs to be further explored rather than abandoned. For example, interactions between governmental entities and individuals in matters related to health risk management and decision-making are dependent on geopolitical context and time, thus there exists a space for further scholarship (Zinn 2009).

When thinking about risk vis-à-vis health issues, even sociologists tend to downplay the sociality and social variables of risk. It is my position that risk continues to be a useful point of inquiry, especially given the complexity of health-related matters. Risks associated with illness and disease warrant further analysis because they can present unique problems at the micro, meso, and macro level concurrently (Hart et al. 2000). European responses to the 2009 H1N1 pandemic exemplify how the administration of vaccines presented a complex issue that required nurses at the personal micro-level, persons working at public health offices at the regional meso-level, and epidemiologists at the national macro-level (Cloes et al. 2015). There are distinct risk considerations at each of these levels. Sociologists have also focused on risk analysis, management, and communication in the analysis of responses to health-related risks (Calman, Bennett, and Coles 1999). The subset of this literature that focuses on risk perception is particularly illuminating for the analysis of health-related risks and warrants further discussion.

The Sociocultural Approach to Risk

Interdisciplinary scholarship on risk has traditionally been oriented towards examining how and why individuals behave in the ways they do. Yet, as risk theorists have noted in their comparison of sociological and psychological studies of risk, such a focus on the rational actor is limited when considering the fact that several risk-related situations often involve more than a single entity and are often influenced by the environment itself (Taylor-Gooby and Zinn 2006). The necessity for a more nuanced consideration of all the social forces involved in risk-associated decision-making processes is poignantly reflected in Vaughan's groundbreaking study of the events that led up to the Challenger incident (1997). Crucial to Vaughan's analysis, is the importance of culture and its relation to risk. Vaughan explains that, over many years, NASA developed an understanding of risk situated within the culture of the organization, measuring danger in relation to the greater context of organizational behavior, budget, and other production pressures.

The origins of sociological analyses on risk, such as Vaughn's lies not in the analysis of decision making, but rather in the discussions of risk in relation to culture, which began with Mary Douglas' (1966) work on risk as a strategy for the perception of danger that is specific to the culture of a given community. In her later work with Aaron Wildavsky, Douglas demonstrates how relationships between and among individual entities shape the social environment, thereby influencing the culture that shapes how risk is perceived and engaged (1983). *Risk and Culture* complicated contemporary notions of risk by analyzing the origins and use of "risk-benefit analysis" in relation to the accelerate development and implementation of new technologies. During this time, the concept of risk had belonged almost exclusively to the domain of

economists and analysts. Risk benefit analysis comprises a technical manifestation of risk as a calculation, one which is vetted as a neutral method of assessment and estimation of future performance and outcomes of markets and policies. Douglas and Wildavsky argue that while risk-benefit analysis is often touted as an objective means of understanding the impact of policy-decisions, much of what comprises that process is rooted in constructed sociocultural meaning. They explain that risk-benefit analyses are inherently biased because they rely upon assumptions, such as “that economic markets are appropriate measures of what is valuable...and...that no resource has intrinsic merit [on its own],” (Douglas and Wildavsky 1983:70) which are more of a reflection of the values of the assessors rather than the reality of the situation being assessed.

Central to this sociocultural approach to risk is the view that risk perceptions can vary because they reflect the patterns of social organization in which they are created and used. Presenting a typology of potential organizational forms, specifically that of the hierarchy, market individualist, and sectarian, Douglas and Wildavsky describe the conditions in which risk perceptions are formed. For example, the hierarchy view conceives of risk as problems that can easily be solved following traditional or well-established practices. The market individualist, on the other hand, views risk as welcome uncertainty, for pursuing its resolution can lead to immediate opportunity. Sects preoccupy themselves with the negative outcomes of risk and devote their efforts to opposing action that would introduce risk in the first place. These organizational forms reflect the kinds of attitudes and practices that are visible in the creation and implementation of policy, providing insight into how variance in risk perception can lead to different outcomes. Much of this framework also forms the basis of the contributions Douglas makes in her separate work on “risk acceptability,” which is also very much informed by sociocultural context (Douglas 1986).

Sociocultural Risk Perspectives on HIV

On the subject of health and illness, Douglas articulated her theory of risk and applied it to the realm of HIV/AIDS. Focusing specifically on responses to HIV/AIDS at the height of the epidemic in the 1980s, Douglas (1992) illustrates how the diversity of risk perceptions is rooted in the culture, knowledge, and beliefs of different social groups. She describes four separate social groups, namely the center community, the enclave, the individualists, and the isolates. The center community possesses the most socioeconomic capital and is best described as the established authority; in the case of HIV/AIDS this includes all biomedical and governmental entities that view HIV/AIDS as a lethal contagion that must be prevented through specific means and actions, with risk being a kind of uncertainty that must be controlled. The enclave consists of people who refute the knowledge created by the center community, such as homosexual men who believe that eating healthy is just as preventative as using condoms when combatting HIV infection and accept risk as an inevitable component of human life. The individualist and isolates are identical to the previously mentioned market individualist and sectarian, with the former welcoming risk while the latter avoids it completely.

Drawing from interviews conducted in Brittany, France, Douglas found that attitudes about HIV/AIDS risk varied drastically within each of the groups listed above. For example, one attitude characteristic of the center community is that the body is a “machine” that must be maintained and protected through the use of prophylaxis, hygienic precautions, and medication to ensure that it works optimally. In contrast, another attitude typical of the enclave views the body as an inherently strong thing that needs no specified routine of precaution to follow to protect it, since disease risk is ubiquitous. The greatest insight to be gained from this analysis is

that communities produce, accept, and refute knowledge about risk that is rooted in the special sociocultural context of that community. Medical organizations and groups of at-risk individuals are both communities, each with their own kinds of risk perceptions that may or may not be compatible with one another.

Douglas finds that the tension that arose from differing risk perceptions, coupled with confusion about the epidemic led to health officials promoting strict regimens of prevention and individual risk management, such as the prohibition of certain sexual activities and the expulsion of immigrants and foreign workers. Bloor's (1995) work relates to this in its examination of how the onus of HIV-transmission was often improperly placed solely on the individual when, in fact, institutions in society contributed to and facilitated infection due to a lack of information and deficiencies in communication. The tension Douglas speaks of also speaks to a fundamental friction between lay-persons and scientists. Douglas' discussion of credibility in science highlights that information produced and disseminated by technical experts is not immune to skepticism and has always been met with some opposition by the non-expert public. This is because expertise, as Eyal (2019) describes it, exists at the nexus of expert judgement and politics, necessitating an entanglement with both scientific fact and social values.

The ramifications of this can be seen in Epstein's (1996) research on initial responses to HIV/AIDS, which detailed how non-experts confronted scientists about their lack of urgency and transparency, especially given the epidemic's disproportionate impact on certain communities. These laypersons demanded representation in counsels and clinical trials in order to better reflect the experiences of the populations that were actually dying from the illness, such as gay men, hemophiliacs, and women. Of particular note is how these individuals effectively negotiated their "lay expertise" to gain credibility in scientific circles that traditionally excluded them (Epstein

1995). In a separate but related case, Nelson's (2011) research on the health activist work of the Black Panther Party during the Civil Rights Movement shows how party members rejected the expertise of biomedicine altogether, mobilizing their own knowledge of science and medicine and skillsets to provide nutrition and targeted medical attention for Black people who were being systematically denied basic healthcare.

Towards a Contemporary Analysis of HIV Risk Perception Formation

The sociocultural approach's view that "cultural assumptions across social groups are powerful bases for ideas about risk and how to deal with it" (Taylor-Gooby and Zinn 2000:5) has gone on to influence the study of risk across the social sciences, though it has not gone without its criticisms. In developing her theory, Douglas fails to mention how crucial components of social location, such as race, class, sexuality fit into the model beyond the descriptive level. Douglas' work also leaves room for expansion with respect to HIV/AIDS. First, it should be noted that the HIV/AIDS epidemic Douglas spoke of is radically different from that which exists today, and as such her articulation of the sociocultural model must be amended. Douglas wrote during the peak of the epidemic when infections were at a record high and knowledge about the illness itself was at an all-time low. During this era, the sociocultural model challenged the notion that an individual's psychological composition determined their likelihood to engage in risky-behavior, placing the onus on the influence of social groups instead (Douglas and Calvez 1990). Since then, advancements in treatment and prevention technologies, coupled with global-scale efforts to raise awareness and accessible education about HIV/AIDS have contributed to a general decrease in new infections each year. Though HIV is now a chronic manageable illness, persistent disparities in HIV infection rates disproportionately affect underserved communities.

Systemic inequalities make some populations, such as LGBTQ-identified people of color, more vulnerable to infection than others, and can further complicate living with HIV (Witten 2008; Watkins-Hayes 2014, 2019).

It becomes clear, then, that a contemporary analysis of HIV risk perception requires deliberate consideration of social location. Recent scholarship has articulated the demand for risk theorization that investigates how gender, class, and other factors that comprise social location intersect with the social values that underlie an individual's risk perception (Montelius and Nygren 2014). This is especially important for illnesses like HIV that are marked by health inequalities that play out along these dimensions. When considering these inequalities, however, it is necessary to avoid essentialist logic that presumes simply belonging to a particular group biologically predisposes one to certain illnesses. Race and ethnicity, for example, are both socially constructed concepts used to categorize individuals and as such do not represent immutable biological realities about their health risks and illness experiences (Roberts 2012).

Instead, these social factors should be considered in relation to associated social conditions that may put a person *at risk of being at risk* of a certain disease (Link and Phelan 1995). In this way, it is not that these social factors are “true, biological” reasons for the experience of illness, but rather the social patterning of disease around these facets of social location is a fundamental cause of illness. Race, class, and sexuality are associated with systemic racism, homophobia, and socioeconomic status, all of which have been shown to underlie health inequalities that negatively impact the health outcomes of those most affected by a given illness (Hatzenbuehler, Phelan, and Link 2013; Link and Phelan 2015). With respect to risk, sociological research operating from this “fundamental causes” perspective has found the racial gap in chronic health conditions between Black and White individuals to be associated with variance in

socioeconomic status, not specific risk behaviors that are inherent or germane to a person's associated race or culture (Hayward et al. 2000).

Though the sociocultural approach has demonstrated how risk perceptions are influenced by social norms and cultural mores, notably absent are explorations of the social mechanisms underlying how individuals form these perceptions for themselves (Zinn 2009). Prior scholarship has shown that sociocultural context informs *what* is perceived as a “risk” and *in what ways*, however, it has yet to fully capture *the process* by which individuals deemed at-risk make use of this information to arrive at their perceptions (Lupton 2006). This is important because the perceptions at risk people hold can vary from those who designate the at-risk status to them. When an external party labels an individual as at-risk of an illness like HIV, they are defining for that person a relationship to some pre-established understanding of threat. It is my position, however, that greater insight is gained by taking a step back to analyze how these individuals would describe their association with the “threat,” if any, and the social factors that influence this understanding. Because risks “are bound up with people’s concerns about dangers, differences, and a menacing ‘other,’” risk perceptions are subjective and cannot be easily calculated nor captured by traditional methods of assessment (Nettleton 2006:35). Additionally, as health-related risks function at multiple levels of society, analyzing risk perception formation demands a multilevel approach that considers how risks are conceptualized and confronted across these dimensions (Hart et al. 2000). Therefore, there is a need for an additional form of analysis that readily considers how the ecological levels of person’s social environment figure into their perception of risks as relevant to the reality of their life. Given the established linkage between perception and behavior, analyzing risk perception formation can uncover the various ways in which hard-hit groups, such as Black and Latino MSM, are navigating the changing landscape of

illnesses like HIV (Prinz 1997; Lidskog and Sundqvist 2013).

The Risk Ecology Framework: A Socioecological Approach to Risk Perception Formation

I highlight critiques of the traditional sociocultural approach not to identify lacunae in Douglas' formulation, but instead acknowledge how they call for a more integrative framework for understanding risk perception formation. I propose a *socioecological* approach that can begin to address this, which I define as the risk ecology framework. Rather than ask how or to what degree people perceive the riskiness of a phenomenon, the REF holds that risk perception formation can be better understood by investigating how people *give meaning to their relationship* to said phenomenon within their sociocultural environment. Reorienting inquiry through this lens not only deepens understanding of how a phenomenon fits within an individual's social world, but also prevents the insertion of risk where it may be minimally present or absent in an individual's understanding of their lived experience (Dowie 1999; Henwood 2008; Green 2009). Organizing analysis in this way makes the conceptual detangling of risk from phenomena like HIV possible, allowing for a more comprehensive consideration of ecological influences and the characteristics of an individual's risk perceptions.

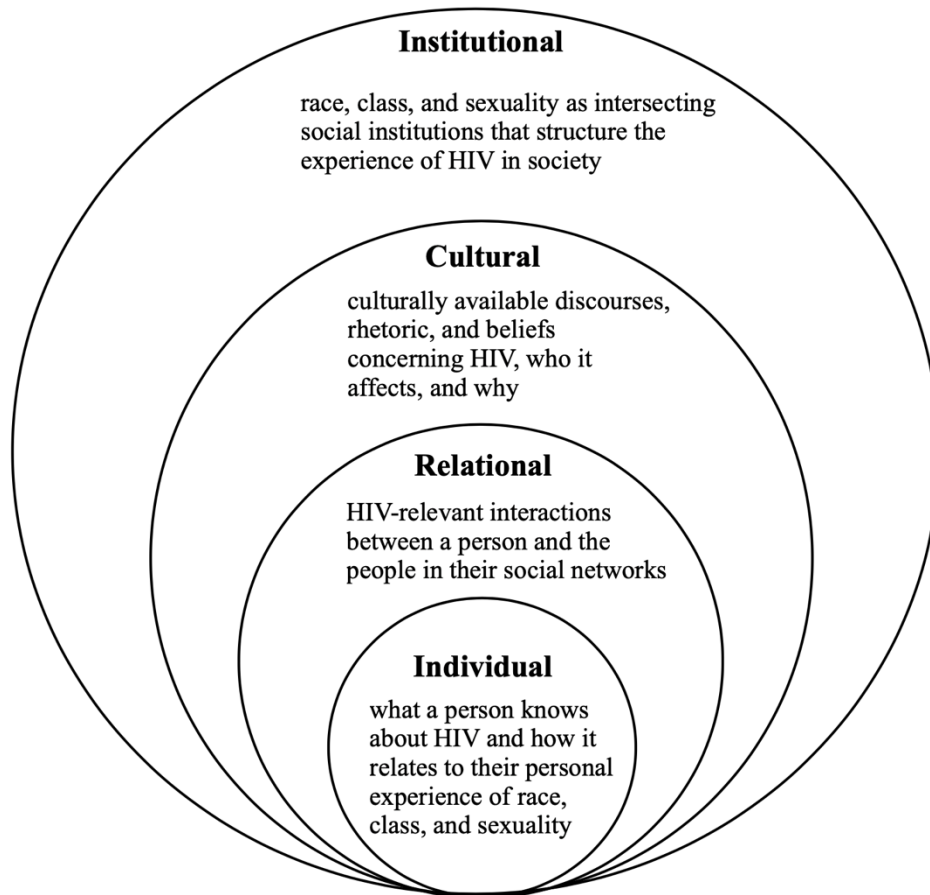
The central argument of the REF is that an individual's risk perception formation is dependent on their understanding of how a given object or phenomenon relates to their experience within a multilayered social environment. Given that health-related risks are multidimensional in nature and impact, and that risk perceptions are informed by sociocultural context, the REF is socioecological in its analytical disposition. Risk perception formation is conceptualized as an ongoing and ever-evolving process; an individual's personal life and social environment can change over time, and as a result, so too can their risk perceptions. Taking up

from the fundamental causes of disease perspective, I contend that analyzing how the social factors that comprise a person's social location are individually felt, structure their relationships, and exist as broader social institutions with cultural resonances reveals what individuals perceive illnesses like HIV to threaten, why, and in what ways. Race, class, and sexuality in particular come to be associated with HIV risk across the ecological levels of an individual's sociocultural context, revealing a *risk ecology*, or a set of interrelated potential threats HIV can pose to various aspects of an individual's life. HIV, therefore, is not inherently perceived as dangerous in some singular way, but instead encompasses a breadth of risks that are contextualized to the reality of an individual's life.

The REF adapts Weick's (1995) "sensemaking theory" as a means of analyzing an individual's risk perceptions at a particular moment in time. Sensemaking details how a person's interpretation of a plausible reality is driven by awareness of their identity within their environment, the influence of images ascribed onto them by social forces within that context, and ongoing individual retrospection that enables rationalization of past events and possible actions. Weick conceives of sensemaking as a multi-level social process that involves not just an individual's input but also the dynamics of the social relations they engage in with other actors, structures, and systems (Weick et al. 2005). The REF draws from sensemaking theory's emphasis on the individual's self-awareness to provide a process-oriented articulation of how individuals form their risk perceptions. People give meaning to their relationship to HIV by considering disease risk associations with their social location and, in so doing, demonstrate how their identity shapes their understanding of the threats HIV poses that are specific to their sociocultural context. A person's sensemaking can be analyzed through a consideration of their discursive acts, such as spoken or written narrative accounts, which provides the opportunity to

witness how people organize their thoughts to convey the meaning they impart to the object they are making sense of (Isabella 1990; Abolafia 2010). As such, qualitative methodologies are best suited for the REF's analytical strategy.

Figure 1. The Risk Ecology Framework - Levels of Analysis



Using the case of HIV among Black and Latino MSM, Figure 1 above summarizes the level of analysis covered by the risk ecology framework. Drawing inspiration from Bronfenbrenner's (1999) traditional ecological model, the REF conceives of risk perception formation as a socially mediated process that expands beyond individual action and includes multifaceted and hierarchical ecological influences. At the institutional level, race, class, and sexuality are facets of social location that can also be understood to have been institutionalized in

society. I focus on these three in particular throughout this dissertation because of their salience in the narratives of the Black and Latino MSM at the center of this study. Race, class, and sexuality are intersecting social locations whose patterning structures and is structured by society (Ferree and Hall 1996; Martin 2004). Though socially-constructed phenomena, these social factors as they function in the United States have real effects on the disproportionate experience of HIV in underserved communities due to their associated inequities, such as racism and homophobia (Watkins-Hayes 2014). The REF holds that an individual's risk perception formation involves considerations of this dynamic, either through personal experience, those of people in their social networks, or knowledge they come across in life in other settings.

Race, class, and sexuality are also significant because they have cultural resonances that undergird the social life of individuals. Language for, discourses of, and beliefs about HIV are cultural resources that contain implicit and explicit associations of HIV risk with race, class, and sexuality. The REF illustrates how these schemata are the foundations for the meanings individuals construct about their to relationship to HIV. This tool kit of cultural resources is also used by the people that comprise a person's social network. How an individual's family and friends talk to them about HIV, for instance, may include rhetoric and values that reflect certain discourses that stem from broader sources of culture, such as religion. In this way, these engagements serve as an avenue through which individuals gain further awareness of how society is engaging with HIV risk vis-à-vis their social location.

All of this comes to a head at the individual level, where one's risk perceptions can be analyzed. Through their lived experiences, individuals amass information about HIV risk and its associations. Specifically, individuals determine whether or not they are at-risk of HIV by drawing upon this knowledge to consider what infection would threaten in their life, in what

ways, and the likelihood of such. Whether or not individuals are explicitly aware of the precise ecological origins of this information is not important, as the REF shows that its influence is present across all levels. Analyzing how individuals frame HIV clarifies how they perceive the possibility of disease to circumscribe an ecology of risks that include proximate and distal impacts.

To reiterate, the REF treats risk perception formation as an ongoing process that is dependent on sociocultural context, while sensemaking offers a means of analyzing a person's risk perception at a particular moment in their life. The way a person understands HIV to fit within the context of their lives can change over time due to personal and ecological shifts. The REF's emphasis on risk perception complements the "social risks" literature's focus on behavior, which has brought to light the social factors that influence seemingly illogical decisions that otherwise make sense to an individual within their sociocultural context (Hirsch et al. 2010; Parker et al. 2017; Khan et al. 2018). Yet the REF also broadens the purview of this research by investigating the social construction of the perceptions that precede such behavior, further clarifying how an individual's actions relate to their acknowledgement of an array of risks situated across the multiple levels of their social world.

Data and Methods

The Exceptional Case of HIV in New York City

New York City was selected as the site for this study because its history with the HIV epidemic presents an exceptional case for examining risk perception formation. Exceptional cases serve a heuristic purpose for analyzing relational patterns that have yet to be made visible in the otherwise normative landscape to which they belong (Ermakoff 2014). New York City is

the only city in the United States to surpass the UNAIDS global “90-90-90” HIV targets², which is notable given that New York City had more AIDS-related deaths than any other US city during the initial years of the AIDS crisis (Jonsen and Stryker 1993; UNAIDS 2014; NYC DOH 2018). However, the disproportionate impact of HIV on Black and Latino MSM in New York City is comparable to national averages. The most recent epidemiological reports show that approximately 45% of all new HIV diagnoses in the US were among Black and Latino MSM, which is comparable to the 42% represented by this population in New York City (CDC 2019). The persistence of racial and sexual disparities suggests there are underlying dynamics that have so far escaped the present focus on improving HIV-related resource awareness, accessibility, and affordability.

Semi-Structured In-Depth Interviews

Using a nonrandom criterion-based respondent-driven sampling method, I conducted forty semi-structured interviews with HIV-negative Black and Latino MSM who are 20 to 29 years age and are residents of New York City. The average age of the respondents was approximately 26 years old. The sample does not intend to be representative of all Black and Latino MSM in the US, but it is indicative of a population that has been disproportionately impacted by an infectious disease. Respondent-driven sampling enabled access to members of this population who are typically difficult to reach (Johnston and Sabin 2010). The selected racial categories, age-range, and sexual practice criterion reflect the populations that, according to the New York City Department of Health (2019), have comprised the majority of new diagnoses.

² In order to significantly curtail the advancement of the HIV epidemic, the UNAIDS established a global program for country- and region-specific efforts to have (1) 90% of people living with HIV know their status, (2) 90% of HIV-positive people receive consistent antiretroviral treatment, and (3) 90% of those on treatment achieve viral suppression.

Given the ethnoracial diversity of New York City's population, the sampling for the study was inclusive of all who identify strongly with either or both Black and Latino racial categorizations, including biracial and multiracial individuals. Purposive sampling from various socioeconomic class backgrounds was conducted to ensure variations in social location. Occupation, education, income, and wealth served as the central components of socioeconomic class based on prior established measures (Wright 1997; Beveridge and Weber 2003; Muntaner et al. 2010). I developed the project's research instruments, recruited participants, and collected all data between August 2017 and July 2018 with approval from the Columbia University Institutional Review Board.

Diversity in participant social location was achieved through postering and the distribution of flyers promoting the study across all five of New York City's boroughs. Key informants, including leaders from community health organizations and members of the Black and Latino MSM population, provided information on appropriate postering sites. These included community health centers, college campuses, popular LGBTQ nightclubs and event spaces, and the surrounding neighborhood areas. Potential study participants contacted me via phone or e-mail and then underwent a telephone screening process to determine their eligibility based on the aforementioned sampling criterion, with the interview date and time scheduled upon confirmation of their desire to proceed with the study. Respondents were told that they would be participating in a study about Black and Latino MSM's perspectives on HIV risk. Potential participants who indicated they were HIV-positive during the telephone screening were notified of their ineligibility and that their personal information would be deleted and not used in any capacity once the call concluded. Recruitment for the study ceased when saturation in the findings was attained after interview data analysis (Small 2009). I conducted each interview,

which were held in locations that respondents indicated would be convenient, comfortable, and quiet enough for conversations about a personal and sensitive subject. These spaces included restaurants, public parks, and respondent homes. I also reserved a private office space for respondents who had no access to or preference for location.

The primary goal of the interview was to trace the development of the individual's sensemaking about their relationship to HIV within the broader sociocultural context of their lives. To that end, the interview schedule was deliberately developed to promote a conversation about HIV and risk spanning the individual's adolescent upbringing, their experiences in early adulthood, as well as their outlooks on the future. Pilot interviews conducted with the key informants helped to refine the types of questions asked on the interview schedule, which was divided into five core sections of substantive inquiry: (1) social and family life (2) general health and well-being (3) knowledge about HIV and prevention methods (4) perspectives on risk and the HIV epidemic (5) romantic and sexual experiences. Pilot interview data was not analyzed beyond this capacity. Further information pertaining to the logistics of the semi-structured interviews are provided in Appendix A.

The semi-structured nature of the interview allowed for ample time to build rapport with respondents, ease into the more sensitive and complex aspects of the discussion, and explore topics of particular import to the respondent in greater depth. A majority of the questions were designed to be open-ended to promote a fuller exploration of respondent's perceptions (Weiss 1995). The concept of risk was allowed to arise naturally over the course of the interview, but targeted questions explicitly referencing risk were also used to encourage deeper exploration of the individual's thinking about the concept (Henwood et al. 2008). Respondents were reminded that they could choose not to answer questions for whatever reason without any repercussions. I

encouraged respondents to ask clarifying questions of their own, as well as about my own thoughts on the questions posed. Engaging in these moments of self-disclosure was central to fostering an open environment in which respondents felt safe enough to provide extensive accounts of their experiences and perspectives without fear of judgement or breach of confidentiality (Dickson-Swift et al. 2006).

All interviews were professionally transcribed. I subsequently coded and recoded the transcripts using an inductive-deductive process informed by Fereday and Muir-Cochrane's (2006) methodological approach. This hybrid process allowed for situating collected data within the existing literature while allowing for the emergence of novel themes and subsequent insight unique to the context of the present study. Data were analyzed from a frame analysis perspective, which offers a means of understanding "how cognitive processing of events, objects, and situations gets done in order to arrive at an interpretation" (Johnston 1995). In the context of risk, frame analysis has shown that individual, social, and environmental variables heavily shape the characteristics of a frame (Kasperson, et al. 1988; Sjöberg 2000). Frames therefore serve as an observational lens that can be used to interpret the HIV risk perception formation process of Black and Latino MSM (Elliot 2003; Lewicki et al. 2003). Interviews were conducted and analyzed concurrently so that prior interview analysis could inform the analysis of future interviews (Miles et al. 2013).

Participant-Observation

To supplement my investigation, I conducted participant observation with Qatalyst (pseudonym), which is a community-focused health advocacy organized by and for gay men who are dedicated to creating health education programming that confronts the stigma surrounding

HIV/AIDS and sexual identity. Qatalyst is open to all members of the LGBTQ community but focuses specifically on men who have sex with men, including gay and bisexual individuals. As such, my intention for conducting participant-observation was to get a sense of how Black and Latino MSM were collectively conceptualizing and confronting the contemporary HIV epidemic outside of the context of a formal interview. A majority of Qatalyst's NYC chapter organizers and volunteers are Black and Latino MSM who develop HIV-related programming that is contextualized for LGBTQ people of color. In my capacity as a volunteer, I attended, participated in, and helped facilitate eight of Qatalyst's scheduled events. I also took descriptive notes about each event's intended purpose and structure, the communication used to advertise the event, as well details about the selected venue. During each event, I had informal conversations with attendees and other Qatalyst volunteers to discuss their perspectives on how HIV affects Black and Latino MSM, as well as their thoughts on how the event was going and its capacity to accomplish its intended goal. These conversations were separate from the semi-structured interviews that comprise the core of this dissertation, therefore they were not recorded nor analyzed in the same capacity. Insights from these conversations were included as part of the field notes I recorded during and after each event.

Overview

The central aim of this dissertation is to advance the risk ecology framework as a socioecological approach for analyzing risk perception formation. To that end, each chapter is devoted to detailing the constituent parts of the framework. Beginning at the individual level and ending at the institutional level, these chapters bring to light the ecology of risks reflected in Black and Latino MSM's HIV risk perceptions. In "Chapter II - Body / Self: The Role of Race,

Class, and Sexuality,” I focus on the individual level and examine how study participants understand their own racial identity, socioeconomic class, and sexuality with respect to HIV risk. I show how respondents’ risk perceptions are composed of a limited plurality of framings of HIV as a risk to bodily health and social well-being, or as an illness that does not present any personally relevant threats. I focus on three individuals whose risk perceptions most clearly align with each framing, utilizing their narratives as points of comparison for the experiences of other respondents throughout subsequent chapters.

I continue with “Chapter III - Kith / Kin: The Influence of Family, Friends, and Partners” where I focus on the relational-level and argue that an individual’s interactions with the people in their social networks influence their risk perceptions. I show how shared experiences inform how individuals understand HIV risk to relate to their race, class, and sexuality. These relationships are also important aspects of an individual life that can be threatened by HIV risk infection. In “Chapter IV – Culture / Schemata: The Impact of Religion, Biomedicine, and the Gay Community” I center on the interplay between the institutional and cultural levels of a respondent’s social environment and how they figure into respondents’ HIV risk perceptions. I highlight how individuals and the people in their lives make use of a sensemaking tool kit when forming and conveying their HIV risk perceptions. Religion, biomedicine, and the gay community activate and diffuse beliefs, rhetoric, and discourses about HIV risk that comprise this tool kit. I demonstrate how the schemata underlying these cultural resources shape respondents’ views about the potential consequences of HIV infection.

“Chapter V - Passion / Peril: On Perception, PrEP, and Sex” serves to articulate the strength of the socioecological approach I develop in this dissertation. I begin by applying the REF to comprehensively analyze the HIV risk perceptions of one respondent, highlighting

comparisons and differences with those of other respondents. I then show how insights from the REF clarify the link between perception and behavior, arguing that risk perceptions shape intended decisions but cannot predict realized actions. I focus on PrEP use and sexual interaction as two health-relevant behaviors that encompass a degree of uncertainty that risk perceptions can acknowledge but not fully account for. I conclude my dissertation with “Chapter VI: Projected Futures / Possible Realities: Policy Impacts and New Directions,” which discusses the broader generalizability of the REF and its broader impacts for health policy. I focus on how Qatalyst’s work as a health advocacy group can inform future risk ecology-based interventions for HIV that are contextualized for vulnerable communities.

CHAPTER II

Body / Self: The Role of Race, Class, and Sexuality

I'm the only one who values my life / and sometimes I don't give a damn.

— “Cordon Negro,” Essex Hemphill

The present chapter focuses on the individual-level component of the risk ecology framework that is critical for comprehensively understanding how Black and Latino MSM form their HIV risk perceptions. I demonstrate how this can be accomplished by inquiring how people *give meaning to their relationship to HIV* given the influences of the broader ecological system they exist within. By focusing on HIV in particular, I exhibit this framework's capacity to accommodate the mutability of both the landscape of an illness and an individual's lived experiences. HIV's recent transformation into a chronic manageable illness, as Celeste Watkins-Hayes (2014) put it, “has produced new social and cultural realities” that are likely to continue evolving as the world moves towards becoming AIDS-free. Analyzing HIV risk perception formation through this approach illustrates how the perceptions people possess are malleable and can change due to ecological shifts.

Across all 40 interviews, I find that respondents made sense of their relationship to HIV at the interface of their lived experience and their knowledge of the virus and its epidemic. In particular, respondents considered their race, class, and sexuality in relation to HIV risk; their sensemaking draws from their integrative understanding of how HIV relates to these social factors, and their intersections, across ecological scales. Aspects of risk arise as a quality of the respondent's sensemaking in ways that are specific to the experience of identity within their unique sociocultural context. These insights underscore how respondents arrive at perception of an HIV risk ecology, or set of interrelated potential threats that are hierarchically situated across

their lives. The HIV risk ecology is cross-cut by three distinct frames: corporeal, stigma³, and irrelevance. These frames constitute patterns of thought that structure the respondent's perceptions of HIV as a risk to their (1) bodily health, (2) social well-being, or its (3) irrelevance as a risk to any significant facet of their own life. These frames reflect the central attributes of their risk perceptions, which include the presence and nature of risk in their sensemaking about their relationship to HIV, what they perceive HIV to threaten in their lives, and awareness about how their lived-experiences compare to those of others. Risk perceptions are not typically categorized by a singular frame, but instead reflect aspects of some or all frames, and one frame can be more salient than others. For example, there are respondents whose perceptions are equally structured by the corporeal and stigma frames, given their understanding of the self as vulnerable to certain threats they perceive HIV to pose to their biological health and social life. These frames lend additional depth to previous research on the social values, constraints, and consequences that inform HIV-relevant health behaviors (Hirsch et al. 2010; Parker et al. 2017).

While the corporeal, stigma, and irrelevance frames could be infinitely individuated per the uniqueness of every respondent's life, this typology is both specified for HIV and broad enough to encompass the innumerable ways in which individuals make use of it. As facets of an individual's sociocultural context can change over time, so too can their perceptions. The irrelevance frame, for instance, is temporally situated within the recent social and scientific developments that have fundamentally changed the nature and experience of HIV today. Though the general qualities of each frame remain constant, the malleability of perceptions can be understood as variations in the degree to which certain frames become more salient as a response

³ I label this frame "stigma" to describe how HIV is perceived as tantamount to the experience of stigma, and how that stigma jeopardizes particular aspects of an individual's social life, such as the status of their relationships with family members and friends. Stigma is not the "risk" per se; rather, HIV is understood as threatening to upend the status-quo of their social world *because* of the stigma it imparts.

to ecological shifts.

To illustrate these points, I focus on the narratives of three respondents, namely Shane, Peter, and Benjamin⁴, all of whom possess HIV risk perceptions that are predominantly characterized by one of the three frames describe above. I treat these respondents as “ideal types” in a Weberian sense, as their narratives most clearly accentuate the traits of each individual frame and can therefore reveal the extent of outcomes of the sensemaking process among all other study respondents (Weber 1949; Gerhardt 1994; Kluge 2000; Swedberg 2017). The corporeal frame is most salient in Shane’s risk perceptions, the stigma frame in Peter’s, and the irrelevance frame in Benjamin’s. Below I detail the characteristics of each frame and the process by which each of the ideal type respondents arrive at them. I then draw on insight from other respondents to illustrate the various ways in which Black and Latino MSM give meaning to their relationship to HIV through these frames. I primarily center on respondents’ perspectives on the CDC’s latest reports concerning Black and Latino MSM, as these conversations frequently led to deeper discussions about how they were thinking about HIV risk and its place in their lifeworld. While the individual level is the primary focus of the present chapter, respondent narratives also bring in the significance of meso and macro factors that are discussed briefly here and more thoroughly in subsequent chapters.

The Corporeal Frame

Shane, a 27-year-old Black and South Asian upper-middle-class gay man, moved to New

⁴ All names of individuals used henceforth are pseudonyms that were chosen to protect the identities and other personal information of the entities involved. To further protect the privacy of study respondents in particularly precarious situations, certain identifying information, such as religious affiliation or country of ethnic origin, were omitted or altered.

York City to work on political campaigns he had grown passionate about during his time in college. Originally born and raised in Florida, Shane is the son of a single mother whose “personality and worldview” he shares. Shane also maintains a relationship with his father and two step-sisters, though given his parents’ divorce shortly after his birth, he has “never known a life that was a two-parent household.” He describes his upbringing as taking place in a “diverse-utopia;” growing up alongside Cubans, Colombians, and Venezuelans, Shane never felt like his identity was an anomaly, nor that his existence was ever “framed or consumed in a way that was fetishized.” Having traveled extensively throughout his life, both for personal and professional reasons, Shane has found this experience of “othering” to be a common occurrence in many of the places he lived. Despite the ethnic and racial diversity of New York City, Shane spent several years of his adult life living in a predominantly White part of Brooklyn. As a “neighborhood-y person,” Shane typically enjoys fully immersing himself in the spaces that surround his apartment yet he describes having particular difficulties adjusting to his new home given how different he was from his neighbors. Even so, Shane never felt isolated, finding community among his college friends that had also moved to the city, as well as establishing new bonds through his extended social networks.

Given more recent changes in his career, Shane has lived a partially bicoastal life, spending significant parts of his time traveling between New York and California. When I first approached him about participating in my study, Shane had recently finalized a major decision he had been mulling over for some time: leaving New York City altogether and establishing himself out west. Certain circumstances surrounding the work he was contracted for ultimately prolonged his stay in California far beyond his original expectations, but this additional time offered Shane the space to question what he was “rushing back to New York for,” leading him to

take root right where he stood. As luck would have it, I too would find myself in California for work a few months later, and Shane was more than willing to pick-up where we left off and speak with me upon my arrival. Though he has called many places home over the course of his life, the years he spent in New York City were particularly formative and were the central focus of our interview.

I met with Shane at his apartment, which was one of several units that faced a communal pool, all tucked away behind a gated enclosure. It was morning and the silence that permeated this suburban neighborhood was striking in comparison to the incessant noise of life in New York City. Dressed in a black t-shirt with matching sweatpants, Shane sleepily greeted me at the gate and told me that this neighborhood, being home to many high-profile and wealthy families, had been experiencing a series of break-ins that necessitated the added protection. As he walked me to the living room area, he let me know that our discussion would be his first activity of the day. I took a seat at one of two chairs beside a small coffee table, where Shane placed a glass of water for me atop a stack of magazines. Despite the fatigue in his eyes, Shane sat across from me and shared his excitement about being able to relay his views on HIV, a topic he tells me he is especially knowledgeable about.

At Risk of the Bodily Costs of HIV

The corporeal frame involves the interpretation of HIV as an infectious disease that is inherently a danger to the biological health of the self and others. Respondents who use the corporeal frame communicate their sensemaking conceptualization of the self as always at-risk of infection, the potential for which must be avoided or mitigated at all costs for the benefit of individual and public health. As an ideal type, Shane embodies the corporeal frame most clearly

among the respondents I interviewed for this study. To perceive one's relationship to HIV through the corporeal frame of HIV means that one understands himself to not be exempt from the possibility of infection unless they are taking active steps to mitigate their exposure to the virus. HIV in essence comes to be viewed as a consequence of not taking proper precautions that are predicated on active efforts on the part of the individual. The potential to become infected with HIV represents an ever-present danger to health that is spoken of in terms of probabilities or likelihoods that are heavily determined by individual action. Regardless of the "degree" to which risk can be calculated or, at the very least, estimated, the individual is effectively always at-risk of infection. Shane reflects this when he talks about risk more generally, stating:

I think risk is, whether it be unintended or intentional, is doing things that would increase your likelihood of exposure to these diseases, whatever that might be...drug use, unprotected sex with people whose status you don't know, anything like that...

In the above excerpt, Shane makes it clear that regardless of intentionality, actions that can increase exposure to infectious diseases like HIV are at the heart of what he understands risk to be. Among those who use the corporeal frame, it is typical for HIV to be understood almost exclusively in terms of the risks it poses to one's health.

Shane further articulates this framing as he goes on to talk about his specific outlook on HIV and specific behaviors that could lead to exposure, saying things such as "having unprotected sex, by definition, puts you at higher risk" of HIV, and that sex should be done "in a way that is informed and safe" regardless of the number of partners one has. Under the corporeal frame, HIV is always a potential negative outcome of sex, and this is reflected in Shane's insistence that sex be engaged in a particular way that mitigates the risk of exposure. Shane's emphasis on being informed resonates with the words of other respondents who also make use of the corporeal frame. For instance Gary, a 26-year-old Black and gay man born in the West Indies

and raised in Brooklyn, understands risk as "doing something knowing that there are potential negative repercussions." He, much like Shane, holds the view that to become HIV positive is to compromise overall health, as the body will always be "constantly fighting something." In all of these cases, the principle of "knowing" plays a significant role as it speaks to the uncertainty at the heart of the corporeal frame, given that HIV comes to be understood in terms of probability.

For individuals who frame HIV as a risk to their bodily health, it is not uncommon for them to adopt this same "biomedical rhetoric" when making sense of the actions they take, as well as their potential consequences. Wallace, a 27-year-old middle-class Black and Latino gay man, currently resides in Harlem but was born and raised in the Bronx to parents from the Caribbean and South America. Wallace describes "risky behavior" as the act of "allowing variables to slip out" of his control during sex with a partner he does not know well:

I can't prevent myself from getting whatever this person may have, because I don't know them. It's already risky in that I don't know this nigga, and so I could get an STD from them ... it's like relinquishing control ... Drinking a lot is risky because then I'm not really thinking about, "Oh, I should be safe." Trying drugs that other people are giving me is also risky. A lot of it is just not thinking through like, "Oh, this could happen, and there could be consequences afterwards that I won't want."

As is made evident in the above excerpt, Wallace views behaviors that reduce his capacity to be fully aware of his circumstances and potential consequences as "risky." Having sex with a partner he does not know well constitutes a risk because of the lack of knowledge he has about their sexual history. Wallace views drinking and drug use, activities that have already been linked to increased HIV exposure through prior research, as risky because they impede him from receiving the knowledge he needs to be certain about his actions and their consequences (Fendrich et al. 2013; McCarty-Caplan, Jantz, and Swartz 2013). Sex, as a primary mode of HIV transmission, is obviously an important topic that merits further analysis. How respondents understand and engage in sex with regard to their perceptions of HIV is touched upon throughout

this work, with targeted exploration of this subject being presented in Chapter V.

Among respondents who make use of the corporeal frame, risk is simply a fact of life itself, and HIV is an inescapable possibility among the sexually active. Merely participating in actions associated with risks is enough for one to be considered at-risk. Shane clearly demonstrates this line of thinking when he states that:

Everybody's always at risk of HIV, that's by virtue of being a sexually-active person... Unless you're abstinent. Which is its own thing. You are at risk of HIV. It's like saying, "Do you drive?" Well, you're at risk of a car accident.

Shane's comparison to the risks that come with driving show how he views the risk of HIV as inextricable from an action that could expose him to it, namely sex. Abstinence for Shane constitutes an immunity from being at-risk of HIV because it involves the individual not participating in a potential mode of transmission whatsoever. There are, of course, other ways in which HIV can be transmitted, such as through the sharing of needles or breast-feeding. Within the specific context of Shane's life, however, sex is the only relevant method of transmission, and given that he is sexually active, he understands himself to be at risk of HIV regardless of the precautions he takes. Indeed, Wallace, the Black and Latino gay man living in Harlem that I introduced above, also states that he cannot think of HIV "in any other way," highlighting a moment in the past where he felt indifferent about his relationship to HIV, but nevertheless noting that he had "been in dark places at that time, so I wasn't being logical." That viewing himself as at-risk of HIV is the logical thing to do, however, is rather telling of the sense of rational objectivity characteristic to the corporeal frame.

Gary, the West Indies-born Black and gay man mentioned previously, offers more insight into this characteristic when he says that even though "it's a low risk," he is "at risk of HIV right now" because "there's always a small chance." The mere existence of the possibility of HIV is

enough for Gary to perceive himself as at-risk. The "low risk" he speaks of stems from his concern about not having been tested after his most recent sexual encounter, despite having used a condom. The corporeal framing of HIV captures a need to be vigilant about one's own health and the behaviors that can compromise it, even in instances where precautionary steps have been taken. Among individuals who make use of this frame, HIV testing is seen as a rational action that provides objective data that can diffuse the uncertainties they have about HIV. Gary's experience and the use of prophylactic technologies and engagement in other preventative behaviors is discussed thoroughly in Chapter V.

In analyzing the significance of risk, one must also consider exactly what has the potential to be threatened or compromised at the individual level. As was previously mentioned, a person's own bodily health is the primary cost in the corporeal framing of HIV. Examining exactly how respondents conceptualize this threat further clarifies how they perceive their relationship to HIV. Shane, who is among the most knowledgeable of respondents about HIV research and care, makes his concern clear when discussing what it means for a person to be HIV-positive and "undetectable":

It means that you can take medicines that can suppress and help your body keep the virus under control and keep your levels at a point that makes you less susceptible to it evolving into AIDS, but you will, at current stages, never be able to rid yourself entirely of the virus. Which means that, as of right now, if you contract HIV then for the rest of your life, even if you will have what scientists say is a maintained life expectancy, you will always be, in some capacity, at risk of AIDS. And also, if you stop taking the medications, then the virus has a chance that it will come back at its unsuppressed levels.

Achieving undetectable viral loads has been the primary goal of medical care providers for HIV-positive individuals as it prevents the development of AIDS. This goal is at the core of initiatives in the care continuum to ensure HIV-positive people are consistently adhering to their prescribed treatment over the course of their lives, and is what has effectively transformed HIV into a

manageable chronic illness. Recently, CDC backed research that verified the long-held and well-supported claims from experts that people with undetectable viral loads cannot transmit HIV to others (Eisinger, Dieffenbach, and Fauci 2019). Despite being aware of this, it is necessary to note the finality with which Shane speaks: one will "never be able to rid" themselves of the virus, and, the risk of AIDS will always exist, even if it is only in "some capacity." For Shane, HIV fundamentally changes an individual's bodily composure by creating a chronic sense of vulnerability, its prior state being completely irretrievable. It is for these reasons why he later goes on to state that while HIV is "not a death threat anymore," he and others should not "be blasé" or apathetic towards it.

Sam, a 24-year-old Black and Queer man from Pennsylvania who moved to New York City for work shortly after college, similarly shares that despite advancements in treatment making HIV more than manageable, he highlights how his concern about HIV is unchanged, as being positive comes with "the potential of getting sick." The possibility of AIDS developing, as well as the state of being immunocompromised and therefore potentially more vulnerable to other illnesses, is why Sam frames HIV as threatening to his health. The social impact of being HIV-positive, of course, is not lost on individuals who align themselves with the corporeal framing of HIV. Sam highlights the "burden of having a stigmatized condition" as being of concern too, but this takes a backseat to the corporeal effects he views as immediately pressing. Adopting a frame perspective in the analysis of risk perception formation can reveal the varying types of frames that define the meaning individuals give to their relationship to HIV. For respondents like Sam and Shane whose risk perceptions are chiefly marked by the corporeal framing of HIV, however, the social aspects of being HIV-positive are secondary to their concerns about HIV's effect on the healthiness of their bodies.

Arriving at a Corporeal Framing of HIV Risk

In the introductory chapter of this dissertation, I proposed an adaptation of Weick's (1995) concept of sensemaking for the analysis of risk perception formation. Employing this analytical approach reveals that respondents' HIV risk perceptions are a product of how they associate the lived experience of their race, class, and sexuality with respect to HIV. Respondents arrive at a set of framings about HIV risk that underscore this consideration of their social location, their "sense" then being made with the telling of their narrative accounts during the interviews. The corporeal frame, along with the stigma and irrelevance frames that are discussed later on in this chapter, comprise the range of overarching patterns of thought that structure how individuals understand HIV to fit within their sociocultural environment and the ways in which it may or may not affect their lives.

This sensemaking process can be seen most clearly in Shane's reaction to the aforementioned CDC (2016) report that claimed 1 in 2 Black MSM and 1 in 4 Latino MSM will have HIV in their lifetime. After summarizing the statistics to Shane and asking him to reflect on his thoughts about them, he states that:

It's maddening that the stats exist, and it's maddening that it seems like the general population is not also mad about it. Like how're you gonna let half your population come down with a chronic illness, and be like, "Okay"? You know?... I think also, I talked to some friends who are not as deeply-engaged with it, cause, my mom...I'm always struck by their saying, "Well, that just seems wrong," as a way to absolve themselves of responsibility ... Like even a refusal to believe that the number is accurate is more infuriating again, because, here we go, back once again, talking about black people and people of color can't just live their damn lives without you over there questioning it because you haven't experienced it yourself or whatever...

Shane's issue with the information provided by this epidemiological report is rooted in his broader disenchantment with the apathy he senses from others towards the experiences of Black

people. Shane had heard about this report prior to the interview and has since been troubled by how the broader United States population does not seem to be as knowledgeable as he is about the contemporary epidemic. Of particular note is his frustration that others who haven't "experienced" what it means to be a person of color in this particular situation may be limiting themselves from empathizing with efforts to reduce HIV infection among this population. It is in this moment that Shane begins to engage in his sensemaking, as he is associating his own experiences as a Black man to the broader impact of HIV experienced by other members of his racial group. The CDC report is one of many sources of information Shane had been exposed to that defined Black MSM as being at-risk of HIV; sexual health education and conversations with relatives also served as influential sources of HIV-relevant knowledge. Because Shane identifies as a Black MSM, he has also come to understand himself to be irrefutably at-risk. The apathy Shane mentions also relates to how race, class, and sexuality function as social institutions America, and the ways in which associated discourses about HIV's impact on minority communities influence the respondent's risk perception formation. These discourses, along with the aforementioned biomedical rhetoric discussed above, are a part of a "sensemaking tool kit," or a repertoire of cultural resources Shane and other respondents draw from to formulate and convey their framings of HIV. This concept is discussed comprehensively and in fuller detail in Chapter IV.

In a more explicit example of this corporeal framing, Shane processes the information from the CDC report and what it means for his existence as a Black man who has sex with men:

Hearing a stat like that and then not taking responsibility to protect yourself is a form of risky behavior, right? ...I think for me it's like, knowing that the statistics and...not just black and brown — races like to have sex with themselves — if you are in a population group that is infected with one person that's infected and then that gets transmitted like that, then it puts you at higher risk....I just need to be more on my guard. You know? Trust no bitch.

Shane touches upon the principle of "knowing" as it relates to his corporeal framing of HIV. For Shane to be aware of the information presented in the CDC report and not try to adjust his behavior would, in his eyes, constitute risky behavior because he is not actively mitigating his potential for exposure. He processes the report's information further by referring to previous research on intra-racial sexual homophily among young black men who have sex, which finds that the sexual networks of these individuals are partially determined by race (Clerkin, Newcomb, and Mustanski 2010; Newcomb and Mustanski 2013). This figures into his perception that he is at higher risk of contracting HIV if he sexually interacts with men who are already deemed at-risk. Rather than ignore an entire subset of potential romantic and sexual partners based on these statistics, Shane interprets this as his reality and chooses instead to be more vigilant, with vigilance being understood as a medical gesture that protects his bodily health. This vigilance translates into a mistrust in potential partners that inspires his more proactive use of prophylactic technologies since he understands himself to be "at higher risk." The dynamics of partner selection and the use of protection during sex are discussed further in the following chapters.

Shane is not alone in how he perceives his relationship to HIV through the lens of a corporeal frame. Gary, for example, admitted that hearing the CDC report brought him "a little bit of anxiety," causing him to pause and reflect on his previous sexual partners who were Black and Latino MSM. He hopes that his previous partners were "different" than the men captured by the statistical projection, but that he ultimately could not be sure and therefore felt that he too was at-risk. Sam similarly identifies himself as at-risk:

...literally being the demographic, I don't take that into consideration just given the background and the privilege afforded to me, but at the end of the day, hell, yeah, I'm at-risk ... I really do because the whole thing of having experienced

violence and still being from the blessed and full privileged background I'm from, hell, yeah, I see myself at-risk. Because I never thought I was at-risk for violence, but then when I got my ass beat, hell, yeah... that could be me. You never know. Just because it's you really never know these days. I mean that's why I take PrEP, but even PrEP isn't a 100%.

There are several important points Sam makes in the quote above, all of which speak to his sensemaking. Most striking is his acknowledgement of how his race and sexuality categorize him as the demographic the CDC is speaking on, yet he did not immediately see himself reflected in these statistics. Specifically, he touches upon the "background and privilege" afforded to him, which is in reference to his upper-middle-class background. Indeed, Sam grew up in a well-to-do household, going on to complete his college education and securing a well-paying job in finance shortly thereafter. As previous research has shown, individuals of higher socioeconomic status are often considered "at lower risk" of HIV due to the social, cultural, and financial capital that structurally stem typical avenues of exposure (Gillespie, Kadiyala, and Greener 2007). Though Sam would like to think himself exempt from exposure to HIV infection, he recalls his previous experience of domestic abuse, something he thought himself to be shielded from. It is this comparison which ultimately leads him back to the uncertainty at heart of the corporeal frame, as he claims he can "never know" whether or not he may be exposed to HIV despite how protected he may feel as a member of this demographic. This perception is what encouraged him to take Truvada, a pre-exposure prophylactic HIV medication to mitigate his exposure, but even the medication's marketed reduction of HIV risk is not certain enough. This reflects his corporeal framing of HIV as an inescapable risk to wellness.

The topic of privilege and background brings to light the significance of socioeconomic factors in discussing the particular impact HIV has had on Black and Latino MSM. As many respondents who were familiar with the CDC report noted, the projections read as alarmist

blanket statements that are devoid of context. Shane, who has been actively keeping himself informed about the current state of the HIV epidemic in the United States, finds it necessary to consider these probabilities as specific to certain socioeconomic circumstances:

I don't think it's an equal distribution...the data shows in areas where public health systems are strong, the rates of infection have gone down. In areas where the public health system and infrastructure is poor, the rates have not gone down, and also, let's face it, our public health system is not equally applied, so...there are communities that are disproportionately affected because of a number of reasons. One of them being lack of access to health services, lack of education, access to education, you know, lots of things.

What Shane describes is information from recent epidemiological research that has found overall national HIV infection rates to be decreasing over the recent years, albeit with increases being identified within particular demographic groups and geographic areas (Meditz et al. 2011). In this way, Shane views the CDC report's statistics being more relevant to the Black and Latino MSM who live in areas where the access to and quality of HIV-related knowledge and care is low. Shane, much like Sam, comes from a wealthy household with medical professionals for parents, thus he has always had access to the knowledge and care he finds to be unevenly distributed in the United States. This does not, however, preclude Shane from viewing himself as at-risk of HIV; like Gary, Shane considers himself to be at low risk of HIV infection, but at-risk all the same because he is still sexually active. Shane's greatest fear is failing to "maximize all of these opportunities and gifts" he was born into; becoming HIV positive would be an affront to the circumstances that are meant to mitigate his exposure. In this way, Shane is interfacing his own socioeconomic class with what he knows about HIV to inform his perception of being at-risk of HIV within the sociocultural context of his own life.

Further insight can be gained through the consideration of the experiences of Wallace, the Black and Latino middle-class gay man who views lack of control in sex due to drug use as

“risky.” Wallace grew up with significantly fewer resources than Shane did. Much like other respondents discussed thus far, Wallace processed the impact HIV has had on Black and Latino MSM as being a result of inequalities that make these individuals disproportionately vulnerable to HIV infection. In his own life, Wallace has noticed an increase in the number of Black and Latino MSM he meets who are positive, to the point where he feels that it is “everywhere,” albeit with an accompanying lack of discussion because it is “just really scary to talk about.” Reflecting on the experiences of an HIV-positive friend of his, he highlights the significance of class when he states:

It's different for him because he has money ... he can take care of himself ... this person is like fully functioning. He's doing well. He's going to law school. He's still seen as desirable. He gets to like date and shit ... he's still struggling just like everybody else, but he seems to be doing okay. It's just like, “Yes. Okay. Someone can lead a normal, fulfilling life with HIV.” At the same time, he has things that a lot of people in my neighborhood or neighborhoods like mine, a lot of people that look like me do not have...Black people are actually dying from it when they shouldn't be, but didn't have access [to] adequate healthcare.

As many respondents mention throughout their interviews, HIV has transformed from a mark of certain death to a manageable chronic illness. Wallace's narrative, however, highlights that the opportunity to lead a “fulfilling life with HIV” is not guaranteed, nor is it equally available to all. Specifically, he highlights how his friend has the capital to tend to his medical needs and maintain his social life, imparting upon him a desirability Wallace otherwise understands to fade should one become HIV-positive. His friend is an outlier whose circumstances are unlike those of Wallace and the others in his neighborhood. It is here that Wallace is engaging with his own socioeconomic class to maintain his perception of being at-risk of HIV. Wallace's narrative also demonstrates the particular influence friends and other people, such as relatives, can have on an individual's perceptions about HIV, a subject that is thoroughly examined in the next chapter.

The Stigma Frame

Peter, a 26-year-old Latino and White working-class bisexual man, was born and raised in the Lower East Side neighborhood of Manhattan. The son of parents who hail from South America and Northwestern Europe, Peter takes pride in his diverse heritage as it intersects with his identity as a tried and true New Yorker. He lives at home with his mother in the home he had known all of his life, spending his free time between playing videogames and frequent nights out on the town. Not one to shy away from the things that bring him pleasure, Peter refuses to feel shame for the joy he finds in casual sex and recreational drug use. While he finds that others often disparage him for what they would consider reckless behavior, Peter understands himself to be acting thoughtfully and with more caution than his peers could ever realize.

A creative mind with an entrepreneurial spirit, Peter forewent the traditional path of completing his college education and chose instead to make a living out of his own fashion and design brand. Growing up in a low-income household, Peter was making good on changing his circumstances and establishing financial security for himself. However, after garnering much success a few years into his early 20s, Peter unfortunately had to abandon his business when a family member had secretly stolen a majority of his earnings. He resolved to recoup his losses by serving as a freelancer in the fashion and design, but in doing so found that he had grown to be resentful of this industry. It was at this moment that he decided to switch focus and pursue his other untapped passion: writing. At the time of our interview, Peter was working on a comic book while also producing provocative essays about his own lived experiences, with particular focus on sexuality and sexual health. Peter did not receive any formal training in writing, but nevertheless has developed it into a fruitful outlet for his formerly stemmed creativity.

I met Peter on a temperate Saturday afternoon outside of the building in which we would be holding our interview. With exhaustion echoing in his voice, Peter apologized for having needed to reschedule our initial morning meeting, as he had gotten very little rest. He was dressed comfortably in the prior evening's outfit, consisting of a simple midnight blue t-shirt and dark green pants, accented with a stylish black jacket and sneakers. Peter shared that an acquaintance of his, who is a fixture in New York City's gay nightlife scene, had invited him to the launch of her new weekend party; he would have been hard-pressed to ever miss the inaugural festivities. If he seemed lethargic, Peter gingerly explained, it was because he had been taking large amounts of drugs and engaging in sex with multiple simultaneous partners well into the early hours. As we walked into the office space I reserved for the day, Peter and I took seats at opposite ends of the small table in the center of the room. Rubbing out the remaining vestiges of sleep from his eyes, Peter smiled and thanked me for the opportunity to talk about HIV, a subject he is as passionate about as he is worried.

At Risk of the Social Costs of HIV

The stigma frame is similar to the corporeal frame in that it reflects the view of HIV infection as always being a possibility; the individual always understands the self to be at-risk. The key difference that exists between these two frames, however, is that under the stigma frame, HIV is perceived primarily as a threat to social welfare rather than bodily health. I label this frame as such not to suggest that stigma is the singular risk HIV presents present, but rather to describe how adherents to this frame conceive of HIV as part-and-parcel to a persistent stigma that can threaten, damage, or disrupt distinct tenets of their social life. The stigma frame conveys a perception of risk rooted in concerns over HIV's threat to their individual social standing, the

well-being of interpersonal relationships, and the perpetuation of societal HIV-related stigma. As is discussed below and in subsequent chapters, these risks extend across the levels of the respondent's social environment.

Peter, the young man who was introduced above, is an ideal type respondent who understands his relationship to HIV in ways that strongly resonate with the stigma frame. "No longer a death sentence" is a description of HIV shared by several respondents, but it was Peter who followed it with a crucial qualification: "it is a life sentence." Now that HIV has effectively become a manageable chronic illness, the fear of death at the hands of a compromised immune system has, for many, been replaced with concerns over how positive status will impact the sociality of their being. These concerns are rooted in the original stigma that arose around being HIV-positive back when little was known about the illness other than the untimely death it brought about, as well as scrutiny of the behaviors of those who were most affected by it.

Peter further captures the essence of the stigma frame when he describes HIV as being different today "because you can live a long healthy life, but you still have to live with the stigma that other people place upon you." To this effect, what individuals feel that HIV threatens to compromise under this framing is akin to some of what those who carry a "mark of disgrace" in society often lose: credibility, public image, self-worth, and the general normalcy of life as a "whole and usual person" (Link and Phelan 2001; Goffman 1963). Because the contemporary HIV epidemic is now better understood, individuals aligned with the stigma framing of HIV understand infection as passing on a sense of shame about not having learned from the experiences of those who preceded them.

Individuals like Peter who make use of the stigma frame come to view themselves as irrefutably at-risk of HIV specifically because of the particular sociality of the illness and its

associated stigma. Peter, for example, says "I don't know why I wouldn't be" at-risk of HIV given what he, a very sexually active person, knows about how it is sexually transmitted. This feeling of being an at-risk person is at the core of his rather proactive HIV testing:

So, I go once a month, every single month to get tested. I used to go sometimes two [times a month] when I was really going crazy because that's super important, especially if I'm going to be having sex with a lot of people. I think a: I always owe it to myself first b: then, I do owe it to other people to make sure I know my status at all times...Personally, I know other people who have sex just as much as I do, and they get only tested once every three months, and I'm like, "that's insane."

Much like Shane and his corporeal framing of HIV, Peter views being sexually active as something that puts him at-risk of HIV. The degree to which he has sex has previously informed how frequently he goes to get tested, but what is notable here is the underlying reason why he goes to get tested at all. The importance he places on knowing his status is less rooted in concerns about his bodily health, but more so in the role that HIV-status knowledge plays in navigating conversations with his potential sexual partners, as well as the lasting impact he could have on their lives. The specific sociality of HIV is highlighted in his discussion of PrEP in relation to other STDs, such as gonorrhea and chlamydia, which the medication does not protect against. At the time of our interview, Peter had been taking PrEP for three years. Of the 800 sexual partners he claims to have been with throughout his life, he has only ever experienced eight STDs, each of which he said were "gone in two days" with "a shot in the ass or in a pill."

For individuals who use the stigma framing of HIV, the lack of a cure imparts a permanence to the illness that makes it more concerning than other STDs. Under this frame, the permanence of HIV is associated with a stigma that will alter one's social life. Jonah, a 28-year-old Latino and White middle-class gay man living in Hell's Kitchen, believes that his racial and sexual identity inherently place him at risk of HIV because of how the disease has affected others like him. When it comes to the concern underlying this perception, however, he Jonah states that

he really worries about the lasting social impact of HIV "because everything else is treatable...nothing else is lifelong." Because of the impermanence of other STDs, Jonah feels that "there's more of a negative stigma with contracting HIV, whereas people kind of joke about chlamydia." In Peter's case, should he fail to know his status and unknowingly transmit HIV to another person, he would also feel responsible for having placed this negative stigma upon his sexual partners. As will be further discussed, conversations, interactions, and experiences between individuals and other people constitute relational interactions, which are particularly influential for those who utilize the stigma framing of HIV.

The negative stigma Jonah and others speak of is at the core of what is stake under this framing of HIV. In the particular sociocultural context of the lives of individuals, this negative stigma is perceived to irrevocably change how they will view themselves, as well as how they are treated by others. Larry, a 23-year-old Black gay man originally from the Midwest who moved to New York City for work, highlights this when relating HIV to his experience of poverty:

I grew up poor and I didn't have nice clothes and I thought ... this is bad, but for somebody else, if I saw somebody else who didn't have nice clothing, I wouldn't be looking at them in that way. It's the same thing, with somebody with HIV ... I'm not thinking negative things about them ... With me, I'm like oh it's a bad thing because it's me.

Here Larry emphasizes that his concern centers on how he would view himself were he to be HIV-positive. Larry feels like he would think negatively about himself were he to become HIV-positive, but has never devalued the HIV-positive people he has met in his life. In this way, HIV is perceived to present a risk to self-worth that can unsettle the normality of the life he has known thus far. As someone who experienced homelessness while he was in middle school, Larry carried a great sense of shame for his unstable living conditions and difficult financial

circumstances in comparison to his peers. He judged himself greatly for his inability to purchase nice clothes, but would never judge another were they to be in that position. As previous research has shown, the loss of self-worth associated with HIV-stigma can have negative impacts on an individual's mental health outcomes (Herrick et al. 2013).

In speaking further about his concern of becoming HIV-positive, however, Larry emphasizes that his negative self-view is borne out of a fear of becoming undesirable to potential romantic partners:

I would be scared that I wouldn't be able to find a partner, somebody wouldn't want to be with me ... Like on a date, "oh I have HIV" ... Maybe they themselves may not think of HIV as that big of a deal, but initially meeting somebody ... that's a one thing that might be, I guess, perceived as negative or something that they might not want to have to consider or deal with. Yeah. I think that would be my fear and then I guess maybe health is a secondary, but I guess the first thing is I guess maybe finding a partner.

Larry very clearly states his worry that becoming HIV-positive will complicate the process of finding a romantic partner, something which he has been preoccupied with some time. Even without considering HIV, Larry speaks on the difficulties he has experienced since he and his boyfriend broke up, especially in New York City where he feels not enough men are looking for committed relationships. Were he to become HIV-positive, however, feeling undesirable and the added necessity of having conversations about his status present additional difficulties he would rather avoid. These concerns persist even if he feels that his potential partner would not take issue with his seropositive status. These kinds of thought processes play a central role in the actual partner selection strategies respondents employ.

What is most notable in the above excerpt, however, is that Larry explicitly expresses the core line of thinking of the stigma frame: "health is secondary." Under this framing, HIV exists first and foremost as a risk to the social dimensions an individual finds most crucial to their

livelihood. For Larry, the social act of finding and being with a romantic partner would be jeopardized, and as such HIV is viewed as a real risk in his life. Peter shares these sentiments as well, saying that being HIV-positive is like carrying a “neon sign above you” that can lead to being ostracized by partners, which he “couldn’t imagine having to deal with” despite being an otherwise “very happy, functioning, healthy person.” As was discussed in the previous section, reaching undetectable viral loads through treatment adherence is the goal for HIV-positive people, as it can prevent the progression to AIDS as well as the spread of HIV to others. Peter has come to understand undetectable status as a novel achievement in the effort to end HIV, but underscores how persistent stigma can limit this progress:

I think it's getting better, again, both medically and socially. Again, the stigma is really the thing that I feel like is making life so much more difficult for poz [HIV-positive] people. I think obviously medically it's advanced. You can be undetectable. People are recognizing what undetectable is ... that's definitely recently backed by the government, and they recognize it, which, again, is amazing, but people don't know what that is. I didn't. People literally choose to just ignore that. They still fully will be like, "Nope. Sorry. Boom. Not ever. Not taking the chance."

Peter’s account demonstrates how perceptions can be malleable due to social and scientific developments, but underscores how persistent stigma can limit this progress. UNAIDS, the NIH, as well as the CDC have recently supported several national campaigns around “Undetectable = Untransmittable (U=U)” to amplify this message to the general population (Rendina and Parsons 2018). Promoting U=U has been a central contribution of HIV researchers and activists alike, but it has only recently garnered governmental support. Despite the established and broad support for undetectable status as the new standard of healthiness for HIV-positive people, Peter believes stigma to have limited awareness and enabled a denial of its merit among HIV-negative people. Peter’s framing of his relationship to HIV continues to be reliant upon how infection would upend his social world; a Peter understands HIV to still be stigmatized among his social

networks and greater society, even reaching undetectable status would not be enough to remove the perceived threat to his social well-being. Even in instances when people do not necessarily “choose to just ignore” it, Peter is aware of a lingering mistrust about U=U that is intimately tied to his framing of HIV as being detrimental to his social well-being.

It is also for these reasons that respondents who make use of the stigma frame can come to view HIV as a tremendously personal and private topic. During an instance in which he thought he may have been unknowingly exposed to HIV, Jonah opted to purchase an at-home testing kit (AHTK) for HIV. He expressed a concern that, had he tested positive, the information would be reflected in his permanent medical record, thereby no longer making it private information. Emanuel, a 28-year-old Latino and Asian middle-class gay man, similarly used an AHTK because he “was afraid for it to be a public thing” and “wanted to face it” on his own first, as becoming HIV positive carries a social “ripple effect.” Emanuel understands the benefits of undetectable status, but the struggle of having to tell his parents and the uncertain aftermath “is the first thing” his mind goes to. Under this stigma framing of HIV, association with HIV threatens the status quo of the individual’s social life, magnifying the degree to which an individual understands themselves to be at-risk of infection. Respondents’ use of prophylactic technologies such as AHTK is discussed in further in Chapter V.

Arriving at a Stigma Framing of HIV Risk

Just as was the case with the corporeal frame, individuals also arrive at the stigma frame through sensemaking that involves their race, class, and sexuality. Both the corporeal and stigma frames are potential outcomes of this process, and while individuals’ perceptions are comprised of various frames as a result of their sensemaking, certain frames tend to be more prominent than

others. My focus is not to determine what social factors are causally related with particular combinations of frames, but is instead to demonstrate how individuals arrive at these distinguishable patterns of thought. In fact, I argue that it is not possible to neatly predict which types of social locations lead to certain perception outcomes. Instead, I make clear how an individual's risk perceptions bring in considerations of how race, class, and sexuality is linked with HIV across the multiple levels of their particular social environment. These considerations bring to light an ecology of risks, some more personally concerning than others, that individuals are confronting when determining whether or not they are at risk of HIV. Individuals experience this in unique ways, as no two people share the same lived experience regardless of similar or shared demographic background. At the individual level, it is the respondent's considerations of how they feel their race, class, and sexuality in relation to HIV that shapes their risk perceptions.

Peter's discussion of the CDC report stands as clear example of this kind of sensemaking. Like many other respondents, rejecting the corporeal frame for a stigma frame, Peter posited that health inequality is rooted in variable access to education, socioeconomic resources, and other forms of structural support in society. In addition to this, Peter highlights certain circumstances that are particularly relevant for Black and Latino MSM in New York City:

[Black men] deal with things differently because of the way other things have affected them. The war on drugs, mass incarceration, all that type of stuff, certain cultural things between them, you know. I mean, it's very similar to a lot of stuff in the Latino community, especially in New York City where they're so connected it's almost like it's the same community a lot of times. I mean, a lot of times it is with the Afro-Latino men. So, a lot of times they face both the language barrier and higher rates.

In the above excerpt, Peter highlights how certain policies and initiatives have placed Black men at structural disadvantage that limits their access to resources that would otherwise mitigate their exposure to HIV. In looking to New York City in particular, he underscores how closely

intertwined the Black and Latino communities such that they may be similarly impacted, thereby extending the impact of things like mass incarceration. In considering Afro-Latinos, individuals whose racial-ethnic identity exists at the intersections of Black and Latino, Peter also indicates how language barriers may be significant as well. When asked to expand upon this point further, Peter recalls a news article he read about how Spanish-only speaking people were disproportionately affected by HIV due to a lack of bilingual HIV outreach centers, a claim that is supported by prior scholarship (Miller, Guarnica, and Fasina 2002).

What is decidedly insightful is how Peter positions himself as separate from the people he is describing. He does not exempt himself from these statistics; much of his sentiments of feeling at-risk are because he could see himself becoming the 1 in 4 Latino MSM who contracts HIV. In using “they” versus “we,” however, Peter’s word use suggests a cognitive separation between himself and his peers. When asked to share more of his thoughts on the CDC report, he clarifies the separation as being a result of a particular geographical and financial privilege he possesses that afford him continued access to quality medical care:

I think [HIV rates] are lower. New York City is doing really well especially because they're doing a lot of outreach, and now PrEP is becoming free for all New Yorkers. We just have lots of ads all over about PrEP, how to get it, where to get it. I just think there's a lot more gay doctors in New York, so that makes it easier for gay people to feel comfortable. ... I think that is a point of privilege ... because I do have Medicaid, which allows me to get tested as often as I want, and I have a great primary care physician. I'm just super lucky to have found him.

Peter’s reduced concern over HIV’s biological impacts is largely due to the fact that he has the resources and means to prevent infection, as well as access quality treatment and care should he ever seroconvert. These serve as a potential buffer against stigma. Medical care, however, cannot treat the disruption of social life that Peter perceives HIV to threaten. His words above emphasize the exceptional case New York City presents as a place that is particularly rich in

accessible and affordable HIV-related resources and support, and what that means for the likelihood of HIV infection for men like him. As was previously discussed, while rates of HIV diagnoses New York City are lower than the national average, the differences are marginal and still highlight a disproportionate impact on Black and Latino MSM. Nevertheless, Peter has experienced particular ease in obtaining resources he has been using to mitigate his exposure to HIV, which he feels may not be as equally or easily accessed by others elsewhere. Interesting, too, is how he views his ability to possess Medicaid as a particular point of privilege. Peter qualifies for New York State Medicaid because of his low annual income, making his otherwise expensive PrEP prescription and HIV-testing costs virtually free of cost. Where upper-middle class individuals like Shane find privilege in their financial security and education, Peter's is essentially rooted in his comparative lack thereof. It is in this way that Peter sensemaking leads him to perceive himself as at-risk of HIV, albeit with the means to dodge the bodily impacts that could come with infection.

Jonah, the 28-year-old Latino and White gay man concerned with the permanent social impacts of HIV, also brings into focus the particular difficulties Black and Latino MSM may face due to shame about their sexuality, stating that “people in these communities might be ashamed of being homosexual and might not be out, so they have to find sex in alternative ways and might not use protection.” Jonah's words also spotlight “down-low” men, or heterosexual-identified men who furtively engage in sex and romance with other men. The term has roots in African-American slang, but is not unique to this population and exists across various cultures and societies (Ross et al. 2003; Boykin 2005; Saleh and Operario 2009). Jonah and other respondents describe this phenomena as a product of homophobia that is situated within their broader racial and ethnic communities, which conceives of same-sex sexuality as antithetical to racial/ethnic

identity (Battle and Lemelle Jr. 2002; Collins 2004; Battle and Bennett 2005). The existence of down-low men in these communities underscores a kind of cognitive divide between sexuality and racial/ethnic identity when it comes to HIV susceptibility. HIV is seen first and foremost as pertaining to homosexuality, and in the case of Black and Latino communities, both HIV and same-sex sexualities are conceived to exist outside the boundaries of racial/ethnic identity (Cohen 1999; Díaz 1999; Hammonds 2001). The diametric opposition of homosexuality with racial/ethnic identity is tantamount to the homophobia down-low men internalize, leading to a concealing of their non-heterosexual activity and reluctance to seek out HIV-related resources and care (Allen and Oleson 1999; Lapinsky, Braz, and Maloney 2010).

Larry, the 23-year-old Black gay man from the Midwest who worries about HIV's impact on his sense of self-worth, adds further insight into how Black and Latino MSM can come to view their non-heterosexual identity is unacceptable or an impossibility:

Well, privilege of knowing, I would say maybe like a lot of Black and Latino men have more unprotected sex because they weren't kind of pushed these messages ... I feel like in the White community White gay men have certain privileges, like where I go to school ... their family members may be a little more open ... So I would just say knowing or being told that at a younger age, "Oh you need to do these things", like "You need to make sure you have protected sex" ... there's more discussion [now], but I think earlier 20, 30 years ago, more White men had the privilege [of knowing] ... more black men were in the closet and it wasn't as accepted, plus they didn't see themselves in the media either so they'd be like I can't be gay.

In discussing the lived experiences of Black and Latino MSM, Larry compares his upbringing to what he knows of his White peers. Growing up, Larry did not have open conversations about sexuality or safer-sex practices. It was only until he reached college that he gained the language to speak openly about his sexuality, as well as a significant amount of information about HIV among gay men. When he came out to his mother, one of the first questions she asked him was whether or not he was "being safe," even though she had never taught him what that exactly

entailed. In the above excerpt, Larry relates that other Black MSM like himself may have had similar experiences, which he believes may lead to lack of knowledge about adequate methods of protection against HIV. Larry also situates himself in the broader history of the HIV epidemic and how it had come to affect Black men in particular. Silence and ignorance about HIV may have been exacerbated by a lack of representation and acceptance of non-heterosexual identity within the Black community itself. Larry's narrative constitutes an example of how he engages with his own race and sexuality to inform how he perceives himself to be at-risk of HIV.

Peter's understanding of his own sexuality has been particularly influential on his perceptions of HIV. One of the few openly bisexual men interviewed for this study, Peter shared that he has no particular preference in his sexual partners' gender or sexual identity so long as there is attraction. Peter's sexual partners were women for a majority of his life, but it was at the age of 23 that he decided he wanted to explore his sexuality and "switch it up," opting to include men in his sexual repertoire. Nevertheless, he affirmed that he has continued to enjoy sex with women. Coming out to his family was a non-issue, though he does find himself having difficulties being "outwardly" bisexual when visiting his extended family in Mexico, who only really understood the difference between "gay" and "straight." Peter adds that he does not "know how to be gay in Spanish," referring to his lack of knowledge of the particular language, cultural norms, and other mannerisms he would use when navigating that cultural space as a man who has sex with men. Peter would, at times, refer to himself as a "gay man" throughout the interview, especially when discussing his sexual interactions with other men. That he "came from being straight" has protected him from any explicit forms of homophobia from his family, as he notes relatives choosing to ignore his bisexuality because he still has sex with women.

Peter's experience speaks to a comment Emanuel makes about rising HIV rates among

Latino men, stating that “there’s a lot more sexual fluidity...you even hear about a straight Hispanic man allowing himself to have sexual relations with a man.” In Emanuel’s eyes, sexual fluidity may contribute to individuals being lax or not as vigilant about their use of protection, especially when engaging with demographics that have been labeled as being at-risk of HIV. Previous research has shown some support for his viewpoint, especially in the context of heterosexual women contracting HIV from their husbands who have furtively engaged in sex with men (Hirsch et al. 2010).

What Peter learned about HIV and other STDs, however, stems from an experience well before he even began having sex with men. At a time in which he had been involved in “a circle of girls” he would frequently have sex with, Peter found out he had contracted chlamydia. Though he was asymptomatic, he recalls feeling “really dirty and really scared” because of how little he knew about STDs. The lack of visible symptoms gave him added pause as he wondered what else he may have unknowingly contracted. As Peter recalls, “it made me do my research,” prompting him to inform himself about all STDs he could possibly encounter and the best way to handle them, including HIV. It was through this research that Peter also came to learn about the severity and curability of each STD, their associated stigmas, and how Latino MSM were disproportionately affected by them. Given that Peter now prefers sex with men because it is “easier...more convenient,” this process was formative to the centralization of his concern on the social, rather than bodily, impacts of HIV. With this newfound knowledge in hand, Peter understands his sexuality to place him at-risk of HIV’s threat to his social life.

The Irrelevance Frame

Benjamin, a 27-year-old Black and Asian middle-class queer man, was born in Brooklyn,

though it was only recently that he considered himself a full-time New Yorker. Benjamin's parents removed him from their low-income neighborhood at the age of 10, sending him out to a wealthy suburb to be educated at "one of the best schools" in the United States. Reflecting on the years he spent being raised by his aunt, Benjamin remembers it all being particularly jarring due to the wealth and privilege of the environment he had come into. There were few others who looked like him there, and the absence of his immediate family intensified his feelings of isolation. Despite these challenges, Benjamin excelled in his schoolwork, eventually winning a prestigious scholarship that afforded him the chance to come back east in his pursuit of higher education.

Benjamin enrolled in a small liberal arts college in New England, though his initial excitement was soon tempered by the reality of his circumstances. During his first two years of study, Benjamin wrestled with the fact that his new environment was not much different from the one he had just left behind. He describes his college as being particularly racist and violent against people of color. He recalls the predominantly wealthy and White student body as being less than welcoming to him. It was at this time that he also began to realize something else that set him apart from others: Benjamin wasn't straight. He already didn't feel safe in this hostile space, let alone supported enough to tell anyone about his sexuality. Things would change, however, his senior year, when he would go on to meet other queer students of color, all who welcomed and embraced the full spectrum of his identity.

With his newfound group of friends, Benjamin became a part of a supportive social network that encouraged his development in a place he struggled to call home. Having studied abroad in China, Benjamin figured that would be the next stop on his life's trajectory. His job opportunity there eventually fell through, but he fortunately found an alternate position back in

New York, where most of his college friends conveniently had moved to after graduation. Now back in the place where he was born, Benjamin has been spending the last five years working as a brand strategist, as well as resituating himself in the borough of his youth. From biking around the city to nights out with friends, Benjamin has established a fruitful work-life balance that has brought him great joy.

I met Benjamin at an apartment he had recently begun renting from one of his relatives who moved away. Located in one of the wealthiest neighborhoods in Brooklyn, Benjamin's home smelled of lavender and matched the warmth with which he greeted me at the door. His white t-shirt and light blue jeans were offset by a salmon-colored bandana that sat atop his head, with an ankh necklace and several rings adding luster to his attire. As I took a seat on the large sofa in the living room, I took note of the art and flowers that decorated the apartment, all neatly strewn about, haphazard and yet very much with an indescribable order. Benjamin ran over to finish writing a work e-mail, grabbing some sage from the windowsill after closing his laptop. Sitting in a lounge chair across the ornate table that separated us, Benjamin burned the small bundle of herbs in his hands and briefly waved it to "clear the air." Blowing out the embers, Benjamin signaled that he was ready to begin our discussion.

Exempted from the Impacts of HIV

The irrelevance frame presents a modern interpretation of the individual's relationship to HIV as one that lacks any personal threat. The existence of an irrelevance frame is in part made possible by HIV's transformation into a manageable chronic illness. Respondents who make use of the irrelevance frame can come to understand themselves as wholly exempt from, protected against, or apathetic towards HIV. This is in stark contrast to the corporeal and stigma frames,

where being at-risk of HIV is understood as an inescapable reality. The irrelevance frame echoes prior research that showed how the exclusion of lesbian and bisexual women in HIV discourse led to a shared sense of biological immunity within this community (Richardson 2000).

Individuals who invoke this frame are aware of the potential bodily costs and stigmatizing effects HIV infection can have on their lives and those of others, but these concerns are viewed as external and inapplicable to their own lifeworld. The irrelevance frame relates respondents' awareness of the broader social structures that have afforded them the social and cultural capital necessary to perceive HIV as a real yet personally irrelevant risk. Risk is absent in the individual's perceptions for the self, but is otherwise conditionally present in their considerations of the experiences of others who share facets of their social location.

Benjamin serves as an ideal type among respondents who utilizes an irrelevance framing of HIV when giving meaning to his relationship to the illness. Unlike the other respondents discussed thus far, Benjamin does not understand himself to be at-risk of HIV. He still conceptualizes and talks about HIV in terms of risk because that is how he learned about it. When it comes to his own relationship to HIV, however, risk has no place in his perceptions. In fact, Benjamin feels particularly exempt from HIV altogether, which he expands upon below:

I don't think it fits for me. But I also realize how many things have gone right in my life to get me where I am. It's not a disassociation from being Black, because I very strongly identify as Black. But when I hear a stat like that, I rarely think like, "that is my experience," because I immediately think of all the people who haven't had the opportunities that I've had. I was born in a neighborhood like that...so that could have been me. But my dad got me into this program in school, and then I ended up moving... I kind of opted out because I got saved.

In discussing his thoughts on the recent CDC report about Black and Latino MSM and HIV, Benjamin makes it very clear that he does not view himself as being captured by these statistics, nor as they relate to his broader understanding of the self as being exceptionally vulnerable to

HIV. Emphasizing his identity as a Black man, Benjamin shows that he still very much understands himself to be a part of the target demographic. Nevertheless, Benjamin feels like he has “opted-out” because he was never confronted with the structural barriers he understands to place others at-risk of HIV. This is wholly unlike Sam and his corporeal framing of HIV, who briefly considered his particular privileges as protective but ultimately still viewed himself as being at-risk. Benjamin locates his feelings of exemption in an understanding of having been “saved” because he was raised in a resource-rich environment that offered substantial support. He considers the hypothetical situation of having never left his childhood neighborhood in Brooklyn, and it is only then that he could see himself as being at risk. Benjamin is aware of the bodily and social costs HIV can have, but when it comes to his own life, he deems these risks to be irrelevant.

Under the irrelevance frame, individuals can still retain an understanding of HIV that is built upon terms of risk. Individuals like Benjamin hold a general understanding of risk that is not unlike those held by the respondents discussed in the previous section, namely that risk is “exposing yourself to an activity, a thing, that you know could potentially lead to an unpleasant ending.” Lucio, a 27-year-old Latino gay man from Florida who has been living in Brooklyn for almost a decade, extends this view by considering the role of agency in risk:

There is no risk-free world, I want to make that clear. We take risks by merely existing in the world. But, to me, risk is a behavior that you engage in, understanding that there could be ramifications that are unwanted for you. Right? So, if I take a risk, I know that means that I made a choice. I've chosen to do something that I want to or would enjoy doing, knowing that it could have an adverse effect on what I want.

Lucio understands risk as being a product of actions being taken despite the knowledge of potential undesirable outcomes. The presence of risk, however, is not a deterrent for Lucio in the way that it is for respondents like Shane and Peter. Instead, it is a form of information Lucio

takes into consideration when he chooses to “take a risk.” Both Lucio and Benjamin understand HIV to “no longer be a death sentence” yet it is also something they do not see as particularly beneficial to their lives. As such, it is not surprising that these individuals speak and think about HIV in terms of “risk” or associated “high-risk” behaviors because of their inherent understanding of it as a possible undesirable outcome of conscious actions they desired to take.

The association of HIV with risk can be further explored through respondents’ experiences of “HIV scares,” or moments of fear and panic that set in when an individual believes themselves to have possibly been exposed to the virus. Lucio touches upon this when recalling prior moments where he did not think to use a condom:

There were moments where I was like "Whoops. I didn't use a condom." You know what I mean? “It'll-never-happen-again” gay moment. And it was like, there are just some times when you're not going to [use a condom], right? And like that's a risk you take. ... So, for me, having unprotected sex is a risk because I could get HIV or an STI, which is something I don't want. But, I enjoy the behavior and I made the choice to engage in it.

Nearly every respondent relates having had a “‘it’ll-never-happen-again’ gay moment” like the one Lucio describes. HIV scares capture the uncertainty that sex can carry for some people, especially when it is done in a matter that does not include the use of prophylactic technologies like condoms or PrEP. It represents the undesirability associated with HIV as well as the concern individuals have about how it could impact their lives. Lucio, however, concedes that his lack of condom use is inevitable. Like many other respondents, Lucio finds that sex without a condom is ideal simply because it feels better. It speaks to the notion of sex as a pleasurable, enjoyable thing rather than a rational process that involves calculated considerations about the likelihood of HIV exposure. Though Lucio associates HIV with risk, this association does not prevent him from engaging in activities that even he would consider “risky.” Participating in risky behavior, however, does not necessitate that he understands his relationship to HIV in terms of risk. As is

discussed later in this chapter, Lucio's consistent HIV-negative status despite his actions informs his perception of being exempt from the possibility of infection.

A key distinction that remains is that individuals who use an irrelevance frame do not understand themselves as being at risk for HIV. They do not view their own personal relationship to HIV in terms of risk, as in the case in the corporeal or stigma framings of HIV. Benjamin is aware of the impacts HIV can have when he states that other people "contract the disease and one, immediately feel like they're gonna die. Or two, feel like they're not worthy of love." This is also why he states HIV will admittedly "cross his mind during sex," especially when he is not using a condoms or other forms of protection. The extent of his own personal concern, however, ends there. In Benjamin's eyes, the designation of being or feeling at-risk is reserved for those who are particularly vulnerable because of their circumstances and lack of awareness. He expands upon this when he talks about HIV in relation to MSM affected by the contemporary opioid epidemic, who he believes are often unaware of "their surroundings and how many partners they're having sex with." Benjamin considers himself well-resourced and more than aware such that he would have to make an active effort to put himself into such a situation. Beyond not participating in certain behaviors he describes as "high-risk," he fundamentally does not understand himself to ever be in a position where his awareness could be jeopardized.

Ricky, a 27-year-old Latino gay man, similarly feels exempt from being at-risk of HIV. Much like Benjamin, Ricky views HIV as undesirable but also believes he is not in a particularly vulnerable position. He is vigilant about his health, typically opting for the use of condoms when having sex, but the sense of exemption he feels extends beyond his own individual behaviors. Ricky expands upon this when he reflects on the CDC's epidemiological report:

I can think of my family when I hear that statistic, but not me. That's very odd to say. But I'm thinking of just I guess if you live in certain neighborhoods with

certain levels of income and education, that could make you a little more susceptible. I feel like a lot of it comes down to education and upbringing really. That might sound silly. My immediate family, I'd like to say, was pretty middle class. A lot of my father's side is on the lower end of that, and so like food stamps.... not making it past high school, so it's very much a different life.

Ricky understands HIV risk as relevant for those who are structurally predisposed to exposure, using his father's side of the family as an example. Specifically, he identifies socioeconomic and environmental factors, such as income and neighborhood, as being important. This is in line with previous sociological and epidemiological literature on the social determinants of health that influence HIV incidence rates (Braveman and Gottlieb 2014). In speaking on his own upbringing, however, Ricky clearly positions himself as different from his extended family because of his upbringing, education, and other resources that have allowed him to feel secure about his protection from HIV. The significant influences family members have on an individual's HIV perceptions is further explored below. What is presently important is that Ricky understands his life trajectory as fundamentally different, with a sense of being at-risk of HIV not being personally relevant. Ricky's awareness of his circumstances constitutes a prime example of how individuals bring their socioeconomic class into consideration to arrive at an irrelevance frame. They feel privileged and exceptional in life and extend this self-perception to their disease risk.

Ricky's risk perceptions also indicate an acknowledgement of the bodily and social costs of HIV while still maintaining a sense of structural protection against the experience of HIV. Recalling prior HIV scares, Ricky describes having "been in situations that I've regretted, where I had unprotected sex, and then do the freakout followup," opting to get an HIV-test shortly after his experience. When asked to describe exactly why he felt such regret, Ricky notes his concern about "coming to terms with it, telling your parents...because that is your health, thinking about

how you need to try and find a partner.” This statement alone reflects what adherents to the corporeal and stigma frame understand HIV to threaten. Nevertheless, Ricky still views HIV to escape the realm of possibility within his particular sociocultural context. This illustrates how individuals’ perceptions are capable of comprising multiple framings of HIV, albeit with one being more salient than another.

In certain instances, individuals can understand themselves to be exempt from HIV not because they feel structurally protected or well-supported, but out of exceptional circumstances that they could have never anticipated. For example Lucio, the 27-year-old Latino gay man originally from Florida, does not understand himself to be at-risk of HIV, but is instead “one of the most fortunate outliers” of the CDC’s statistical report:

Because, if you didn't meet me and you just looked at my information on paper, like my number of sexual partners, my age, where I grew up, where I came from, my ethnic identity, my sexual identity, you were like, "Fuck. This kid's in danger." You know what I mean?

Lucio’s narrative speaks to the general importance of taking an individual’s sociocultural context into consideration when seeking to understand their relationship to HIV. For all intents and purposes, even Lucio feels that he should understand himself as at-risk in the way that others would describe him given his demographic make-up. As a Latino MSM who grew up in a low-income and homophobic household, in a neighborhood that was less than welcoming or open to discussions about HIV and sexual health, Lucio’s upbringing mirrors the kind that Benjamin and Ricky understands to place others at risk. Lucio also frequently enjoys condomless sex and has, in the past, even engaged with partners he later found out were HIV-positive. Despite these experiences, Lucio remains HIV-negative and has come to understand himself as an exception to the established rules of “risk” as he has come to understand it. The particularities of his experiences are further described throughout the following chapters, but what is most important

to note is how Lucio's lived experiences have contributed to his understanding that he is not at-risk of HIV.

The sense of exemption that characterizes the irrelevance frame, however, is not always so clearly aligned with the respondent's consideration of their social location. Certain respondents may see a desirability in risk more generally that figures into their HIV risk perceptions and associated health-relevant behaviors. Max, a 24-year-old Black and Latino gay man from the Bronx, for instance has never understood himself to be at-risk of HIV because of his preference for being the penetrative partner. As previous research has shown, receptive partners during anal sex are more likely to contract HIV during sex, and these preferences in sexual practices are often linked with perceptions of masculinity (Wright 1993; Fields et al. 2011). Several respondents, regardless of their framing of HIV, allude to or directly reference these findings when articulating whether or not they understand themselves to be at-risk of HIV. Beyond this, however, Max explicitly states that he has always "had weird relationships with knowing that things are unsafe and still doing them anyway." He speaks of the appeal of activities that are generally understood as "risky," such as his frequent nonuse of condoms or PrEP with multiple partners. Expanding upon this, he states "part of it is just, like, the risk factor of it is... 'Oh, it's so risky and I'm not supposed to do this, so I'm going to do it.'"

Max's narrative resonates with previous research on the desirability of "risky" activities, such as when people willingly participate in extreme sporting activities, but is unique in its focus on an infectious disease (Machlis and Rosa 1990). Apart from aspects of pleasure and sensation, Max's engaging in sex that he understands could expose him to HIV is consciously done because of his acknowledgement of it as inherently "risky." To be clear, Max "definitely still wouldn't want to contract HIV," though he understands that should he ever become HIV positive, he will

“be fine” so long as he adheres to treatment “to be safe and take care” of himself. Such a stance can only be taken today given the current state of HIV as a manageable chronic illness, as well as Max’s awareness of such. Yet Max’s view of HIV as undesirable does not negate the draw he feels to sex that could expose him to the virus. For Max, bareback or condomless sex imparts a particular sense of empowerment, especially when he ejaculates in his partners, that surpasses his concern about HIV, so much so that he states “I don’t care,” demonstrating apathy towards it altogether. In his irrelevance framing of HIV, the illness embodies a risk that he understands himself to be exempted from albeit equally tempted by. The associations between risk perceptions and sexual practices among respondents is further analyzed in Chapter V.

Arriving at an Irrelevance Framing of HIV Risk

As was the case with the previously discussed framings of HIV, race, class, and sexuality are significant factors that respondents negotiate to arrive at the irrelevance frame. As detailed above, it has already become evident that class plays a particularly important role in this sensemaking process, especially for individuals like Benjamin and Ricky who view their socioeconomic circumstances as a form of protection against HIV altogether. Examining the significance of race and sexuality offers further insight into how individuals give meaning to their relationship to HIV through the irrelevance frame. Benjamin’s continued discussion of the CDC report lends insight into this when he states:

I get that the CDC has to report these things statistically. It feels slightly devoid of context, which is that poverty is also a huge ... You could almost flip that to say that one in two poor queer people are going to get exposed to HIV, and you'd probably be talking about the same group of people. ... I don't think it's a false stat. But I do think it's a bit like gas lighting to frame it in that way... It just feels like a death sentence. ... If you're queer, and maybe your community doesn't understand you ... Maybe you resort to the streets ... We've heard that story with the queer trans kids who sit on the pier at Christopher Street. ... It's not that like

black people are having more sex, or Latino people are having more sex than anybody else. Or they're just these crazy sex-riddled, disease-riddled people who are prone to getting HIV.

Benjamin's critique of the CDC's report on HIV among Black and Latino MSM is that while it signals an illness with his race and sexuality, thereby making his being inherently a "risk" in the eyes of important message, it is being conveyed without proper context. Specifically, Benjamin finds poverty to be a significant factor in the report's projections that he feels is not being adequately communicated. Without this context, HIV can once again feel like "a death sentence" for Black and Latino MSM despite the strides that have been made to end the epidemic. In Max's opinion, this can drive others to be "wary" of people like himself, as it suggests an essentialist association between Black and Latino MSM and HIV. Max states that he does not believe his identity necessitates a "higher chance of contracting HIV or AIDS," but he worries others may be conflating his race and sexuality with the risk of infection.

In relaying more of his thoughts, Benjamin touches upon the experiences of New York City's homeless LGBTQ youth, who have for years sought refuge, community, and means of survival at the Christopher Street Pier. These youths are disproportionately Black and Latino people, many of whom were disowned by their families due to their sexuality, whose precarious circumstances increase the likelihood of exposure to HIV (Gibson 2011). As he compares himself to these individuals who share his racial and sexual identity, Benjamin better understands how his radically different socioeconomic class has placed him in a position to circumvent being in a position of vulnerability.

Lucio similarly found reporting of the CDC statistics lacking in their consideration of aspects of class, especially as they intersect with race and sexuality. Specifically, he is concerned with an overall lack in access to adequate healthcare, as well as particular forms of stigma that

can impede Black and Latino men from seeking out resources that are available to them:

Access to healthcare and stigma are the two biggest factors for me. ... Either due to economic issues, or because of their citizenship, or immigration status or something like that. There are a number of issues, right? But there're so many barriers for people of color to get access. Access to testing. Access to a primary healthcare physician, who has to be the one that writes the prescription for PrEP. You can't just get that from a pharmacy or walk in, you have to have a primary care. So it's like, are these people being armed with the tools?

Having done a significant amount of research on HIV out of his own personal interest, Lucio's comments are deeply informed. As prior scholarship has shown, racial inequalities in access to and affordability of quality care has been associated with increased rates of HIV among Black and Latino populations (Lanier and Sutton 2013; Sullivan et al. 2015). What Lucio contributes, however, is a consideration of barriers that go beyond income, such as issues with citizenship among immigrant communities, and how that can complicate timely access to appropriate HIV prevention and care (Epstein and Carrillo 2014). Lucio also speaks from personal experience; during a brief period of unemployment, Lucio was also unable to afford his PrEP prescription due to a lack of insurance. Reflecting back on this time in his life, Lucio views the condomless sex he engaged in as "risky" since lapses in PrEP use can decrease the medication's ability to prevent HIV infection. All this, however, is placed in the context of the low-income communities of queer people of color he perceives as being more likely to be in such situations that are also not as brief.

With regard to stigma, Lucio is speaking on a culturally-rooted reticence and lack of discussion surrounding sexuality, sexual health, and non-heterosexual identity. He explains this when he states:

I think in communities of color in particular, many of us have family members and come from a heritage that might paint men in a certain light or view men in a certain way, as the providers for family ... Machismo is prevalent throughout Latin America for example, right? ... My parents have literally tried to fight the

queerness within me, and so I felt a stigma about the way I was, about the way I acted... I could have been exposed to HIV while I was a teenager and just not known it, you know what I mean? And never gotten tested... So, I think part of it is that. You know, a lot of Black and Latino men do stay closeted or are quieter about their sexual activity.

In the above excerpt, Lucio touches upon the issue of machismo and how it can lead individuals to not be aware or adequately informed enough about HIV protection. Black and Latino men, regardless of their sexuality, are both subjected to machismo, which encompasses expectations of male cis-gender presentation that includes staunch adherence to masculine traits and behaviors. It is intimately related to the previously discussed experiences of down-low men. With this in mind, Lucio specifically highlights his family's efforts to "fight the queerness" within him, reaffirming for him that his non-heterosexual identity is stigmatized and a threat to masculinity. The pressure to adhere to machismo led Lucio to feel shame about sex and other aspects of his sexuality.

As a "fortunate outlier," however, Lucio relates that his ability to access HIV-related knowledge and resources, despite his circumstances, are not the norm. It was only until he went to college that Lucio acquired the comprehensive sexual health education he was not afforded in high school, something he takes great issue with because "that's when people start being sexually active." This issue is exacerbated when he and others, such as Benjamin, consider how higher education is not always guaranteed and often out of reach for individuals like themselves. Also like Benjamin, had Lucio not been able to leave his hometown, he believes that he would have likely been HIV-positive today. It is through this kind of consideration of his social location that Lucio can give meaning to his relationship to HIV through the irrelevance frame. This framing captures how respondents like Lucio can possess a simultaneous view of the self as being both a member of a population heavily impacted by HIV, as well as an individual exempted from the

risk of HIV altogether. The risk ecology framework I advance in this dissertation brings light to the existence of such nuance in HIV risk perception, revealing how a person's risk perception formation is more than the product of individual rational action.

Conclusion

I have shown that HIV-negative Black and Latino MSM in New York City form their risk perceptions by reflecting on the lived experience of their race, class, and sexuality with respect to their knowledge of the disease. Respondents like Shane, Peter, and Benjamin possess differing views on HIV's potential impact on their lives that speak to the presence of a breadth of hierarchical threats with varying levels of personal concern. They also serve as ideal type respondents whose HIV risk perceptions accentuate the dominant patterns of thought observed among respondents. Individuals can frame their relationship to HIV as being characterized by an ever-present risk to their bodily health and/or social well-being. Others can also frame the relation as personally irrelevant or non-existent, understanding themselves to be protected against, exempted from, or indifferent about the possibility and impacts of HIV infection. HIV risk perception can be characterized by combinations of these framings. How people construct meaning about their relationship to HIV is malleable and can change in reaction to developments in their lives and social environment, with certain framings becoming more salient than others.

Examining how people understand themselves to relate to a given phenomenon, rather than investigating how they perceive its riskiness, allows for a more grounded understanding of the intricacies of risk perception formation. Risk arises as a complex and conditional facet of HIV-related threats individuals perceive within their broader social environment. Risk exists not as a fixed quality of an individual's risk perception, but is instead as a possible and varied aspect

of it. The sensemaking approach I employ throughout this and the following chapters brings to the fore the social factors and underlying dynamics that are otherwise lost when perception is reduced to objectivistic definitions of risk. For instance, the designation of someone as being at-risk of an illness is, in other words, a definition for how a person may relate an illness; that others external to the individual can label them as at-risk is emblematic of how these definitions are often ascribed. However, as was made clear in this chapter, individuals can develop their own understandings of how they relate to an illness, which may or may not align with those externally ascribed to them.

The REF widens the breadth of insight to be gained from sociocultural analyses of risk. While this chapter focused on the individual-level dimensions of risk perception formation, it is evident throughout the respondents' narratives that the people in their social networks are also impact how they give meaning to their relationship to HIV. Relatives, friends and acquaintances, as well as romantic/sexual partners all play a significant role that warrants further analysis. As such, the relational interactions between Black and Latino MSM and these key actors in their social networks are the primary focus of the next chapter.

CHAPTER III

Kith / Kin: The Influence of Friends, Family, and Partners

Do not feel shame for how I live / I chose this tribe / of warriors and outlaws

— “Overtones,” Essex Hemphill

Peter’s friends are at the very heart of his livelihood. At the time of our interview, Peter had been living with his mother, sharing the apartment with an additional “one and a half” other people: a friend, with whom he shared the same room, and another person who was using part of the space as personal storage. Privacy was a luxury he could not afford, but Peter found freedom in the world outside his bedroom. A self-proclaimed “very social” person, Peter spends a majority of his time hanging out with several different social groups, though he only considers six people among them as his “core” circle of friends. From karaoke nights to house parties, Peter describes his friends as instrumental to the enjoyment he finds in living. More than just people to visit a bar with, Peter’s friends are also the confidants whose views and opinions he values, especially those concerning HIV.

Family has consistently been an immense source of support for Benjamin over the course of his life. Benjamin lost his mother at a young age, with his father, step-mother, and extended relatives serving as his primary caretakers. During his time out west for secondary school, Benjamin grew so close with his cousins that he came to view them as his twin sisters. Benjamin describes talking to his sisters every day, even well after he left for college. At the time of our interview, Benjamin shared his excitement over the news that their frequent calls and texts would soon be replaced with in-person hangouts, as they were moving to New York City. Benjamin fostered a sense of trust with his sisters and other close relatives, which was necessary for him to

feel safe enough to come out to them about his sexuality. Reflecting back on his upbringing, Benjamin expresses an appreciation for the resources and insight that have allowed him to lead a life with good health and peace of mind.

In Shane's eyes, relationships with people are "what make life worth living." From platonic friendships to romantic partnerships, these are "the people who you move through life with." At the core of the bonds Shane forges with the people is love; not a singular kind of love, but one that can vary in texture across bonds while maintaining the same intensity. The way he loves his friends is different from the way he has loved the men he has had sex with. Even so, Shane approaches all relationships with the specific kind of love he has for that partner. Whether in pursuit of a long-term relationship or casual sex, Shane makes it a point to know his sexual partners beyond their physical appearance so that he can lead their connection with love. Aside from making room for love, Shane values looking beyond the superficial because it helps reduce his likelihood of HIV infection. Even though Shane makes it a point to never engage in unprotected sex, Shane find that truly "knowing" one's partners can make all the difference.

This chapter further elaborates the risk ecology framework by detailing its relational level of analysis. I argue that the relational interactions between an individual and the people in their lives influence their HIV risk perception. These include the day-to-day and long-term communications, exchanges, and other shared experiences between individuals and their social networks. I contend that these experiences inform how individuals associate their social location with HIV risk, thereby further cementing how and in what ways they understand the disease to fit within the context of their lives. They also offer the individual insight from the lives and experiences of others, providing further information individuals incorporate into their risk

perceptions. Taken together, these interactions serve as key influences that facilitate an individual's sensemaking about their relationship to HIV by reinforcing, extending, or challenging the framings of HIV risk they employ. I detail how this interplay influences how respondents come to identify and grapple with this risk ecology.

To illustrate these points, the present chapter is divided into three sections focusing on the individual's dealings with their friends, relatives, and romantic/sexual partners. Peer and familial bonds comprise the social networks that were the most prevalent in the analysis of respondent narratives. Interactions with romantic/sexual partners are also particularly impactful to Black and Latino MSM's perception of HIV given the association with potential exposure to infection. I return to the experiences of Shane, Peter, and Benjamin — the ideal types introduced in the previous chapter — along with those of other respondents throughout the chapter to illustrate how their HIV risk perceptions are as much a product of these engagements as they are of their individual sensemaking.

Friends

“I learned it through friends”: Friends as Sources of Knowledge & Social Support

In examining an individual's friendships, it becomes evident that these relationships can serve as crucial sources of knowledge, awareness, and support with matters concerning HIV. Almost all study respondents make note of having learned at least some of what they know about HIV through formal avenues, in particular sexual health curriculum in school. Many of these respondents, however, also highlighted the importance of the knowledge they received through their social network of friends. Previous research on Black and Latino MSM has found supportive social networks to be associated with more proactive HIV-testing behaviors, as well

as a reduction in engaging in unprotected sex (Lauby et al. 2011). While this research has predominantly focused on the protective role friendships can play by influencing the behaviors of individuals, insights from respondents reveals how these bonds also shape how an individual comes to perceive HIV. For example, Nolan, a 29-year-old upper-middle-class Latino gay man, identifies his friends as being sources of HIV-related knowledge that are more accessible and relatable than that which he received from formal sources. Nolan emphasizes this when reflecting on where he gained the knowledge he possesses about HIV:

I truthfully think the bulk of it [learning about HIV] happened from word of mouth and friends, from the media, from TV shows, and just from socializing with other gay people. I think I felt more comfortable that way, because it was another gay guy. So, he maybe had the same questions or fears that I did versus school. I was in public school until eighth grade. They generally talked on it, but it was in a very scientific way that didn't feel personal. Just through all these other vehicles and friends and gay themed media, I think that's where I feel most comfortable learning about HIV.

In the above excerpt, Nolan emphasizes how influential informal sources of knowledge were to his understanding about HIV. Specifically, he identifies a particular kind of comfort that was facilitated by having a shared sexuality with the friends he spoke with as it allowed for a discussion on HIV more focused on their shared fears about it, rather than the scientific facts of the illness. The limits of sexual health education during schooling arises throughout many of the respondent interviews, but Nolan's experience in particular highlight how such knowledge can be received differently depending on the identity of the individual. One of his earliest memories, for example, include an event in grade school where an HIV-positive person came to discuss all the scientific facts of the illness, while also emphasizing the severity of the illness should any of the students become positive themselves. Such events can structure knowledge about HIV to be about fear alone, which can lead to increased stigma. Nolan's conversations with friends who share his sexuality, however, serve as a space for him to more deeply explore his fears about the

illness with regard to their shared experiences as gay men. In terms of the REF, this serves as an example of how friendships can inform how individuals associate their sexuality with HIV when forming their risk perceptions.

Billy, a 25-year old Latino and White gay man originally from Florida, similarly learned most of what he knows about HIV through friends, though these conversations actually led to a consideration of the structural reasons for how and why the epidemic has disproportionately impacted certain communities over others. Reflecting on the shortcomings of HIV education in school, Billy shares how his knowledge about the illness came from his friends, in particular those of a certain socioeconomic background:

...I learned it through friends, who either had the benefit of being part of these [comprehensive health education] classes, or having certain medical professionals that their parents' wealth allowed them to have access to. I think there's immense stigma in Latino and POC (people of color) communities to even talk about anything queer, LGBT, or even of an intimate nature. Forget gay stuff, talking about sex alone is ... very inappropriate and uncomfortable. Especially with a religious background. I mean, you're not even supposed to be sexually active, how could you talk about being safe while doing it? ... I just think it has to be an intervention done within schools. I think it has to be done early and comprehensively.

Earlier in his interview, Billy reflects on how a lack of comprehensive health education within communities may explain why HIV infection rates are higher amongst Black and Latino MSM. As he thinks upon the origins of his own knowledge about HIV, he notes how it stemmed from friends who had the privilege of accessing the knowledge he himself did not receive through his schooling. The significance of these conversations is compounded by his acknowledgement of how candid and personal conversations about HIV within people of color communities may be lacking due to issues of stigma and discrimination. This adds an intersectional layer to his earlier point on lack of access to knowledge within communities of color, contributing a consideration of how socioeconomic class, as well as the normalization of stigma within communities of color,

may interact to limit access to knowledge about HIV. These findings add further nuance to previous research on how lack of conversations about discrimination among family members can lead to higher rates of unprotected sex. Where sexual health education in schools should technically serve to overcome such barriers, Billy finds it to be severely lacking and in need of reform. Billy considers himself fortunate to have had access to such informal sources of knowledge and is at the same-time aware that not everyone who shares his demographic background has been afforded the same opportunity. This awareness is indicative of how his friendships inform the ways he gives meaning to his relationship to HIV, which he believes himself to be “distanced-from” rather than “at-risk of.”

Conversations with Friends: Sources of Awareness about Stigma

Conversations with friends who did not share aspects of the respondent’s demographic background were also particularly insightful, as they offer an understanding of how certain antiquated views of HIV still persist in society today. For example, the idea that HIV is only of concern for individuals who engage in sexual activity with members of the same sex was prevalent during the early years of the epidemic in the United States. As most of the cases of infection that were highly publicized were those among gay men, HIV came to be viewed as a “gay plague.” Decades later, with copious amounts of epidemiological research pointing to persistent disparities in HIV incidence rates among MSM versus their heterosexual counterparts, especially those who are Black and Latino, HIV continues to be intimately associated with individuals from these demographic groups. Matt and Victor’s interactions with their friends lend insight into what this association looks like in practice. When Matt, a 22-year-old working-class Black gay man, told his friends about wanting to move to Atlanta because of the large Black and

gay community, he notes that many of his heterosexual friends immediately go on to warn him about the city being a hotbed for HIV. In a similar case, Victor, 28-year-old working-class Black gay man, had conversation with his heterosexual female friend that made him reflect on how non-MSM individuals are making sense of HIV with respect to sexuality:

I had a girlfriend of mine that I had to clue her in one day because she was having unprotected sex, and I was like, "Have you gotten tested," and she was like, "No, should I," and I was like, "Of course you should get tested." She's like, "Why, I thought it was [a gay disease] ... " and she has the same education level...she's someone who grew up in the same school system that I did, and I learned more about HIV and AIDS through the school system. Maybe it's I always knew that I was gay that I paid more attention to it, and there was always that constant focus on that and she didn't. Her face turned white when she realized that it was a possibility for her.

In the excerpt above, Victor's friend expresses a concern that she likely hadn't held until Victor brought it up: HIV is as much of a possibility for her as it would be for him. As is made evident throughout several respondent interviews, the concern about HIV as a potential outcome of unprotected sex is not frequently held among an individual's heterosexual friends. Individuals such as Victor note that the use of prophylactic devices such as condoms is typically done with the goal of preventing pregnancy, whereas HIV and other STDs/STIs rise as the primary concern for MSM. What is most telling about Victor's experience, however, is the persistence of the stigmatizing notion of HIV only being relevant to gay people. Despite the decades of research and communication of findings that have illustrated how the illness can impact anyone, its disproportionate effect on gay men and the degree to which efforts against HIV have been communicated towards this population has supported the conflation of the illness with the sexuality. Victor considers aspects of socioeconomic class, such as education, and notes how even this was not enough to disabuse his friend of this incorrect notion. The normalcy of HIV testing, which Victor engages in regularly, is also brought into question here, as it has become

expected of men like him but less so of women like his friend. This experience informs how he engages in the sensemaking process described in Chapter II, which in this case involves a personal consideration of his sexuality vis-à-vis HIV and how this may have caused him to take more seriously the possibility of HIV infection in his lifetime.

“I definitely have people”: Social Standing Among Friends

The stigma of HIV can often be amplified by an individual’s peer networks, with infection posing a threat to an individual’s standing among their friends. Where certain individuals may have concerns about what HIV may mean for their health, a significant portion of the uncertainty potential infection carries is how it will change an individual’s social life. For example, when asked about what actions they would take upon hearing a positive HIV diagnosis, Peter and Emanuel both express an awareness of how a positive HIV diagnosis would demand a significant change to their daily regimens so as to maintain good health as a positive person. However, they also relay a concern about how they would be perceived by others, especially the individuals they consider their closest friends. When Emanuel told his closest friends that he had been dating an HIV-positive man for some time, his closest friends’ first concern were for his health and what others, especially his family members, would think if they found out. For his friends, Emanuel’s romantic partner embodied a risk to his overall wellness, including his bodily health and social life. This is part of the reason why so many individuals stated a desire to keep their status information private or within the confines of the confidential relationship between themselves and their healthcare providers. The advent of novel technologies, such as at-home testing kits like OraQuick, has allowed for an additional layer of privacy that keeps the limits knowledge about status to just the individual alone. Nevertheless, the views of individuals like Peter carry a

particular weight when thinking about the types of risks HIV can present that go beyond the realm of bodily health. When asked who, if anyone, he would share his hypothetical positive status to, Peter states:

I mean, it wouldn't be the people who I want it to be. There's just certain people I'm not as close with but I know who are poz or who are well-versed in this kind of stuff. So, I know I definitely have people. I don't think I'd do it with my close friends. Again, just with the stigma of everything, I'd just be terrified...you can live a long healthy life, but you still have to live with the stigma that other people place upon you.

One would expect that Peter would find solace and support among his closest friends, who in Peter's case come from diverse backgrounds and different spheres of his social life. However, these are exactly the individuals Peter would not want to know about his HIV status, as he has noticed the persistence of HIV stigma within this peer network. One of his closest friends, for example, works in an industry concerned with matters of sexual health, and is a person Peter has extensively discussed his views on HIV with. HIV stigma is something he admittedly is taking active steps to disabuse himself of, but for Peter, HIV still encapsulates an uncertainty about the future that places it at the top of his concerns about health. Peter frames HIV as potentially jeopardizing his standing among his close friends, the exact individuals he would otherwise want to share this information with. Granovetter's seminal work on the strength of weak ties lends insight into why this may be the case (1977). Peter finds greater comfort in reaching out to his acquaintances who are HIV-positive or more knowledgeable about life as a HIV-positive person, as he knows they would be undoubtedly supportive and helpful. Acquaintances, however, comprise weak ties that are more tenuous than those of the strong ties of close friendship, thereby presenting a peer network where social standing is of little importance to the individual. The support this group of acquaintances can offer Peter is useful, but it is dispensable in relation to the strong ties he fears would deteriorate should he ever test positive for HIV. This offers

insight into the persistence of HIV stigma even at a time when knowledge and awareness about the illness is at an all-time high.

The jeopardization of an individual's standing within their social networks holds significance beyond an individual's personal level of comfort or sense of belonging within a friend group. As prior research has shown, supportive social networks are central to an individual's wellness, especially those who are deemed most "at-risk of" or have already been affected by HIV (Lam, Naar-King, and Wright 2007; Power et al. 2003). The significance of possessing and maintaining strong ties with friends can become more apparent to an individual through engagements with their peers who have experienced life without such support. For example, when asked to reflect on his general thoughts and feelings about HIV, Kyle, a 23-year-old working-class Black gay man, references a deeply held fear he has of HIV because of how it impacted the life of a friend:

It's a very scary thing for me when I hear that, just because I did have a friend who received news about that and because of it he committed suicide, so it's kind of scary for me to think, because he had no one, really, to turn to. He had his friends, but his parents weren't really accepting of his sexuality. It's a very scary thing knowing that and also this history of HIV...Maybe down the road I will find someone that I would trust and I would feel comfortable turning to, but as of now, I don't think so.

For Kyle, HIV is associated with the loss of life, not due to a compromised immune system, but as a result of homophobia and feelings isolation. Suicidal behavior has been documented across many populations affected by HIV, with research highlighting social and psychological roots of the distress associated with a positive HIV-serostatus, with suicidal ideation being the highest among non-heterosexual individuals (Carrico et al. 2007; Komiti et al. 2001; Cochand and Bovet 1998). Among homosexual male individuals, suicidal ideation is frequently associated with depression due to experiences of discrimination due to their sexuality (Iguarta, Gill, and Montoro

2003). For those who are HIV-positive, this discrimination can be further exacerbated as it can also stem from individuals who share the individual's sexual orientation. In the case of Kyle's friend, friendships were not enough to outweigh the impact of having parents who did not approve of his sexuality. The type of support family members can provide is different from that of friends, a topic that is explored in the following section, but it is worth noting how the mere availability of supportive friends may not adequately protect an individual from negative outcomes associated with HIV. Of particular note, as well, is how Kyle takes a moment to put himself in his friend's shoes to realize that he would be in a similar position were he to ever test positive for HIV. Despite having friends and family who support him regardless of his sexuality, Kyle still would not feel comfortable divulging information about his status for fear of how it may change their view of him.

“How do they just, live?”: Awareness of the Lived-experience of HIV

The excerpt from Kyle's interview also touches upon another important role relational interactions with friends can play: they can provide an individual with awareness about the social aspects of living life as an HIV-positive person⁵. The sharing of these experiences is important because they provide the individual a relatable and contextualized space through which they can grapple with their identity in relation to HIV. As Kyle demonstrated, the core of his concern surrounding HIV relates to a fear of isolation due to stigma and discrimination. Billy also lost friends to the illness, an experience he describes as traumatic insofar that it made the potential for infection seem that much more of a possibility in his lives. For those who have friends who are currently living as HIV-positive individuals, the considerations individuals make can move

⁵ To reiterate, all study respondents are HIV-negative individuals. Their HIV-positive friends, however, play a significant role in shaping their risk perceptions.

beyond discussions of death, focusing instead on how they currently perceive HIV as well as how it would alter their life were they to seroconvert. Wallace, for instance, is part of a closely-knit group of Black and gay male friends that have generally been supportive of one another and functioned as a sort of “family.” When the youngest among them revealed that he had contracted HIV during college, Wallace describes how devastating it was to learn that the “child” of their friend group had been affected by an illness they would collectively speak of in terms of fear. Having a close friend become HIV-positive solidified their shared fear, and while Wallace feels like he and his friends could be more supportive, they “don’t really talk about it because...it’s a scary phenomenon.” In this case, Wallace both witnessed and participated in the transformation of an HIV-positive person’s social life due to their serostatus.

Lawrence, a 28-year-old Black and Asian upper-middle-class gay man, similarly had a close friend become HIV-positive, though this experience caused him to more readily reflect on his own relationship to the illness, as well as ponder what a positive serostatus would mean for his own social life:

I think that beforehand, I would say, I would do AIDS walks and be like "Yes, let's be about it and let's spread some information and let's make sure certain causes are supported." But having a friend who is HIV positive, it's made it more real for me on "How does this translate into everyday life? How does someone navigate their career? How does someone navigate dating and love life? How does someone take care of themselves? Like, from a health standpoint. How do they just, live?"

The questions Lawrence poses to himself upon reflecting on the life of his friend are crucial to understanding the ways in which individuals come to make-sense of their relationship to HIV. They are emblematic of the uncertainty that HIV encapsulates for HIV-negative people, their answers seemingly unknowable unless they themselves were to seroconvert. Lawrence describes himself as a good and supportive friend to the HIV-positive person he describes above, stating

that he doesn't view this person as his "friend who has HIV" but rather just his friend. This supportive friendship is what has enabled him to glean insight into what life as an HIV-positive would be like for him, a reality he said would be a disappointment because managing the illness would be "another thing that I have to deal with." There are other concerns he shares too that were made evident due to his friends' experiences, such as what finding a romantic partner would be like within the LGBTQ community, which he views as generally unaccepting of HIV-positive people. HIV perceptions with regard to romantic/sexual partners are discussed further in the following chapters.

Learning about the lived experiences of HIV-positive friends can also shape how an individual understands the social dimensions of transmission. All study respondents were aware of common forms of HIV transmission, such as the sharing of bodily fluids through unprotected sex or the sharing of needles. The ways in which individuals understood such transmission could occur, however, were made evident in their sharing of their friends' conversion experiences. Respondents who used a corporeal framing of HIV typically made use of the language of "risky behaviors," either alluding to or explicitly describing activities such as consistent condomless sex with multiple partners, or sex with partners that a person did not know very well. Respondents frequently cited online dating through popular applications such as Grindr and Jack'd, as well as participation in organized sex parties around New York City as likely sites for HIV transmission to occur. Given that the respondents are HIV-negative, the view that HIV transmission could occur at these sites is still personal speculation, regardless of whether or not these individuals used online dating applications (apps) or attended such events. Yet when a friend tells an individual about being exposed to HIV through these methods, the speculation can come to be substantiated.

In examining the social dimensions of HIV transmission, a salient theme that arose was that of infidelity. Infidelity has long been associated with the potential for STD/STI transmission, with previous research demonstrating how the potential for HIV infection raises particular concerns for people in monogamous or committed relationships (Hirsch et al. 2010). For men who have sex with men, much of the research has focused on measuring the risk of HIV transmission in instances where individuals engage in sex with secondary or extra-dyadic partners (Klesse 2007; Murphy 2006). In speaking with respondents for the present study, it became evident that infidelity or cheating on a primary partner was intimately associated with the possibility of HIV infection. Individuals like Hugo, a 29-year-old middle-class Black gay man, would make statements such as “do not bring anything back to me” in reference to sexual partners who may have had sex with others outside of their primary relationships. These statements speak to a greater view of HIV as a potential consequence of infidelity, which also serves to further stigmatize the illness and those affected by it. For HIV-negative individuals like Benjamin, hearing his friends’ experiences with seroconversion due to infidelity can serve to reify that stigma:

...the tricky part is the two people that I know who have HIV, is that they got it from their boyfriends who were cheating on them. Which puts a bad taste in my mouth for the disease a little bit. But I always try to check it. Because I know that is problematic. But most of the people that I know who are HIV positive have contracted it from a fuckboy. So, that has made it a bit harder to reconcile some of that behavior. Because you do start to associate it with bad behavior.

As Benjamin relates, having two friends become HIV-positive because of instances of infidelity influences him to associate HIV with “bad behavior.” He calls this view “problematic” as a way to signal his awareness of how such a perception could contribute to the stigmatization of HIV and those affected by it. Nevertheless, the fact remains that his most proximate awareness of conversion is limited to friends’ experiences with “fuckboys,” or men who are liable to cheat due

to their lack of genuine consideration for their romantic/sexual partners. His friends' sharing of these experiences encapsulate a particular kind of relational interaction that has affected how Benjamin views HIV and his relation to it. These experiences serve not only as cautionary tales, but rather significant influences on individual perceptions of HIV as a risk to health. Benjamin, for example, describes bareback or condomless sex as a "high-risk behavior," but not within the context of a monogamous relationship. Monogamy therefore takes on an additional meaning as a protective relationship structure against HIV transmission, with infidelity being the primary social dimension of exposure. Previous research, however, has shown that despite the meaning monogamy can hold for gay men, rates of HIV transmission are noticeably high among individuals who engage in sex with a primary partner (Duncan, Prestage, and Grierson 2014; Sullivan, Salazar, and Buchbinder 2009). Benjamin and other respondents who frame HIV as an irrelevance do so partly because of their relegation of penetrative sex to monogamous relationship configurations.

A friend's experiences with unfaithful romantic/sexual partners were also frequently associated with what many respondents described as "HIV scares," or instances in which the individual strongly believed or had enough reason to believe they may have been exposed to HIV. Aaron, a 29-year-old middle class Black gay man, invokes aspects of both the corporeal and stigma frames in his perception of HIV as "a life changer." Aaron understands the disease to disrupt the status-quo of life as he knows it because of the impact it has on the immune system, but also how it could alter his relationships with others. He describes his knowledge of HIV as a product of years of learning through the experiences of friends and others close to him. When he found out that a regular partner of his, with whom he had been engaging in condomless sex, had been cheating, Aaron's immediate concern was that of the potential for HIV infection. Once he

decided to go get tested, he called upon his friends for moral support, but in so doing had his understanding of HIV transmission challenged:

I called one of my friends to go get tested with me. Just to go for support because I was, for me. I was like, I don't know and I tried to keep everything under locks. I called one of my friends who knew what happened, you know. I didn't like everybody in my business and stuff like that. Then he went with me and I got, and he was just like, "Well I'm going to get tested, too." Now this is the crazy part. My friend, he was in a relationship and they were in a relationship by that point, for like, six years or something like that. Living together, all of that. He's like, "I'm going to just get tested with you just for support." I got negative, he got positive.

Like Benjamin, Aaron held the view that HIV could be a result of infidelity, and monogamy could therefore be adequate protection from it. However, despite experiencing infidelity, Aaron was surprised to learn that he remained HIV-negative while his monogamous friend had received a positive diagnosis. Aaron recalls his friend collapsing in his arms and remaining in a state of denial for well after the initial diagnosis. This friend had been faithfully committed to his partner and, as Aaron describes him, "so innocent, as far as he never stepped out," suggesting that it must have been the friend's partner who had cheated in the relationship. This speaks to previous research that explores how monogamous intentions in a relationship do not necessitate monogamous practice (Worth, Reid, and McMillan 2002). Aaron supported his friend in sharing the news about his status to their mutual peer networks, a process that ensured his friend's social standing was not compromised. In fact, Aaron's assistance with sharing his friend's positive status led a mutual friend to feel comfortable enough to share his own seroconversion. Aaron had known this mutual friend to be taking the "necessary steps" to prevent HIV transmission with his long-term HIV-positive partner, so he understood why this person was reluctant to share his status, as it could have threatened how his friends viewed him. Aaron's getting tested with a friend and the resultant events demonstrates how friendships can be both a source a support as

well as insight into the social dimensions of the HIV lived experience.

HIV-positive friends can also afford individuals an opportunity to challenge their own deeply held or internalized forms of stigma regarding HIV. Having HIV-positive friends allows individuals to see for themselves what the illness can look like and how it compares to the ways they initially viewed the disease. Many respondents, for example, expressed an awareness of the countless deaths that characterized the early years of the epidemic, a drastic comparison to the way things are today. Knowing that things are different, however, is not the same actually seeing that difference. HIV has, for so long, been associated with a social death, and much of the HIV stigma people can hold relates to how the illness would transform their way of living. Benjamin, for example, shares that despite the circumstances surrounding his friends' seroconversion, he notices that they have "amazing lives and do amazing work," a view he did not previously hold. Steven, a 23-year-old middle class Black bisexual man, similarly shares that since a very young age he has held "antiquated views about what HIV looks likes" which led him to presume that his HIV-positive would be hospitalized at any given notice. Contrary to his expectations, Steven's friend is living a life that he views as completely "normal," thereby disabusing him of his prior fatalistic notion of HIV. Being able to "put a face to it," his worry about HIV is less about health concerns and more focused on how he would be stigmatized by others should he ever become HIV-positive.

Conversations with HIV-positive friends about their experiences can lend particular insight into how these such exchanges serve to challenge internalized stigma. Peter, for instance, highlights impact knowing HIV-positive around his age has had on his perceptions:

Being friends with people who are more of my peer and not an older family member definitely... and just the newer generation of poz people and different outlooks about it definitely changed my perception and view on what it is to live poz.

As was discussed in Chapter II, Peter primarily perceived HIV risk through the stigma frame, but the experiences of his friends living with HIV have helped to reduce his concern over the impact of stigmatization. Stigma is rarely ever held solely within a singular person and is often instead the result of collective societal discrediting of some characteristic or aspect of an individual's being (Goffman 1974). Reflecting on how having HIV-positive friends has affected his perception of HIV, Duke, a 27-year-old middle class Black gay man, explains how his friends' experiences have caused him to reflect on the origin of HIV stigma:

...I think just from even what I know in terms of friends that I've spoken to and things that I've read, it's definitely not a death sentence and it's very possible to live a very healthy lifestyle with HIV...You know, without actually knowing someone's status it was, at least around me in my communities it was something that was projected onto people if they looked "sickly", but knowing people that do not look that way and that I know for sure are positive, they live healthy lifestyles, they have great friends, etc. So yeah, it's definitely changed my beliefs.

Duke makes a particularly interesting claim in the above excerpt about HIV being projected onto “sickly”-looking individuals by members of his communities. In his interview, Duke defines the communities as the social spheres his friends belong to, specifically the LGBTQ, Black, and Christian communities. In Duke's view, people can be presumed to be HIV-positive because of their sickly presentation, a presumption he has since rejected after learning from his HIV-positive friends. He makes the statement that HIV is “not a death sentence” definitively because he has been able to see that it is possible to be HIV-positive and healthy. Indeed, given the impact the epidemic has had over the years, HIV has been widely conceived as the antithesis of healthiness. Biologically, the virus itself compromises an individual's immune system, the very bodily defenses that exist to protect against illness and disease. The reality of the contemporary epidemic, however, is that HIV has become a manageable chronic illness due to advancements in treatment and care. Knowing that HIV no longer has any one specific “face,” individuals can

undo their internalized HIV stigma and abstain from projecting it onto others. It is what has allowed Duke to say that, were he to hypothetically test positive for HIV, he would feel “a little bit saddened” due to his own expectations but ultimately confident that he can continue living a full life. The experiences of Duke’s friends have helped him to acknowledge the real impact HIV can have on social and bodily well-being. They also serve to reinforce his framing of HIV as irrelevant, not only because he takes steps to prevent infection, but because he knows how his life can still continue on fully were he to ever seroconvert.

Family

Familial Networks of Social Support

Just as is the case with friends, family members can also serve as important networks of support for individuals, especially with regard to HIV. There exists, however, a notable difference in the type and degree of support family members can offer individual, especially when parents are involved. As previous research has shown, individuals tend to feel more comfortable seeking social support from friend groups than from relatives, but individuals with supportive familial networks indicate less experiences of stress and overall better health outcomes (Kalichman et al. 2003; Kimberly and Serovich 1999). This research, however, has predominantly focused on how family support can reduce “risky behavior” among individuals; this research does not provide insight into how such support may inform the ways individuals may even come to perceive HIV as a risk at all. In speaking with respondents for my study, it became evident that family members played a crucial role in crafting the sociocultural environment individuals exist within as adolescents at home, as well as the ones they enter in adulthood. In Chapter II, Benjamin’s narrative touched upon this when he described the impact

his family has had on his life. Benjamin frames HIV as personally irrelevant partly because his family moved him out of what he understood to be a neighborhood disproportionately affected by HIV. More generally across respondents, family members are foundational to how individuals understand their race, class, and sexuality, and the ways in which these social factors impact their relation to HIV.

Lucio's experiences with his family serve as another example in which communications with relatives were influential for their HIV risk perceptions. In the previous chapter, Lucio's narrative illustrated the contentious nature of his relationship with his parents who were not accepting of his sexuality. Apart from the difficulty of these experiences, however, Lucio expresses great gratitude for the support his family nevertheless provided. In the following excerpt from his interview, Lucio shows how his family was instrumental in his sensemaking of HIV as a personal irrelevance:

But, I feel so fucking lucky. I feel so lucky because I could have been that statistic if I had not taken leaps and had my parents supporting me in college. Or, not necessarily supporting me, but pushing me to pursue an education and pushing me to be responsible for my actions and educate myself about anything, anything that I need to know more about. My parents were the first to be like, "Let me buy you a book on this shit. Let me help you look up shit on this." You know what I mean? I hated my parents for a long period of time in my life, but they always encouraged me to seek out knowledge. To read a fucking book and look up a thing and turn to sources that are trustworthy. ... But, then I also had the resources at [college] to do that research, right? Because I'm sure there are many queer youth of color who wish that they knew more about that, but they don't know who to turn to for access or information about this ...

Despite the turmoil he endured at home from his parents struggle to accept his sexuality, Lucio is ultimately thankful that they instilled in him the value of education and being knowledgeable of things. Though he never had the opportunity to have explicit conversations with his family about sex and HIV, it is from them that Lucio learned the drive to be knowledgeable about things that could affect him. Lucio is aware of the socioeconomic privileges and resources he gained

through his college education and is careful not to reduce the issue of HIV among Black and Latino MSM to issues in education alone. What becomes clear here, however, is the role his family played in being able to acknowledge as much.

Interactions with relatives can provide crucial social support that is not only emotionally beneficial, but also influential in the respondent's sensemaking about their relationship to HIV. Among respondents who experienced "HIV-scares" and sought support from relatives, Victor's relationship with his family is particularly insightful for understanding how this process can occur. Some time ago, Victor, the Black gay man whose female friend thought HIV was a "gay disease," had engaged in condomless anal sex with a person he "thought he knew" to be HIV-negative given their previous interactions and their shared social networks. This would be the first time he ever had unprotected sex, a decision he made precisely because of how comfortable he felt with this person. A mutual friend, however, would later reveal to Victor that this person had actually been HIV-positive all along, including during the times they would have sex. This knowledge sent Victor into a severe panic, setting off a series of continued visits to the doctor, as well as the purchase and use of several at-home testing kits, in hopes of verifying his HIV-negative serostatus. In the process of these doctors' visits, Victor came to learn he had contracted gonorrhea, an experience which further amplified his fear that he may have contracted HIV. Victor described these events as traumatic and at the root of a depressive episode he would go on to endure well-after he received several confirmations of his negative status.

It was the support of Victor's family, however, that would be instrumental to his emotional recovery. Victor disclosed his fear of possible infection to his family and how it had consumed his life; he tells of spending most of his days self-diagnosing through information he found online, a practice his aunt, who is a nurse, dissuaded him against because it would "drive

[himself] crazy.” His father also showed support by accompanying Victor to the testing center, as well as relating his own experiences with STDs/STIs in his youth. Victor states that his father’s admission gave him a sense of security since he clearly identified himself as a person he could turn to for support. When asked why he felt so overwhelmed with concern over a possible positive diagnosis, Victor explained:

There's this stigma. It's that dirty feeling. It's that feeling of dread. That feeling that you're literally about to basically write your own expiration date. My mom actually walked me through that. How did she say it? She said it in a very beautiful way. Basically like, no one can judge you but God, that's number one, and stop punishing yourself, but it was like, stop writing your own sentence. When she said that, I was like, "Holy shit."

Here Victor clearly identifies stigma as being at the core of his fear of HIV. Mentioning dirtiness and dread echoes previous research on the type of rhetoric of HIV stigma that is used to negatively characterize individuals, which often amplifies experiences of distress due to their seropositive status (Garrett-Walker and Torres 2017; Chapman 2002). More specifically, that he views it as a writing of one’s own date of expiry is emblematic of the particular gravity HIV stigma carries due to its association with personal responsibility (McDonell 2013). Research has shown that attributions of personal responsibility to HIV infection can contribute to a lack of sympathy among people in an individual’s social network, which can contribute to isolation associated with HIV stigma (Norman, Carr, and Jimenez 2006 ; Zagummy and Deckbar 1995). In Victor’s case, however, his mother played a critical role in ensuring he did not continue to hold onto such a view, especially given the fact that he had still been receiving negative diagnoses with every test. The above case also shows an instance in which religiosity is mobilized against stigma, specifically through its influence on Victor’s mother and how she consoled him. The significance of discourses stemming from religion are explored more concretely in a subsequent chapter.

Family can also normalize the practice of regular visits to the doctor, which can subject respondents to biomedical perspectives of health that impact their HIV risk perceptions. Roman, a 25-year-old Black and Latino lower-middle-class gay man, describes his family's history of disease as inspiring his deep desire to not have to suffer from the same or worse illnesses. He notes complications related to abnormal blood sugar levels and blood pressure, such as diabetes and strokes, on both sides of his family, which has motivated him to be more physically active and vigilant about his health in general. Roman is aware of the disproportionate impact HIV has on Black and Latino MSM, thus he makes it a point to get tested for periodically. Apart from this awareness, however, Roman mentions his mother as being a key factor in his adherence to regular doctor visits:

I think I was on a much more routine schedule when my mom was making my appointments. I think since I've been more of an adult, I'm like ... will go every year and a half or forget a few months, and then have to have my mom remind me. Like, "Oh, have you made an appointment?" Even now, I think my last appointment was like last year, so I'm probably definitely due for a checkup.

Here Roman describes how his mother used to be the person to remind him to make his medical appointments, which Roman would also use as opportunities for STD/STI screenings. Roman lived with his mother throughout his childhood and part of his early adulthood, but now that has moved out and leads an independent life filled with work and other obligations, Roman finds himself more likely to forget to schedule an appointment. Roman later explains his lack of urgency about getting tested because he at the time did not find himself "having unprotected or risky sex," opting only for oral sex which he also uses condoms for. Even so, Roman recognizes a need to get tested that he plans to address during his next checkup. Roman's narrative shows the role family members can play in ensuring respondents are consistently exposed to biomedical knowledge via medical care, knowledge which informs how they understand themselves as at-

risk of HIV and the individual actions they can take to address the potential for infection.

There are, of course, individuals who do not have both or any biological parents involved in their upbringing, such as those respondents who only grew up with their mother in their lives. Others like Kyle were not directly raised by their parents and were instead under the care of close relatives, such as grandmothers and aunts. In these instances, family networks played an even greater emotional support role due to the stipulations of the individual's parents' absence. Kyle had a traumatic experience with the loss of his mother, who was fatally shot by his father when he was just three years old. Kyle describes this experience being the root of the depression he has dealt with for much of his life. He was raised by his aunt, who he would go on to view as his mothers, with his cousins serving as siblings. Kyle's experience with depression lends further insight into his previously discussed concerns about HIV. Kyle worries that were he to ever test positive, he would not feel comfortable enough trusting anyone with that information. As he lost a friend due to a lack of familial support, it is interesting to note that Kyle still would not feel comfortable sharing news of a positive diagnosis with an otherwise supportive adoptive family. Kyle does, however, share that only his aunt and her children are the only ones who know his sexuality, emphasizing that only certain people in his family know. Taken together, Kyle's experience demonstrates how sexuality can figure can affect dealings with relatives and inform his perception of the self as at-risk of the social and bodily impacts of HIV.

"Hopefully you don't get HIV and AIDS": Conflation of Sexuality with HIV

Another notable way relational interactions with family members can impact an individual's perceptions involves the conflation of sexuality with HIV. As was mentioned in the previous section on friends, HIV was once thought of an illness that strictly affected gay men,

which has contributed to the formation and persistence of stigma that disproportionately affects MSM. Where conversations with friends bring awareness about the continued presence of such antiquated views, those with relatives lend insight into how such views are further propagated. For example, a majority of the men I spoke to for this study shared their coming out experiences, and throughout these narratives arose a common occurrence where parents would express immediate concern over their child's likelihood of exposure to HIV and other STDs/STIs. Larry, for example, felt comfortable coming out to his mother as they have an exceptionally close relationship, having endured and supported her during periods of homelessness and unemployment. After telling her that he identified as gay, her brief silence was immediately followed with questions about his sexual activity and whether or not he was "being safe."

Larry's experiences are characteristic of implicit ways in which family members inform how individuals consider their sexuality when giving meaning to their relationship to HIV. More explicit cases can be seen in the experiences of Jackson and Roger, who both had parents that associated their sexuality with HIV risk. Jackson, a 27-year-old Black gay man originally from Pennsylvania, states that there was a "worry of [him] possibly getting HIV" when he came out to his parents. Jackson does not personally hold the same worry, as he considers himself very health-conscious and knowledgeable about HIV. Nevertheless, he goes on to describe how his father would continuously send him articles about how HIV was disproportionately affecting gay Black men such as himself. Jackson meets this with frustration because his parents fail to see that "there is more to [his] community," as they are reducing his sexuality to the confines of riskiness. It is important to note here that Jackson's parents are also aware of the intersection between race and sexuality and its relation to HIV. For Jackson, that intersectionality is at the core of the community he belongs to, but for his parents it is simply what makes him at-risk of HIV.

Jackson's exchanges with his parents reveal a perception of HIV as a risk that is antithetical to his own of HIV as a non-issue. Rather than alter how he gives meaning to his relationship to the illness, these interactions present an opposition that serves to reinforce the individual's initial perceptions.

Sam, the 24-year-old Black queer man who frames HIV as a concern to his corporeal health, had several conversations with his father after his coming out that informed how he thought of his social location with respect to HIV. Specifically, Sam's father highlighted the particular difficulties that come with being a Black man and how these can be further complicated by possessing a non-heterosexual identity. Among these complications, Sam relates, is the heightened risk of HIV. This exchange speaks to how race, class, and sexuality are institutionalized in society in ways that place Black MSM like Sam at a systematic disadvantage. As previous research has shown, Black gay men's experiences marked by instances of discrimination, stereotyping, and homophobia by others within their own racial group because of their non-heterosexual identity (Bowleg 2013; Lemelle and Battle 2004). These experiences can also lead to exclusion and lack of visibility of these individuals within their own communities, which can have adverse effects on their overall wellbeing (Moore 2010). With regard to Sam's sensemaking about his relationship to HIV, this interaction with his father shows how his risk perceptions incorporate information that extends beyond just the respondent's individual health.

Roger is a 28-year-old middle class Black gay man whose mother did not reprimand him for his sexuality when he came out, but instead told him "hopefully you don't get HIV and AIDS." When examining why family members immediately associate homosexuality with HIV, it is critical to note that may age play an important role in the formation of such an association. The parents of all the individuals I spoke to were old enough to have witnessed the height of the

HIV epidemic for themselves in the late 80s. When knowledge about HIV was limited and the narrative of the "gay plague" was commonplace, it is not surprising that this may have been how respondents' parents came to perceive HIV. What is notable, however, is the fact that this association persists today despite the wealth of knowledge and resources that show how HIV can affect anyone. As will be made evident throughout the remainder of this chapter, as well as portions of the next, awareness of these generational gaps are at the core of how individuals understand their perceptions of HIV to be different than those of older than them. This holds true not just for family members, but for the people that comprise the communities and social networks individuals are members of.

Prodigal Son Stigma

Just as individuals are concerned with jeopardizing their standing among their friends, they are equally concerned with the way HIV may damage their social standing within their familial networks, as well as compromise the resources they gain from these resources. Recalling the experiences of respondents that were discussed in the previous section of this chapter, Emanuel's friends positioned their opinions of his HIV-positive partner in relation to what his parents "would think," implying that they would not be accepting of his partner nor of the position he has placed himself in. Similarly, Aaron, the 29-year-old middle-class Black gay man who associated infidelity with HIV after his friend's experiences, worries that a positive diagnosis would place an inordinate amount of worry on his mother's life. As was discussed earlier in this section, parents can provide individuals with the wealth and resources to be in a position such that an individual can feel they are less susceptible to HIV exposure, effectively changing how an individual understands their relationship to the illness. Parental health

insurance is another such resource that individuals can benefit from should they want to be proactive about their HIV-related health matters. Colin, a 23-year-old working-class gay man who identifies as Black, Latino, and White, touches upon this when he describes how seeking PrEP medication under his parents' health insurance would be a complicated decision to make:

...I thought about it getting [PrEP], but then I didn't want it going my parent's insurance, so that also made me afraid of getting it...they see everything. Even when I get tested, so it's like I definitely don't want that question and even though it would help prevent anything that would be happening, which is great, I think it's also just another stigma that I haven't overcome yet is just like, "What are they gonna think if I get this thing? They're gonna think that I'm having sex everywhere," ...they are very traditional and they still do have that mindset about like ... that little mindset of like, "Oh, this is what gay people do, right?" I'm like, "No, I grew up with you all my life, this is actually what I do."...they've had to learn that that is just ... it's not a blanket statement for gay people.

Colin demonstrated a knowledge and awareness about PrEP as a potential option for him to proactively prevent exposure to HIV though, as he relates in the above excerpt, he has yet to seek a prescription because he is under his parent's insurance plan. More specifically, he does not want his parents seeing him so much as getting tested because it would, in his mind, resurrect or confirm concerns his parents expressed regarding his sexuality. In fact, it is Colin's parents' views on gay sexuality that bring him the most concern, which as was described in Chapter II, is often associated with and subsequently demonized for notions of overt promiscuity. Colin's mother in particular had the most difficulty with his coming out, expressing self-blame for Colin's sexuality, but ultimately coming to accept him. However, as a native of Texas who moved later moved to New York City for school and work, Colin states this his parents' were worried he would not only be overly sexually active, but also more likely to become HIV positive because of it. Pondering on how he would react were he to hypothetically receive a positive diagnosis, he states that he would first think of his family because he feels "like they would be disappointed because...that's been their number one worry." Given this, Colin has chosen not to seek PrEP

until he gets his own insurance, and goes to free clinics for his HIV-testing concerns. He has come to view himself as someone who has been at-risk of HIV, though what he feels it threatens more would be his place in his familial networks rather than his health. In this way, it becomes evident how Colin's family have not only created conditions for his health-related behaviors, but also shaped how he views his sexuality with respect to HIV risk.

Race can also figure into how family members inform the individual's perception of HIV as a threat to their social standing. More specifically, where an individual's sexual identity can already label them as "different" due to their not being heterosexual, the degree and extent to which the individual is othered can be affected by cultural norms rooted in their family's race and ethnicity. Emanuel, for example, said he was hesitant to come out about his sexuality because of the "conventional" cultural values stemming from his parent's Latino and Asian heritage, which typically is not very accepting of homosexuality. As a 25-year-old Black and Latino gay man, Roman felt a similar way, with sexuality being something he doesn't openly discuss with all relatives because of their views. However, when HIV is introduced into this analysis, it becomes evident that the disease further amplifies the exclusion individuals may already be experiencing in their familial networks. Roman describes this in further detail when he states:

I guess particularly for Black, Latino men who are out and who may come from families that are either one: they may not be supportive or two: they are supportive, they just hold on to very outdated ideas. Where you don't necessarily want to be the black gay person in the family who did contract HIV, it's almost like "well, what did you think?" ... I think that might be a concern for me and I'm sure others.

Roman describes a phenomenon that he locates specifically within the shared experiences of Black and Latino MSM, namely that their family's acceptance of their sexuality is rooted not just in their views of the individual but their views on other non-heterosexual Black and Latino people in general. In particular, he highlights "outdated ideas," which in this case is in reference

to the thought that HIV isn't just a "gay plague," but is rather an inevitability for Black gay men. As was discussed in Chapter II, individuals are aware that HIV has disproportionately affected certain demographic groups more so than others, which shapes how they understand themselves to be deemed at-risk of HIV by others. One of Roman's worries about becoming HIV-positive is that he would prove his relatives right, verifying and affirming deeply their deeply held views that Black gay men are bound to become HIV positive at some point. As is further explored in the experiences of other individuals discussed in the next two chapters, such views can be culturally embedded in the Black and Latino community. For Roman and the other Black and Latino men he feels share his concern, becoming HIV-positive would lend credence to an otherwise harmful view of individuals who are already ostracized within their familial networks for their sexuality. For these reasons, Roman has come to frame HIV not just as a risk to his biological health, but also the status-quo of his life.

Kin as Models of the HIV Lived-experience

As was the case with friends, relational interactions with family members can also provide individuals with insight into what life is like as an HIV person. This insight is crucial for clarifying some of the uncertainty that HIV presents as a phenomenon that can effectively alter a person's life in some form or another. It provides a grounded, accessible, and contextualized look into what it means to be and live as an HIV person today, albeit from the perspective of a person who may not fully share all aspects of an individual's identity. As previous research on HIV-positive relatives has shown, family members can view as less helpful than friends when it comes to HIV-related social support, though the presence of such support has been associated with reduction in behaviors that are characterized as "risky," such as condomless anal sex

(Kimberly and Serovich 1999; Schwarzer, Dunkel-Schetter, and Kemeney 1994). Nevertheless, there are instances where the parent or relative is HIV-positive, with the individual serving as a source of social support for this person. Previous research on HIV-positive mothers, for example, found that children are a major source of social support and motivation for mothers to continue managing their illness (Andrews, Williams, and Neil 1993). Parents typically disclose their HIV-status to their children once they are older, and while scholars have examined how children impact the lives of their parents, there is little research on how the experiences of parents and relatives more generally affect the child's perceptions of HIV (Lee and Rotheram-Borus 2002).

Analysis of the narratives of the individuals I spoke to for the present study can begin to offer the insight necessary to fill this information gap. Several respondents identified having at least one person in their familial network who had been affected by HIV. Hugo, the Black gay man who associates HIV with infidelity, spoke of his uncle who had passed away when he was a child. Hugo explained that when he died, most of his family never knew why, but it was his mother who told him that "it was because he was positive." Hugo describes this experience as being one of the few that made him "pay attention" to HIV even when he "didn't want to" or "wasn't thinking about it." Throughout his narrative, Hugo never explicitly speaks of HIV in terms of risk. The word itself is remarkably absent. He does, however, illustrate an awareness of how HIV has disproportionately impacted individuals who share aspects of his identity. For example, he considers the CDC report on HIV rates among Black and Latino MSM to be applicable to him. What put HIV "in [his] face" as a possibility in his life, however, were the experiences of his uncle and friends who were affected by it.

Among the individuals I spoke to, William was the only respondent who has an HIV-positive parent, whose experiences have been central to the formation of his perceptions of HIV.

William, a 26-year-old working-class Black and Latino gay man, shares that he does not know when or how his mother became HIV-positive, a topic he has yet to broach with his mother out of respect. Despite being raised by his great-grandmother for the majority of his life, William describes his relationship with his mother as substantially close, especially after he moved in to support her husband passed away. His "biggest cheerleader," William's mother is also the first person who showed him what it is and looks like to live healthily as an HIV-positive person. Attending his mother's doctor visits and HIV support groups has been particularly insightful for William:

I know there are treatments and some people could take one pill daily, some multiple like my mom. I do know that there's a big stigma behind it, and a lot of people aren't educated on it, they think it's the end-all, be-all, and obviously speaking, I don't wish it upon anyone, but cancer is worse. I've had family members with cancer and so, I feel because people are so afraid and people think it is the end of the world that might shy them away from being treated or tested...My mom goes to a group every other week where she can go with other people who are positive. I feel like now, more people are talking about it, and so we have a better understanding of generally how many people might have it.

When asked to share what he knew about HIV, Will stressed that he felt it to be much more manageable and less of dire situation that would lead to immediate death or unsurmountable complications. The existence of treatment regimens so that HIV-positive individuals can live full and healthy lives, such as what his mother takes, is what allows him to feel less fear surrounding HIV. What does concern him is the persistence of stigma and the accompanying lack of awareness about the contemporary existence of HIV that he feels drives behaviors that can promote infection, such as the fear of getting tested. Indeed, previous public health research has centered on promoting efforts to increase awareness about HIV testing and prevention as an effective means to prevent infection (Brown, Macintyre, Trujillo 2003). This has been coupled with more recent efforts that Will has noticed to have an effect his own social circles, such as the

CDC's "Start Talking. Stop HIV" campaign, which promotes discussing HIV openly with sexual partners and friends as a means to increase awareness about and adherence to treatment and prevention (CDC 2017).

What is particularly insightful about his narrative, however, is how much his mother's experiences have served to clarify the uncertainty of what life may be like were he to ever become HIV-positive, and how less frightening it all truly is compared to what he previously imagined. His reduced worry about HIV does not necessitate that he now engages in activities or behaviors conducive to potential infection; in fact, witnessing his mother's experiences has reaffirmed his choice to consciously be less sexually active and to always use some form of protection during sex. William's comparison of HIV with cancer, which occurs at several points during the interview, reaffirms that uncertainty about an illness is what can shape risk perceptions. With cancer affecting his relatives at a time when the origins of cancer are still not fully understood, cancer fits William's definition of risk as something that is "out of your control." Knowledge, however, can offer control and therefore disabuse an individual of the notion that they are at-risk of an illness. William's mother influences why he "wouldn't be afraid" of an HIV diagnosis, as he possesses the knowledge of how to live healthily regardless of his status, as well as what the future would hold should he ever become positive.

Interactions with family members that provide awareness about the HIV lived experience do not always have to center around a parent or immediate blood relative. In certain cases, familial networks can include the close friends of relatives who effectively become part of an individual's family despite the lack of biological relation. Peter who was predominantly raised by his mother, for example, recalls his mother's best friend being a constant fixture in his family life. Peter shares that his mother's best friend was diagnosed with HIV around the same year he was

born, so he has only ever known this person as HIV-positive. Reflecting on his own upbringing, Peter shares how his mother's best friend has influenced his perception of HIV:

My mom's best friend...had his own problematic views on his own diagnosis. He wouldn't let other people eat from the same silverware as him, but that didn't really sink into me. I just saw this happy, healthy, muscular, in-shape guy who had an amazing disposition on life, who was still leading a very healthy sex life, who was poz. But it wasn't something that you talked about much. It was just like, "he has HIV."

As a person who became positive during the height of the HIV epidemic in the United States, it should not be surprising to hear that Peter's mother's best friend held views about HIV that Peter considers "problematic." Early forms of HIV stigma arose due to lack of information on how the virus was effectively transmitted, leading to notable misconceptions, such as the virus being easily transmitted through benign actions such as the sharing of utensils. Globally, this led to HIV-positive people being viewed as social pariahs worthy of quarantine and other forms of societal exclusion, as well as the internalization of such stigma by HIV-positive people themselves (Hansen and Groce 2001; Piot et al. 2001; Gruskin, Hendriks, and Tomasevski 1996).

Peter, however, did not view his mother's best-friend solely as HIV-positive, but rather a generally healthy person who just so happened to be HIV-positive. Peter mentions this person's "healthy sex life" in particular, suggesting that he knew the individual to be taking active precautions against exposing others to HIV. This comment also speaks to Peter's broader stigma framing of HIV. Peter is well-aware that, were he to ever be HIV-positive, there are treatments available that can allow him to live a life as healthily as his mother's best friend has been living. This is made evident in his comparison of the outlooks between members of his peer group and those of his familial network. His major fear about HIV, however, is how he would come to be perceived by others and how it would alter his sex life. As is discussed in the following chapters, Peter views the HIV crisis as an incident that constrained the sexual freedom of men who have

sex with men. As a bisexual individual who considers sex to be an indispensable and necessary to life, becoming HIV positive would for him mean the forfeiting of this aspect of his humanity. In Peter's view, HIV no longer equates to an untimely death, but it does demand a fundamentally different and undesirable way of life that he perceives himself to be at-risk of.

Romantic and Sexual Partners

Respondents' romantic and sexual partners are also influential forces in their HIV risk perception formation. Below I primarily focus on respondents' partner selection strategies as a form of interaction between themselves and their partners. Prior research on sexual partner-choice has largely considered this process an action mostly mediated by interpersonal assessments of characteristics held by the individuals involved in the potential sexual interaction (Morris and Kretzschmar 1995; Klovdahl 1985). I build upon this work by examining the how HIV's association with race, class, and sexuality play into how people consider themselves and others desirable. I also broaden partner selection strategies to be inclusive of respondents' practices of vetting one another's HIV status, and the actual methods by which they locate, contact, and connect with their partners. It can be argued that partner selection serves as a health-relevant behavior, as the sexual interaction that may result from these interactions has the potential to facilitate HIV transmission. For instance, explicit considerations of HIV risk are most evident within these bonds as they can serve as potential sites for transmission. However, as was seen in Shane's narrative above and will be made further evident in the analysis below, respondents typically find meanings in these relationships that extend beyond just possibility of HIV infection. As such, the present sub-section does not limit the scope of its analysis to how these partner selections strategies map onto respondent's health outcomes. Instead, partner

selection is viewed as an avenue through which an individual's sensemaking about their relationship to HIV can potentially take place. Direct analyses of health-relevant behaviors in relation to HIV risk perceptions are discussed in detail in Chapter V.

Identity and Desirability

Romantic/sexual partner selection brings to the fore the relational dimensions of how identity and its associations with HIV risk impact individual risk perceptions. The race, class, and sexuality of respondents' and their potential partner's social location are taken into consideration when determining who is a viable and desirable partner. For men who have sex with men in general, the history of the HIV epidemic and efforts to curtail its spread within that population has, for decades, served as an implicit reminder of the views of outsiders: sex among men is potentially dangerous and should not be taken lightly. For Black and Latino MSM in particular, the idea that they and those who interact with them romantically or sexually should take added precaution is compounded. This can be seen most clearly in respondent's discussions of how epidemiological reports and other health communication have impacted how individuals understand their and their partners' identities in relation to sex. For instance, Gary, the Black gay man from the West Indies, discussed in the previous chapter, expressed shock when hearing that the CDC recently reported 1-in-2 Black MSM will have HIV in their lifetime, stating that:

I knew the numbers were high. I didn't know they were that high. I'm not totally surprised. It's still kind of scary. Shit. That is scary. I probably would have expected the number 1 in 4 black men, 1 in 2, that's terrifying... That brought me a little bit of anxiety. I think it could be me. I like to think ... a switch is my anxiety thinking that when you look at this across different demographics ... I would hope that the men that I'm having sex with, the stats look very differently.

Gary's words above are indicative of his corporeal framing of HIV; understanding himself to be a part of the at-risk population the report speaks of is at the core of his perception of HIV as a

potential reality in his life. Of note, however, is that Gary also thinks of the men he may be engaging with who also fall under this demographic, and what that may mean for his likelihood of contracting HIV. Beyond concern with the probabilistic projections associating Black and Latino MSM with HIV, Gary's risk perceptions also include a stigma framing of the disease, as he describes how equally troubled he was by the impact such information has on society's assumptions about other Black gay men such as himself:

I think there are stereotypes that probably relate to the actual statistics. People are probably more likely to assume that a person of color has HIV. I think there's a lot of assumptions that gay men are more likely, people are more likely to make that assumption that a gay person has AIDS, versus a straight person. Again, I think it's based on statistics.

That people would assume a non-heterosexual person of color would be more likely to have HIV is not new; in fact, there has been extensive research on the experience and internalization of race-based HIV stigma and stereotypes (Smit et al. 2011; Arnold, Rebchook, and Kegeles 2013). Notable in Gary's response, however, is the "anxiety" he feels when considering his past sexual partners, who he states are predominantly men of color. In Gary's view, the statistics, however accurate a portrayal of reality they may be, can fuel stereotypes that may negatively impact the experiences of men such as himself. Nico, a 26-year-old upper-middle-class Black living in Brooklyn, reflects these concerns when he wonders "are people looking at us as 'less'? And, also am I looking at somebody like [that]" because of what the statistics suggest about Black and Latino MSM's likelihood of HIV infection. His aforementioned anxiety about his previous and potential romantic/sexual partners may be shared by those he reaches out to for sex and romance. It is through such consideration of past and potential partners that Gary and others like him further solidify their HIV risk perceptions.

Shane's experiences also reflect how respondents incorporate their own and their

potential partner's race in considering the prospect of romance and/or sex. As was touched upon in the previous chapter, Shane finds that epidemiological data and report cause him to be wary of his potential partners who are Black and Latino MSM, with racial homophily causing him to feel the need to be "on guard" when interacting with men. Interestingly, Shane first brought up the CDC report of his own accord during the phone screening interview during recruitment, mentioning that he did not count himself as at-risk specifically because his partner at the time was a white man. Despite Shane understanding himself to fit the at-risk demographic because of his own race and sexuality, he initially considered himself discounted by the report's findings because he was not interacting sexually with members of this at-risk group. Nevertheless, during the course of the actual interview, Shane amended his original statement after he realized he assumed the number was based on the outcomes of Black and Latino MSM who strictly had sex with other Black and Latino MSM. In this instance, he considered himself to be represented by the statistics, albeit the 1 in 2 Black MSM who would likely *not be* infected because of his vigilance in selecting romantic/sexual partners. These are, however, probabilities, and given Shane's perception of an ever-present risk of HIV through sexual interaction, he still fundamentally understands himself to be an at-risk individual.

The associations between HIV and identity also undergird the partner selection strategies of irrelevance frame adherents like Ricky, the Latino gay man who views HIV as a potential reality for his extended family but not himself. As was explored in the previous chapter, inadequate education and low income are what Ricky associates with increased rates of HIV incidence among Black and Latino men who have sex with men. Coincidentally, when describing what he looks for in a partner, Ricky gauges their level of education and income before engaging with them in any physical capacity. Ricky's conversations with potential sexual

partners therefore assess the person's desirability not just through their attractiveness or romantic compatibility, but also their likelihood of being HIV positive. As is discussed later in this subsection, individuals like Ricky use initial conversations with potential partners to both explicitly and implicitly determine their HIV status. For Ricky, his perception of the self as protected from the risk of HIV stems from his deliberate vetting and selection of partners.

Respondents also describe how physical racial presentation, gender expression, and mannerisms affect their own desirability and that of their partners in ways that are linked to HIV risk. Many of the Black and Latino MSM I spoke to described themselves as falling outside of ideal expectations of partners due to aspects of their identity. They describe white, cis-gendered male-presenting, masculine bodies as the default that most MSM are looking for when seeking romance or sex. Previous research on experiences of racism and discrimination within the gay community has shown this to be a significant source of emotional and psychological distress for men of color (Plummer 2007). Gay-centric dating and hook-up apps, such as Grindr and Jack'd, offer a novel avenue through which men can interact with one another, but for Black and Latino MSM, they often serve as a digital arena in which such prejudice is made exceedingly apparent. Benjamin laments this when he states:

I feel like the apps are just ... it's hard to represent yourself. Like it's hard to paint a picture of who you are with just a tiny picture and a few words. But also they're just so racist. They're just not set up for black people to win. So, I think it's really difficult when you get on the apps. Especially in a neighborhood like this, right. Because [they're] location-based. So this is obviously a very white neighborhood. So I get no attention here. And it becomes this thing that is harmful actually. Because I start questioning whether or not I'm attractive, whether or not I am capable of love.

Here Benjamin is reflecting on the particulars of how these phone applications work and how they propagate the experience of racism among Black MSM like himself. Gay dating apps typically present a grid or some other organized layout of icons that are comprised of a picture of

the person, along with some general demographic information. These online dating programs are highly visual, thus men are typically expected to select flattering photos that best represent who they are and what they are looking for. Benjamin's words, however, reflect a frustration many other respondents have: the individuals who receive the most attention on these applications fit the aforementioned ideals of self-presentation. This is exacerbated by the fact that these applications use GPS data to show users potential partners within a certain radius. Benjamin is one of the few people of color he sees on the application when he uses it in his predominantly white neighborhood. That he does not receive much attention here underlies his view that the White men sees on these apps would rather engage with one another than reach out to him. As other respondents have indicated, part of the racism Benjamin views as rampant on dating apps may arise from the association of Black and Latino MSM with HIV.

In the instances that they do get to interact with other men through these applications, respondents state that certain aspects of their identity are often fetishized by their potential sexual partners. Rather than being full human beings, the Black and Latino MSM I spoke to state that they are often reduced to their body parts or manifestations of fantasies rooted in stereotypes. They experience this at the hands of White men as well as other men of color. This is not unlike the dynamics Sharon Patricia Holland explores in her work *The Erotic Life of Racism* (2012), where desire is not diametrically opposed to racism, but often rather intricately intertwined with it. Frank, a 24-year-old Black middle-class queer man from Brooklyn, conveys his worry of being fetishized when he states:

Also, I think one thing that's frequently on my mind, especially as a black person, a person of color, it's like with any ... I guess with any sort of sexual act, with someone that's just not feeling like I'm being fetishized, or knowing that someone generally respects me and will respect boundaries of, suddenly become uncomfortable with something.

The fetishization mentioned above is in reference to comments men make to other men of color that focus on aspects of their being that have been conceptualized as erotic objects to be consumed. Black men are presumed to be well-endowed with an insatiable sexual appetite, and Latino men are expected to be passionate and “spicy” lovers with sexual prowess. These fantasies based on stereotypes constitute a form of dehumanization such that the person is no longer a person but rather a source of pleasure to be used and then discarded. They are interpolated as participants in sexual encounters primarily to fulfill a fantasy, rather than to engage in intimacy or relationship building. The belief in these stereotypes can lead to moments of isolation or neglect, as people may not even come to consider Black and Latino MSM as viable sexual partners without much thought. The linking of HIV-likelihood to the bodies of men of color who have sex with men also gives way to further fetishization of their identities. Several respondents also state that many of their encounters with men on online platforms involve them receiving requests for condomless or “raw” sex, something they felt may be due to the fetishization of their race. In these cases, the men refer to the overt sexualization of their bodies and the particular expectation placed on them to engage in condomless sex. Previous research has shown how such race-based sexual stereotyping at the root of “raw fantasies” with Black men impacts sexual partnering decisions and sexual networks (Robinson 2015; Han 2007).

The Black and Latino MSM I spoke to who are more feminine in their self-presentation are also met with an added kind of rejection from their sexual prospects that is rooted in misogyny and homophobia. Wallace, the 27-year-old Afro-Latino gay man introduced in the previous chapter, explains that even when he isn’t shunned for his race, he is often ignored because he does not fit the typical masculine ideal:

The thirst for masc [masculine] beings is unquenchable. They're just wanted. They're wanted all the time. That's another thing for me that's difficult, which is

why I often feel out of place, because I feel like I'm pretty femme [feminine]. I'm kind of like ... well, there are obviously people do it a lot more than I am, but I'm definitely in the femme category. So it's just like, okay, I want people to do what they want to do and feel fulfilled in whatever way they want to feel fulfilled, but I feel like a lot of it is just stereotypes and like, I don't know, everybody wants a masc man, and so it makes it difficult for people like me.

This particular narrative demonstrates how expectations of gender expression figure heavily into the politics of desire, especially among men who have sex with men. The ideals respondents note among their prospective partners sharply define what conventional attraction should be, and femininity is not within those bounds. This can lead to what Wallace describes as feeling “out of place” because of a lack of acceptance from a pool of eligible romantic and sexual prospects he would otherwise be included in. With regard to perceptions of HIV, discrimination against the feminine presentation stems from a linking of the virus to this form of gender presentation. Howard, a 28-year-old Black gay man living in Harlem, conveys these sentiments when he states:

I think because there is such a negative connotation on anything feminine, especially in the community, that people perceive at the most, people who are HIV positive are ran through, queen bee bottoms, if that makes sense. I know that sounds so bad but you know what I mean.

Howard brings to light an association between the negativity associated with femininity and the stigma that is placed upon HIV-positive individuals. In describing the negativity HIV-positive MSM face, he describes a common assumption that these men are HIV-positive because of how and the degree to which they have had sex in the past. Specifically, the idea that they are "ran through, queen bee bottoms" implies these individuals are outwardly feminine anal receptive partners who have a seemingly abnormal number of sexual partners than what is typically expected. Howard is aware of how harmful such a view can be, but he is primarily describing what he has observed to be a salient view among other men in the broader gay social network.

Almost all respondents acknowledged a view of feminine-presenting men as primarily serving as receptive partners during anal sex, an activity they also associated with greater likelihood of HIV transmission. As gender presentation figures into the ways in which men have sex, the feminine becomes inextricably linked with notions of HIV risk.

A closer examination of how Black and Latino MSM engage with online dating apps to find romantic/sexual partners also reveals a normalized expectation of sex that has implications for HIV risk perceptions. While there are still instances of more traditional modes of meeting partners, such as through encounters at bars or introductions through mutual friends, a majority of respondents highlighted phone-based gay dating applications and websites as the primary way they met people for sex. Recent research on the rise of online dating websites and applications in the past decade show that they have been highly adopted by men who have sex with men (Bauermeister et al., 2011). Nolan, the 29-year-old Latino gay man who learned about HIV through his friend, describes the use of apps as almost being mandatory in a place like New York City. In his view, the pervasive use of gay dating apps that has made sex more easily accessible than it has ever been for MSM:

I just think we're all on this chessboard of Grindr and Scruff...sex is too easy in the gay community, so I guess you have the privilege of today wanting a daddy bottom and tomorrow wanting a twink Asian...[Straight people] still seem to have the stigma of sex being a means to an end, like kids or a relationship or you know. I think the gays got rid of that shit...it's part of our community. I mean, if you go to a bar or an app or just in general, I think it's hard to be gay and not think of sex. Not that for straight people it's not like that, but I don't think it's a huge priority for them as it is for us.

Of note here is how Nolan views sexual interaction as being part and parcel to gay sexuality and the broader gay community he and the men he interacts with belong to. Apps have facilitated the degree to which MSM can find and interact with one another, and in a place like New York, Nolan finds that they contribute to the acceptance of sex as a practice that does not necessarily

have to serve a purpose beyond procreation or intimacy. Sex provides pleasure, which is a sufficient enough reason for Nolan to seek potential partners. Nolan identifies this as a kind of sociocultural norm within the broader gay community he draws his potential partners from, contrasting it to the perspectives of straight-identified people, who he believes are concerned with sex being an entry point for committed or long-term relationships and procreation.

However, not all respondents were of the same mindset. Ricky for instance spoke at length about his frustrations with how difficult it is to find other men on dating-apps who seek more than a transient sexual interactions:

I mean with all the apps there's no follow-through really. I am that person who's on Grindr and is using it for things that are not really what Grindr is for, like, "Oh, would you like to get a coffee?" And they're like, "Want to come over now?" ...The biggest obstacle is actually meeting someone, making plans, then following through.

Here Ricky emphasizes how he holds a more conventional understanding of what dating entails, such as meeting up for coffee to get to know them better, but being met with proposals for immediate sex instead. Many of the men I spoke to mentioned having difficulties with a seemingly ever-present presumption that interactions between men who have sex with men must ultimately end in sex and not move past that. Billy's frustrations resonate with those of Ricky's when he states:

So now, on Scruff and Grindr, and that's just really, I mean, it's totally sex-driven, I find it really difficult to even have someone to agree to a drink...I mean, like personally, I would love to date someone like substantively, long term. Will I find that through an app? I don't know, I'm not terribly optimistic.

As will be discussed in Chapter V, sex is extremely important to Billy, as it is an experience he finds brings him a sense of being "alive" unlike anything else. At the same time, Billy values the intimacy that comes from a long-term bond with another. Billy still wants to have sex, so he "goes along with" the norms of gay dating app use, but he does not deny that his needs and

desires are not being fully met. What these narratives bring to light is the existence of expected rules of engagement when it comes to finding and interacting with potential romantic/sexual partners. Tensions arise for respondents such as these when they must navigate the ubiquity of sex-centric gay-dating applications that value sexual interaction over relationship building. This is especially significant for respondents who view the reduction of sexual activity as a means of decreasing their likelihood of HIV infection. Ricky, for instance, views sex as a pleasurable “way of connecting with someone on another level, of gaining intimacy.” Ricky also will not have sex with someone he does not trust or has not known for some time, partly due to the risk of potential HIV infection, but also because of the degree of vulnerability that sex entails. In this way, Ricky’s framing of HIV as irrelevant to his life is supported by his limiting of sexual interaction to only trusted partners, which he understands as generally incompatible with online dating apps.

Relating through Conversation

Conversations about HIV status comprise key engagements between respondents and their potential romantic/sexual partners. As was made evident by the narratives of respondents whose sensemaking is characterized by a stigma framing of HIV risk, the HIV stigma can be viewed as a threat to social well-being. A significant portion of HIV stigma is constituted by discrimination and devaluation of people who are HIV-positive. Prior research on the disclosure of HIV-positive status within communities of gay men indicates instances of health-based discrimination and exclusion from their peers (Parker and Aggleton 2003). Many of the respondents I spoke to for this study expressed worry about how being HIV-positive would severely diminish their desirability in matters of sex and romance. Jonah, a 28-year-old Latino and White man touches upon this when he states:

If I find out I have HIV, I'm not going to find a partner, they're not going to want to be with me...at least first seeing somebody for the first time, since it has somewhat of a stigma, less so, but still for some people it a big thing in their head. They might think that, without knowing the person, oh it's a bad thing. It might be just because it's it sucks because people are going to be like, I don't want be with somebody who's positive.

Here Jonah explains that much of his concern about being HIV positive centers around the idea that he would no longer be viewed as desirable to others, and would effectively be disgraced from the pool of potential sexual and romantic partners. While he does not point to any particular instances in the lives of others who may have experienced such exclusion, this kind of generalized fear of being marked as unwanted due to HIV-positive status reflects an embodiment of the very same HIV-stigma that has persisted for decades. Jonah expands upon his thoughts and demonstrates how he would hold the same exclusionary views when asked if he would consider being in a relationship with a potential partner who disclosed their HIV-positive status:

I would love to-Yeah, I would love to be the person that would say, "Yes, I definitely would," but ... And also, I guess, it depends on the situation. How I met them, how long I've known them, if we've been dating a while and then it came up ... I don't know. But I feel like me, personally, I might just have too much anxiety.

Jonah's high degree of concern about HIV is made evident given the stipulations he would require to consider being in a relationship with an HIV-positive person. When asked whether his opinions would change given the recent advancements concerning undetectable viral loads, Jonah notes that undetectable status carries a negligible risk that makes transmission virtually impossible, but that a small "percent is still a risk." Thus, while he would "love to be the person" that would still sexually engage with HIV-positive partners, he personally would not want to given his HIV risk perceptions. Jonah's central worry about HIV pertains to the "negative perception associated with it" especially in the broader gay community, where he feels that "people might pity" him or think he was being "a huge slut" even if he was only engaging with a

single partner.

How respondents navigate discussing their and their potential partner's HIV status also lends insight into their HIV risk perceptions. Gay dating apps have facilitated more direct conversations about HIV-status, with several having built-in sections on user profiles where a person can indicate their HIV status. Certain online dating apps do not have such a subfield built in, but do allow a certain amount of text to be entered where a person can write about themselves, including their status. In practice, however, it is more common for men to not disclose their status at all on their immediate profiles. This information is typically gleaned from initial conversations individuals engage in when first reaching out to each other. An example of this can be seen in Shane's conversations about HIV status, which he finds to be necessary if he plans on having sex with someone:

The basic questions I always ask are, "What's your HIV status? When was the last time you got tested?" And those are the two, and then I don't believe whatever they say, but just good to know what it is. But as far as my mind is, act as if everybody is HIV positive and has never been tested.

Shane's corporeal framing of HIV risk is reflected in the directness with which he asks his partners about their HIV status. His choice to "act as if everybody is HIV positive" and not "believe whatever they say" is not a reflection of his moral assessments of his potential partners, but more so indicative of how committed he is to ensuring he is fully protected from contracting the virus. Many respondents, however, differ from Shane in that they choose not to bring up HIV status out of concern of making the situation awkward or uncomfortable. Others also do not speak on it for fear that such conversations could contribute to HIV stigma. Sam echoes this when he states:

I don't bring it up, because I feel like the whole stigmatizing of people with HIV thing. People who are all like, "Are you clean?" I'm like, "It's not about cleanliness, bitch." It's about being informed and regularly testing, and it's

negative, not clean. Usually, most people bring it up initially on apps and stuff.

It is important to note here that while more open conversations about HIV-status are being had, they can still come from a place of stigmatization. Specifically, the language of “cleanliness” is pervasive in these discussions and imply that an HIV-positive person is dirty and, therefore, undesirable. Prior research has shown that the use of such conceptual metaphors can shame individuals into not being open about their health-status (Groves et al. 2013). What is clear from the narratives of respondents is that considerations of HIV-status has become a requisite component of their partner selection strategies. Whether this conversations happen explicitly and immediately, or implicitly and at a later time, respondents come to perceive HIV as intimately linked with their potential partners. Exactly how and in what way HIV may present a risk is dependent on their individual risk perception formation. Nevertheless, the respondent’s HIV-status conversations with their potential romantic/sexual partners are influential in how they give meaning to their relationship to HIV.

Conclusion

In this chapter, I outlined the relational component of the REF by focusing on the significance of the interactions between Black and Latino MSM and the people in their social networks. At the relation level, race, class, and sexuality continue to be significant social factors in respondents’ sensemaking process insofar that they structure the relationships that inform their HIV risk perceptions. These facets of social location come to be associated with HIV in implicit and explicit ways that are made most clear in respondent’s relational interactions with their family, friends, and romantic/sexual partners. Friends and family members possess their own knowledge of, views on, and experiences with HIV, which inform how an individual interfaces

with HIV risk. Respondents' interactions with their romantic/sexual partners through their partner selection strategies also serve as avenues through which an individual's sensemaking takes place. These interactions therefore serve as sources from which respondents draw information that help give meaning to HIV's place within the broader sociocultural context of their lives. The corporeal, social, and irrelevance framings of HIV respondents use are therefore partly established through the input of their peers, relatives, and partners. These findings broaden current risk theorizations by illustrating how individually-held disease risk perceptions are jointly constructed by individuals and their social networks.

A closer analysis of the content of the conversations and other interactions respondents share suggest there are broader structural forces at play that must be considered. Specifically, discourses drawn from religion, biomedicine, and a broader gay community underlie the words and actions of the people that comprise respondent's lives. These discourses are deeply tied to associations of race, class, and sexuality and HIV risk that transcend beyond the individual or relational level dimensions of risk perception formation. In the following chapter, I outline the socio-structural component of the REF that illuminates the context in which Black and Latino MSM confront the uncertainty of illness in their lives.

CHAPTER IV

Culture / Schemata: The Impact of Religion, Biomedicine, and the Gay Community

What will you accept / in exchange for your silence? What life do you want / for one more day?

— “Overtones,” Essex Hemphill

Coming out was a significant event for Benjamin. He decided on doing it gradually over the course of his early adulthood, letting his closest friends in first about this aspect of his identity he had kept to himself for the majority of his life. In the final years of college, Benjamin opened up to a few more extended relatives, until six months after his graduation when he finally mustered the courage to tell his father and the aunt he considers a mother. Benjamin shares that the reason why he waited so long was because his parents were West Indian, Jamaican to be exact; fears of being disowned and experiencing religious homophobia, which he understood as the cultural norm in his experience, frequently arose as roadblocks that kept him silent for so long.

Benjamin, however, was surprised to find their conversation went far smoother than anticipated. His mother met him with love, laced with regret, as she found herself annoyed for ever having spoken to him with language steeped in “the homophobic things that Jamaicans would say” in their day-to-day. His father embraced him with the same kind of care, albeit with the request that Benjamin give him time to adjust before they start talking about his relationships with men. Though Benjamin is thankful he did not experience violence at the hands of those who raised him, he is nevertheless cognizant of the beliefs underlying the conditionality of their compassion.

Throughout Shane’s adolescent years, his parents had been wondering about his sexuality

and had consistently tried to get him to be outward about this aspect of his identity. His mother in particular would confront him almost daily in a perfunctory way, which Shane suggests is likely due to her medical training, because “it's her job to get people to confront things in their life that they don't want to confront.” Shane would respond to her inquiries with tantrums and other forms of deflection, not because he feared confirming her suspicions, but because he simply was not ready to be public about it. Shane describes his childhood neighborhood as being a tightly knit and closed network where one person’s gossip becomes everyone’s business, especially in the schools he was attending. To come out to his family would be to come out to his known world.

When he finally felt ready to be public, Shane’s fears were realized, yet he was prepared to face them. His mother initially met him with bible verses describing the sinfulness of his sexuality, but soon softened and turned to more pragmatic concerns about what this means for his health. Shane’s extensive network of relatives suddenly contacted him on all forms of communication to confirm if what they had heard was true, to which he paid little mind to. Shane took to Facebook to make his coming out more of a fact than a rumor and as he had suspected, the initial backlash faded with time. Having always had a strained relationship with his father, Shane decided to tell him last. His father flatly stated his acceptance, but left the conversation at that. It was, in fact, the last time they would ever speak on it. Shane is confident that while his sexuality may inspire discomfort among his relatives, it will not compromise his sense of self-worth. Shane finds his self-advocacy a necessary source of strength, for every day he must face “the reality of what it means to be a Black male in America” whose life is consistently devalued.

Peter’s coming out was met without much affair from his family. For a majority of his life, Peter had considered himself and was perceived by others to be straight. His romantic and

sexual partners were always women until one day at the age of 23 when he “chose to be gay” and decided to incorporate men into his sexual repertoire. Men provided Peter with an experience that differed from but was as enjoyable as the sex he was having with women. When he came out to his family in the United States about his bisexuality, he was not taken seriously at first. He recalls relatives stating they would just choose to ignore his interest in men because he still “liked girls.”

Peter describes his mannerisms as “feminine-esque” but not enough to be read as non-heterosexual by his family, especially because he has an openly gay cousin who is more feminine in self-presentation. With regard to his family in South America, Peter does not hide his sexuality but also does not “know how to be gay in Spanish,” citing his lack of knowledge about the language and behavior that would allow him to be read as non-heterosexual in a different cultural context. For Peter, his sexuality is intertwined with his participation in the gay community of his hometown of New York City. What he knows about his sexuality stems from shared experiences, norms, and values that are specific to the cultural environment he grew up in.

The idea that HIV infection is strictly an outcome of individual thought and behavior is fundamentally shortsighted. The ways in which individuals come to perceive HIV risk must be comprehensively understood. So far, I have established the individual and relational components of the REF, demonstrating how risk perceptions are socially mediated and expand beyond individual risk assessments. I now turn to the institutional and cultural levels of analysis to examine how Black and Latino MSM’s sociocultural moorings structure their conceptualizations of HIV risk. I argue that individuals construct meaning about their relationship to HIV by drawing on their “sensemaking tool kit,” or a collection of language for, discourses of, and

beliefs about the disease. Adapting from Swidler's (1986) theorization of culture, these tools are "symbolic vehicles of meaning" that respondents utilize to formulate and convey their framing of HIV. Respondents build their sensemaking tool kit through exposure to distinct sources of culture that shape thought about HIV risk as it relates to race, class, and sexuality across ecological scales. Specifically, I find that religion, biomedicine, and the gay community diffuse schemata, or "fundamental tools of thought" that concretize associations between HIV risk and the social locations of Black and Latino MSM (Sewell 1992). These associations underscore the ecology of risks respondents perceive HIV to present within their social environment.

I base my argumentation on the synthesis of sociological theorization about social institutions and culture. Social institutions, as Giddens (1984) describes, form the "rules of social life," or the recurring set of social practices people embody and enact that maintain the order of society. In this way, social institutions constitute and are reconstituted by the people who internalize them. Building upon this and other related works, Martin (2004) contends that social phenomena like race, class, and sexuality all exhibit the common features of social institutions whose intersections form the basis of the systems that structure society (Ferree and Hall 1996). Resulting from this are racial, social, and sexual inequalities that are institutionalized through ongoing social processes of racialization, social stratification, and societal gendering (Sprey 1969; Wilkinson 1995; Bonilla-Silva 1997). These social processes in turn drive and are replicated by organizations such that the aforementioned forms of inequality continue to be upheld (Ray and Seamster 2016; Ray 2019; Acker 1990). This is accomplished through actions built upon schemata derived from the organization's culture that direct the unequal "accumulation and distribution of organizational resources" along lines of race, class, and sexuality (Sewell 1992; Ray 2019). As DiMaggio (1997) details, schemata "provide default

assumptions about [the] characteristics, relationships, and entailments” of social objects and are made culturally available to individuals not only by organizations, but other sources of culture as well, such as networks and social movements. These schemata are at the core of the cultural repertoire individuals use to guide their own thought and action (Swidler 1986). Taken together, it becomes clear how race, class, and sexuality function as intersecting social institutions with cultural resonances that affect all levels of an individual’s sociocultural context.

Given the above, it follows that there exist significant institutional and cultural aspects to Black and Latino MSM’s risk perception formation. Drawing upon these schemata to make meaning of one’s relationship to HIV, I contend, suggests that risk perception is built upon and incorporates sociocultural factors that extend beyond assessments of proximate hazards to individual wellbeing. Understanding the self as at-risk involves implicit and explicit considerations of how institutionalized inequalities have structured their social ecology and, consequently, the types of threats HIV can present across the dimensions of their life. I focus on religion, biomedicine, and the gay community as important sources of culture primarily due to their salience in respondents’ narratives, but also because they each encompass intersecting organizations, networks, and social movements that have continue to impact on how people experience HIV. I show how respondents engage with these sources of culture throughout life and discuss how the people they interact can facilitate their exposure to them. I begin with an examination of how religious beliefs associate HIV risk with sexual identity that affect Black and Latino MSM’s sensemaking in manners specific to their race and ethnicity. I then move onto an

analysis of biomedical rhetoric⁶ and its cementing of essentialist notions about HIV's impact on members of this demographic. Lastly, I focus on the gay community and its discourses of it means to "belong" in terms of HIV risk and likelihood of infection, as is made evident by respondents' experiences of inclusion and exclusion. I return once more to Shane, Peter, and Benjamin's narratives as they relate to those of other respondents to illustrate how Black and Latino MSM use these sensemaking tools in their framings of HIV.

Religion

Religion has a pronounced influence on the ways individuals navigate everyday life in society. Religion as a whole encompasses numerous belief systems and traditions of faith. In the United States, recent reports from the Pew Research Center (2019) state that Christianity is by and far the most prevalent religious system of faith. For Black people in the United States, religion and the church have been central to community building, serving as both a symbolic and physical meeting point around which experiences, practices, and beliefs are shared (DuBois 1903; Itzigsohn and Brown 2015). Religion has played a similar unifying role among Latinos in the United States, especially given the shared presence of Catholicism and other Christian faiths among diverse immigrant groups (Putnam and Campbell 2012). For some time, most notably during the Reagan administration as is discussed below, conservative religious principles informed HIV prevention policies, such as the Helms Amendment that barred the funding of programs that supported homosexuality and non-marital sex (Padamsee 2018). Given this high

⁶ I conceive of biomedicine a source of culture from which the distinct cultural resource of biomedical rhetoric is derived. Biomedical rhetoric can be seen most clearly in those who invoke the corporeal frame, such as in their use of objectivistic language about how Black and Latino MSM are predisposed to HIV's biological effects. However, the use of biomedical rhetoric and its underlying essentialist schemata is not reserved for the corporeal frame alone. Respondents who frame HIV as an irrelevance, for instance, draw upon this rhetoric when discussing HIV's bodily impacts they understand themselves to be exempt from.

religiosity, along with the ways in which religious conservatism stigmatizes homosexuality and HIV status, religion arises as an important social force in Black and Latino MSM's risk perception formation.

Religion has perhaps the earliest impact on respondents' lives, with respondents recalling exposure to religious beliefs from a young age. Among the individuals interviewed for this study, nearly half make mention of religion playing a significant role in their adolescent upbringing or their adult lives. A majority of these men identified being exposed to and affected by Christian or Catholic religious views in some way by parents and other relatives at home. Several respondents who grew up in these households highlight exposure to the belief of HIV as a potential negative consequence of behavior that is deemed unacceptable by religious doctrine. Underlying this belief is a schemata that links HIV risk with sexuality. Specifically, HIV is rendered a divine punishment for homosexuality, pre-marital sex, and other behaviors that are culturally non-normative within religion as they are believed to compromise one's spiritual constitution (Somlai and Heckman 2010; Jeffries IV et al. 2014). Some respondents also demonstrated positive relationships with their own spirituality that helped them reconcile with their identity as it relates to HIV risk, supporting previous research on the importance this can have for overall well-being (Foster et al. 2011). These instances illustrate that while such beliefs are carried by religion, individuals can use them as tools in their sensemaking without actually aligning their perceptions with its underlying schemata.

“Two layers of shame:” Religion, Homophobia and HIV Risk

With respect to risk perception formation, respondents indicate discourses rooted in religious homophobia as being particularly formative for their understanding their relationship to

HIV. As previous research has shown, men who have sex with men's experience of religiously-based homophobia can have remarkably negative impacts on their mental health and overall well-being (Page, Lindahl, and Malik 2013). With regard to HIV in particular, these experiences can lead to the internalization of homophobia, which has been associated with greater likelihood of engaging in activities that may expose them to HIV (Balaji et al. 2012; Meyer and Dean 1998). Active engagement in and support from religious communities has been found to be a form of social integration that can prevent against HIV transmission; when the homophobia stems from these communities, however, the potential impact this can have on their health outcomes is made ever clear. For Black and Latino men in particular, participating in non-affirming religious communities or settings can lead to the internalization of the very same homophobia they are exposed to, which can lead to behaviors that are conducive to HIV infection (Barnes and Myer 2012; Brooks et al. 2005).

Analysis of respondent interviews shows that the influence of religion is primarily facilitated through interactions with family members, regardless of whether or not respondents considered themselves believers of a given faith. Respondents' relatives use religious beliefs and discourses to impute meaning to HIV risk during conversations and other shared experiences. These exchanges reveal to the respondent the schemata their family deploy, which respondents can then adopt as tools for their own understanding of HIV's place in their life. These schemata associate HIV risk with the respondent's sexuality in ways that are culturally specific to the race of the individual, their relatives, and their shared communities. A clear example of this can be seen in the experiences of Roger who, despite spending most of his life in cities that are generally more accepting of non-heterosexual identities and lifestyles, describes an ever-present homophobia rooted in religion that persists within the broader Black community he belongs to:

In the [Black] community there's still don't ask don't tell...I'd say I'm 90 percent out. There's still 10 percent, certain family members who, I'm just like, "you're still so old school and super religious..." Whites have not as heavy of a shame unless they're of the super Anglo-Saxon strict Christianity and Presbyterian and all the religious ideologies, especially in the Bible belt. But when you get to our community, I think the main reason we are not getting tested and we are becoming stigmas is because we have to do our dirt and due diligence of keeping our dingalings hidden from the public. So it's two layers of shame. I'm gay and then it's a whole 'nother layer, I'm gay and I have this disease that is unfortunately attached.

Roger explains how he is not fully out about his sexuality to everyone, in particular some of his family members because of their religiously-based disapproval. It is crucial to note that he links his experience to what he perceives to be a norm of refusing to acknowledge or accept homosexual identity within the broader Black community. In Roger's view, this conservative stance is commonplace among religious communities within the Black community beyond his own relatives, so much so that he views it in opposition to the ways religion functions in White communities. In his comparison of Black and White religious communities, he notes that this kind of homophobia would only exist among the more orthodox members of White religious communities, suggesting that Black religious communities engage in this homophobia regardless of how strictly they follow scripture.

The culture carried by religion can be seen to have a structural force that significantly shapes social life. Roger's statement that his sexual identity carries a shame within the Black community that is rooted not just in religious homophobia but also the stigma of HIV. These "two layers of shame" speak to the race and sexuality as social institutions in society, and how individuals can be placed at a systematic disadvantage for falling outside of cultural expectations shaped by these social institutions. In Roger's case, this disadvantage is made clear in the discourses his relatives employ; as a result, Roger understands his relationship to HIV to be one of risk partly because his family has led him to perceive his own racial and sexual identity to be

inextricably linked to HIV. Roger can derive this perspective from his sensemaking tool kit because his relatives exposed him to it as a tool for thought about HIV risk. Due to the lack of acceptance he has noted within the broader Black community as well, Roger feels that a pressure exists for him and other Black MSM to keep their sexual lives hidden from the public. Roger's experiences call back to what Cathy Cohen (1999) noticed was a religiously-rooted rejection of same-sex people in Black communities because of the "evils" of homosexuality and its associations with HIV, which had already been viewed as destructive to Black identity.

Roger's sentiments regarding racial differences in experiences of homophobia are supported by previous research on the topic. One study based on data from the General Social Survey found that African Americans are twice as likely to hold unfavorable views about homosexuality than their White counterparts. Among the MSM surveyed, the view of homosexuality being "always wrong" was predominantly held by African American MSM versus White MSM, suggesting the internalization of homophobia, a process that can contribute to greater HIV exposure (Glick and Golden 2010). It cannot be said, however, that African Americans are inherently more homophobic than their White peers. For example, another study has shown that Black individuals are more likely to oppose discriminatory antigay legislation, as well as support gay civil rights causes. Religion impacted the civic engagement of Black individuals, which has beneficial spillover effects for the support of LGBTQ causes (Lewis 2003). Despite this, previous research on the impact of religion on the experiences of Black MSM has highlighted the centralization of homophobia within Black religious communities as having negative effects on the health outcomes of this population (Balaji et al. 2012).

Attention must also be paid to how religion has functioned in Black immigrant communities and the impact this has on respondents' exposure to religious beliefs about HIV.

Benjamin, for instance, understood his mother's homophobic remarks during his coming out experience to be resulting from her cultural upbringing on a Caribbean island where homosexuality was explicitly viewed as unacceptable. Wallace, the Caribbean and South American gay man from who frames HIV as a bodily risk, had similar experiences of homophobia with his mother that make the influence of religion much more apparent. Wallace describes his adolescent life as one marked by much silence and equal interrogation regarding his sexuality. His brother, who is a trans man, was the first member to openly disclose their non-heterosexual identity, which was met with resistance from their family but ultimately set the stage for Wallace's eventual coming out. Reflecting on his interactions with his mother in particular, Wallace illustrates the role religion played in the animosity he faced:

[My mom is] Jamaican, and our family's homophobic... she was the youngest. I think her beliefs were a little more subject to molding than other family members... she would go back and forth, but you could see over time, she used to call people fags, and say, "Oh, it's a shame that this person's gay."... And she slowly moved away from that... there's push from other family members, and her brother will talk shit. We have our godfather, who's a piece of trash, in the church, who would say mean stuff to me and in front of me. And I would get really upset, and she was just like, "Oh, why are you getting so upset?" And I'm just like, "It's just really interesting how you defend him over your own child."

Wallace prefaces his description of the homophobia he experienced by noting that his mother's side of the family is from Jamaica. This is important given the extreme degree to which homophobia exists within this particular country. Previous research on homophobia and HIV stigma in Jamaica points to a cultural adoption of a "Don't ask, Don't tell" policy that makes the existence of non-heterosexual Jamaicans "unthinkable, inconceivable, unheard of," a view that is rooted in both religious homophobia as well a culturally specific construction of masculinity (White and Carr 2006). Wallace finds that his mother, being the youngest of her siblings, was the most impressionable and as such embraced the homophobia her relatives expressed. Though

Wallace notes that his coming out, as well as his brother's trans identity, motivated his mother to move towards acceptance, he still notes instances of tension, such as her supporting the homophobic views of his godfather.

Despite growing to be more supportive and understanding of one another, Wallace also notes that his mother still associates his sexuality with the potential for HIV transmission:

My mom is always just like, any time she has any inkling of me literally interacting with other men, she's like, "Make sure you're using protection." I'm like, "I'm not even having sex. What are you talking about?" She's like, "Make sure you're using protection," so there's that...

More than just a motherly concern for her child's well-being, Wallace's mother's worry reflects a schematic structuring of HIV risk as intrinsic to non-heterosexual identity that originates from her religious belief. Wallace's narrative also demonstrates the potential for change, as his mother made conscious efforts to be more accepting of her children, but this is an ongoing process that has taken much time. Nevertheless, this serves as an example of homophobia can stem from culturally-rooted religious associations between HIV risk and homosexuality.

Within both the Black and Latino communities, homosexuality is often positioned as inherently negative because it is viewed as detrimental to the health and survival of the family. Religious homophobia typically hinges on this rationale, which begets an expectation of a traditional heterosexual patriarchal family; MSM identity is at odds with this, thus leading to homophobia and other forms of disapproval of homosexuality within the family itself. As previous research has shown, religion is central to the ideological family within the Black community, and homosexuality is therefore viewed as unacceptable (Douglas 1999). Latino families, most notably those aligned with Catholicism or other Christian traditions, can similarly exhibit homophobia as a response to their beliefs as well as their associated cultural conceptualization of the "normal" family (Ellison et al. 2011).

Lucio, the Latino gay man who views himself as a “fortunate outlier,” had difficult experiences with his parents that are emblematic of this dynamic. Growing up in a predominantly Latino neighborhood in Florida, Lucio reflects on the strict Roman Catholic views held by his parents and neighbors, as well as other Latino households across the United States. Among these views is a lack of acceptance of deviations from heterosexuality. This becomes evident in Lucio’s recounting of his tumultuous coming out experience and the strains it put on his relationship with his mother:

...I went to a summer camp, and I met a kid and we were texting, and my mom caught that two years later. It's like she knew and it was that constant push, and my dad would always make her yell at me, even though it was clear my father was the more homophobic and uncomfortable of the two... The first time my mom caught gay porn on the computer was when I was 14 or 15...she drove around to the back parking lot at school, and was right next to my homeroom. She said, "You're getting out of this car, and you're going right to your homeroom, but I want to tell you something. No child of mine is gonna be gay. I don't know what we need to do, if we need to go to therapy, if we need to talk about this. You get out of this phase. You get over this shit, or I'm taking you out of theater. I'm taking you out of all these circles where I know you hang out with these people, and this isn't going to happen anymore." ... It was an abusive household. All these Catholic Latino things that I just pushed away.

Lucio’s intimate childhood communications with another boy, coupled with his viewing of gay pornography, were two actions that his parents hinged their disapproval upon as they were emblematic of the homosexual activity they would not accept in their household. As was mentioned previously, living in a neighborhood where most residents were devout Roman Catholic Latinos reinforced Lucio’s parents’ stance on his sexuality. Lucio’s mother was so steadfast in her views that she even considered taking him to therapy, heavily suggesting that his behavior was abnormal and in need of reconditioning. The things he loved, including his potential partners, were not to be loved in his parents’ home. Lucio considers his upbringing as particularly abusive due to constant reinforcement of his sexuality as being profane in a religious

sense. These thoughts would form the basis of Lucio's sensemaking tool kit during his adolescence:

I thought until the age of 16 ... that gay men could just spontaneously give each other HIV. I thought that HIV was just something that happened-... if gay men had sex without condoms. I didn't know it was a virus. I thought it was literally a gay disease that you got from putting your dick in another man's butt. Would have sworn. I thought babies came out a woman's ass until I was nine. Sexual health education in Florida is abysmal. It's abysmal. Especially, when you come from a tight knit family that's really ... Difficult about these things, I guess for lack of a better word.

Lucio notes how he was exposed to the idea of HIV as an outcome of condomless anal sex among gay men at an early age. Of note is his focus on the state of sexual health education, both in school and at home, which Lucio finds exceptionally lacking. In his case, the religiosity of his childhood environment made it such that he came to view HIV as a fundamental aspect of what it means to be a sexually active gay man. With respect to his present framing of HIV as personally irrelevant, Lucio's understanding of himself as a "fortunate outlier" is further clarified. It was ultimately his ability to secure the resources and knowledge necessary to keep HIV at bay that allowed Lucio to perceive HIV as a personal impossibility. The religious schema linking HIV risk with homosexuality no longer has a place in Lucio's sensemaking tool kit now that he knows it to be invalid and inapplicable to his own lived experience.

Exposure to religious HIV-related discourse can reinforce the association of sexuality with the risk of infection even in instances where the familial and neighborhood environment are supportive. Billy, the 25-year-old Latino and White gay man who also grew up in Florida, spent much of his adolescent life in Catholic school much like Lucio. His parents, however, differed in that they were markedly more progressive in their views than Lucio's were. Billy's experience with coming out about his sexuality exemplify this:

So I was raised very Catholic. That was difficult but I was very fortunate to have

progressively minded parents, who lived in Europe...I don't know, queerness was never ever spoken about in my house, like I had never heard my parents talk about gay people. So even though I knew them to be, like compassionate and open-minded people, I didn't know what, how they felt about gay people in their lives... I hated hiding [my boyfriend] from them...So after two months, or three months of dating I sat them down, told them. They took it well, I mean they're emotional and they were scared that I would get HIV/AIDs and ruin my career, you know. But they like very much embraced me and reiterated their affection. And they met my boyfriend a couple months later which is huge.

Billy describes the difficulty he experienced growing up in a Roman Catholic household, most notably the lack of discussion about gay people with his parents. In his interview, he never mentions experiencing blatant forms of homophobia from his relatives, nor any clear statements of disapproval of his sexuality. Nevertheless, the absence of open conversation about non-heterosexual identity reinforced for Billy idea that anything other than heterosexual identity and behavior is aberrant. Billy's fears and concerns about his parent's potential disapproval of his sexuality are made most clear in his decision to hide his relationship with another man from them, despite knowing his parents to be "compassionate and open-minded people." It is interesting to note that Billy highlights their time in Europe as the potential cause to this, suggesting a stark cultural difference in degree of conservative Roman Catholicism from that of Florida. His parents' more tolerant religious perspective led to their open acceptance and affirmation of Billy and the man he chose to love, but they still go on to reify an association of HIV with his sexual identity. This is made evident in their initial concerns that his sexuality would make him more predisposed to HIV, something that not only would compromise his health but also, in their view, potentially "ruin" his career. Billy has incorporated this schema in his sensemaking tool kit, leading to an ongoing concern about HIV's bodily and social impacts as potential consequences of his sexuality.

Biomedicine

Biomedicine, the division of medical science concerned with the application of biology and physiology in clinical practice and medical research, has been at the core of global efforts against the HIV epidemic since its inception. Put into perspective, the four or so decades of research on HIV is relatively short in comparison to that which has been produced on other illnesses, such as cancer. However, much has been accomplished within this period of time, with advancements in treatment and prevention technologies essentially redefining how HIV is experienced by individuals today. Biomedicine is home to the medical researchers who identified HIV as the root cause of AIDS, but as Steven Epstein shows in *Impure Science* (1996), much of the work towards effective treatment methods would have been impossible without the invaluable efforts of AIDS activists who demanded equitable representation in clinical trials.

Biomedicine has the most noticeable presence in general knowledge and thought about HIV. Most significant is its worldview of all illness and disease as inherently dangerous or detrimental because of their potential to compromise individual and public health. Biomedicine is host to schemata that situate HIV in diametric opposition to meanings of health and wellness, conceiving of it as an indisputable risk individuals are expected to actively avoid or lessen for the sake of personal and public health. These schemata exist within a biomedical rhetoric of risk that emphasizes the individual's personal responsibility for accessing and using the resources necessary to curtail the epidemic especially for Black and Latino MSM who have been deemed to be particularly at-risk. Prior research has shown how this focus on individual action can lack contextualization and lead to poorer outcomes in HIV-testing rates, treatment adherence, and disclosure of HIV-status (Arnold, Rebchook, and Kegeles 2013). Nevertheless, this rhetoric is pervasive and stems from the organizations, systems, and networks that fall under the purview of

biomedicine. These include, among others, federal and state health departments, the collective of companies in the pharmaceutical industry that produce HIV-related technology, and the community-based health organizations and programs funded through HIV-specific grants and other initiatives.

Biomedical Associations of Sexuality with Infection Risk

As a cultural resource in sensemaking tool kits, respondents use the biomedical rhetoric of risk to form their HIV risk perceptions, and its use is not limited to a corporeal framing of HIV risk. Stigma frame adherents like the ideal type respondent Peter, for instance, can say that bodily health comes second to social well-being only by acknowledging how HIV impacts the body and disproportionately affects Latino MSM such as himself. The same can be said about Benjamin, whose risk perceptions most clearly reflect the irrelevance frame, who draws upon biomedical rhetoric to convey how HIV can threaten bodily health, even though he understands himself to be exempt from that experience. The schemata underlying the beliefs and discourses the sources of culture discussed thus far reinforce associations between HIV risk and identity, but their use in sensemaking does not necessitate that the user align themselves with its central logics.

In the case of respondents like Shane who invoke the corporeal frame, using biomedical rhetoric is how they convey their understanding of the self as intrinsically at-risk of HIV. As was the case with religion, respondents can be exposed to these sensemaking tools by the people in their lives. Coming from a family where immediate and extended relatives are medical practitioners of all sorts, Shane has, for the majority of his life, been exposed to languages and practices about HIV moored in biomedicine, all of which he deploys in his framing of HIV as a

pressing threat to bodily health. His mother in particular is an HIV specialist who works with the LGBTQ community that has a proclivity towards sharing her expertise in everyday conversation. The effect this has had on Shane is apparent, as throughout the interview he expertly answered questions concerning both the biological and social aspects of HIV. An example of this can be seen in his response when asked about how PrEP works:

PrEP is...you take HIV medication once a day...as someone who is HIV negative. And the research shows that it is able to reduce your likelihood of infection dramatically. And so, if you are somebody who has risky sexual behavior, male, sex with male or otherwise, then it might be a good option to consider. But it is still not 100% effective, though it's like, really effective, and it doesn't block against other STIs.

This quote demonstrates a familiarity with the topic of PrEP that few other respondents had, such as his knowledge of the PrEP pill actually being identical to some of the daily medication HIV-positive individuals take to maintain their health, as well as awareness about contemporary research on the subject. Shane expressed a sense of relief after answering these questions correctly, saying that all he knows about HIV comes from his mother, thus not knowing it well would disappoint her. More interesting, however, is the rhetoric of risk Shane employs when describing the stipulations of PrEP usage, which extend throughout his interview. Of note is how he specifies PrEP as a tool to for those who engage in "risky sexual behavior," identifying sex among men as an example of such. In this utterance, Shane is highlighting an awareness of an association between sexuality and risk that stems from biomedicine but is now a part of his sensemaking about HIV risk. For Shane, sex takes on a biomedical meaning as a health behavior, rather than a source of pleasure or connection as other respondents describe it as. The meanings individuals have about sex itself can offer additional insight into respondents' HIV risk perceptions, a topic that is further explored further in the following chapter.

Sam, the 24-year-old Black queer man introduced in Chapter II, offers another similar

case in which biomedical rhetoric figures into his corporeal framing of HIV risk. Sam's first discussions about HIV with his parents arose during the time he spoke to his parents about his sexuality. Sam describes his mother, who is an OBGYN doctor, as someone whose medical expertise tends to extend into her daily conversation with family members. Prior to going away for college, Sam chose to come out to his family by writing and leaving behind a letter describing this aspect of his identity. His parents eventually found and read the letter sometime after his departure, the ensuing conversation revealing the nature of their concern about what his sexuality may mean for his risk of HIV:

So then they saw it [his letter] and they called me and they were crying and blah, blah, blah, ... "This is not the life I would have chosen for you, but this is your life, so you have to do what you want to do." [My mom is] like a medical professional so she's like talking about HIV and AIDS and stuff like so she's always pathologizing literally all the time...Then my dad was like literally the opening lines of Paris is Burning like "I know it's hard life for you because you're a black man, but like to be a black man and gay or queer...I know you're going to have more hardships in life because of that..."

In this exchange, Sam's parents expose him to the biomedical schema that associates his sexuality with HIV risk. That Sam's mother would not have "chosen" this for his life is significant, as it demonstrates just how worried she is about his health, and implies that heterosexuality would offer him more protection. Sam was not surprised by this response; as a surgeon who has worked in clinics and "done it all so she's seen it all," Sam's mother was simply offering a response rooted in the biomedical knowledge as she has always done. Sam recalls his mother "always talking about [HIV]" since high school, which she would couple with words of caution about refraining from "being wild and having sex." Nevertheless, it is telling that her concerns about his sexuality are based on the likelihood of HIV transmission. Sam incorporates this into his own sensemaking tool kit, which enables his corporeal framing of HIV.

The influence of biomedicine can also be seen in the HIV risk perceptions of individuals who do not have immediate or extended family members that work in medical fields. Rather than drawing from their own professional expertise and experiences, parents can transmit HIV-related information they've come across to their children, which can serve to expose them to the biomedical rhetoric of risk they would have otherwise been ignorant of. An example of this can be seen in Colin's coming out experience. Colin, the multiracial gay man who moved to NYC from Texas, describes his mother, who is not a medical professional, initially taking issue with the news about his sexuality, but ultimately becoming more accepting and involved in his personal life with time. Along with this care, however, also came a concern from both of his parents about the potential for STD/STI transmission, which they had immediately associated with his sexuality:

[My mom] was the hardest one to take it... I thought my sister and my dad would be the hardest...She took it hard for a while and then, my dad was just, "It's who you are. No one else's opinion matters. It's okay. I love you. This is great"...She thought that it was all her fault... She's very concerned. So's my dad...Especially when I first got here and they knew that I hadn't really been with anybody, he was sending me things like "Oh, hey, I saw this article in the news, and it was saying that there's a new strain of ..." I don't know which one it was, it was either Chlamydia or gonorrhea. And he was like, "There's a new strain of this just to let you know. And they said that it's more alive in the gay community in New York right now..." I think my dad is very logical, my mom's very emotional, so he took on the logic part of, "It doesn't really matter as long as you're safe and okay."

Having come out at the age of 19 and moving out to New York a few years afterwards, Colin notes how his relationship with his parents changed. Colin's father in particular was extremely supportive and affirming of his identity, which helped his mother come to terms with his sexuality. Given Colin's distance from home, his interactions with his parents were often limited to phone and internet conversations, but it is here that the influence of biomedicine can be seen. Specifically, Colin's parents would send him news articles concerning STD/STIs that were

affecting gay men living in New York City. Though this is an example of parents genuinely caring for the well-being of their child, it also reflects how respondents come to be exposed to schemata based on essentialist associations of sexuality with HIV risk. Colin's mother's acceptance of his sexuality is conditional on his safety as a gay man, suggesting that she views this identity as one predisposed to risk of STD/STI exposure. Colin brings this into his sensemaking about his relationship to HIV. As discussed in the previous chapter, Colin frames HIV as a threat to his social standing with family, so much that he refrains from seeking PrEP treatment on his parents' health insurance, as that would confirm their view of HIV as an intrinsic risk of homosexuality.

Parents can also pass on information they receive from their own doctors onto respondents. Though the parents may not be Black and Latino MSM themselves, they are the guardians and caretakers of individuals who are, and it is not uncommon for parents to seek advice from others to assist in protecting their child's well-being and development. Nico, the Black gay man who worries HIV inequalities negatively affects the public's view of Black and Latino MSM, shared an experience with his father and brother that illustrate this dynamic. During a conversation with his brother, who is also a Black MSM, Nico learned that their father had learned about PrEP and was recommending that they both seek out a prescription. Shocked to hear that their own father was knowledgeable about the medication, Nico came to learn that it was his father's own primary physician who had made the PrEP recommendation. Nico's father had been talking to his primary care provider about his concern for the well-being of his own two sons due to their sexuality, and the doctor suggested his children look into PrEP as an option to reduce the risk of HIV.

As a gay man living in New York City with friends who had PrEP prescriptions, Nico

was already familiar with the medication and had formulated his own opinions on it. His father's knowledge and promotion of the medication, however, was wholly facilitated by a medical professional that neither Nico nor his brother come into contact with. Neither the doctor nor father had any reason to suspect Nico or his brother were in particular need of HIV prevention aside from the fact that they were both Black gay men. Nico's experiences demonstrate how his father served as a vector for the biomedical schema linking HIV risk with his intersectional identity. Nico ultimately chooses not to use PrEP because he feels that it would be an affront to the monogamous, long-term relationship he has built with his partner. The relationship between HIV risk perception and the use of PrEP is further explored in the following chapter.

Nico's narrative also demonstrate how the use of biomedical rhetoric of risk as a sensemaking tool involves depends on the respondent's trust of medical expertise. Nico is an example of a respondent whose risk perceptions are contain aspects of both the corporeal and stigma frame of HIV. Having lost his mother to cancer and serving as her caretaker during the final moments of her life, Nico greatly valued the medical expertise of the doctors who helped him facilitate at-home care, thereby bolstering the trust he has in doctors and medicine. During the course of his interview, Nico describes himself as someone who is very cautious when it comes to matters of health, to the point where he feels that he may blow things "out of proportion," such as when worried that he may have been showing early signs of skin cancer due to a mark on his skin. Nico describes his own mind as a "hype machine," which he does not find a detriment since he believes it to be "aware of what my risks are" and "mindful of when I expose myself." With Nico's trust in medical expertise comes an amenability to the biomedical rhetoric of risk that underlies his perception of being at-risk of HIV's bodily impacts given his identity as a Black MSM. This extends to his practices concerning HIV testing given what he

knows about HIV among Black MSM like himself. Nico typically gets tested during his routine check-up or at a clinic when he feels it necessary. The one time he used an at-home HIV testing kit was because he did not have immediate access to a testing location, as he would have preferred the guidance of a trained professional. It was the doctors, after all, who confirmed that what he thought was skin cancer was simply a subcutaneous scab that would heal on its own.

The Gay Community

In general parlance, "the gay community"⁷ is a term typically used to describe the network of individuals whose sexual orientations and gender identities do not conform with the heterosexual cis-gendered normativity that permeates society. The gay community as it exists today can also be understood as having arisen from social movements, protests, and organizing around issues that affected non-heterosexual people in the United States. Drawing from Aldon Morris' (1984) indigenous perspective approach to the analysis of the Black community's experiences and activism during the Civil Rights movement, the non-heterosexual individuals who make up the gay community can be considered a "dominated group" that was "excluded from one or more of the decision-making processes that determine the quantity and quality of social, economic, and political rewards that groups receive from a society," albeit due to their sexuality rather than their race. As Morris suggests, dominated groups experience powerlessness, which leads them to engage in "legitimized and non-legitimized struggles with power holders." In the case of the gay community, a clear example of these can be seen in the aforementioned work of activists to be included in the research and policy discussions that took place at the start

⁷ While some respondents use more inclusive terms such as "LGBTQ community" or "queer community," a majority refer to it as "the gay community," especially when referencing other MSM, and so it is referred to as thus throughout this dissertation.

of the HIV epidemic. The activism surrounding HIV and its disproportionate impact on non-heterosexual people is perhaps one of the defining social movements through which the gay community was solidified (Gould 2009). Other equally relevant cases include the organizing that took place around combatting California's anti same-sex marriage Proposition 8 in 2008, as well as countless protests across the nation against homophobia (Ghaziani, Taylor, and Stone 2016).

The gay community carries shared cultures arising from social networks of people united under non-heterosexual identity, along with the organizations and social movements that have appealed to and supported their common social values. In theory, the gay community is inclusive of Black and Latino MSM due to their sexuality. However, as analysis of respondent narratives shows, it is common for such individuals to feel excluded or misrepresented for a variety of reasons. That the prefix "gay" is frequently used interchangeably with more inclusive terms like LGBTQ is no coincidence, as the interests of gay men have historically taken precedence over those of their peers. This is reflected in previous research that has shown how bisexual individuals are often delegitimized in both discourse and in everyday life, due to their sexuality not fitting the binary model of "straight" versus "gay" (Marcus 2015; Erickson-Shroth and Mitchell 2014; Whitehorne 2017).

The gay community is comprised of a variety of experiences and owes its complex diversity to such. However, while a variety of cultures may be represented, the gay community is typically recognized by the most dominant one. What makes a culture dominant is defined by the experiences of certain individuals that take precedence over those of others. Within the gay community, the experiences of cis-gendered White gay men are the most privileged the most visible and upheld. A relevant example of this can be seen in the overt focus that was placed on the health of White gay men during the initial years of the HIV epidemic, despite research at the

time showing how the experiences of people of color, such as a Black teen named Robert Rayford who died of AIDS in 1969, did not receive equal attention (Carey and Milan 2018; Moseby 2017).

The gay community can be characterized by its "homonormativity," the corollary to the default of heteronormativity in society, which describes that norms of life as a non-heterosexual person. Homonormativity mirrors everything in heteronormativity save for sexuality, as it roots itself in finding commonality with the cultural norms of heterosexuality as a means to validate homosexuality as equally normal (Duggan 2004; Stryker 2008; Brown 2012). This process, however, comes at the cost of discrimination within the gay community itself, which is cast against those who do not fit the homonormative ideal. In the ways heteronormativity privileges the experiences of White cisgendered heterosexual men, so too does homonormativity benefit those of White cis-gendered homosexual men (Vitulli 2020; Furguson 2009; King 2009; Nielsen, Walden, and Kunkel 2005; Frankenberg 1993). Though diversity is a central to the gay community, its underlying values equally reflect various forms of social division rooted in the differences it is built upon, as is made evident by the ways in which individuals within the gay community have experienced exclusion due to their race, class, and sexuality. This can present unique challenges that impact the life chances of Black and Latino MSM who are often excluded from their racial communities due to homophobia (hooks 1989; Ibañez et al. 2009)

The gay community is unique in its treatment of HIV status as a social marker with a particular kind of duality. On the one hand, those living with HIV are welcomed and play a foundational role given the historic impact of the HIV epidemic. On the other hand, *becoming* HIV positive is highly discouraged and situated as counterintuitive to the broader collective goals of the gay community. This perspective similarities with the biomedical view of HIV as an

objectively negative risk that must be eliminated at all costs for the betterment of public health. The overlap between biomedicine and the gay community is further cemented through the existence and work of LGBT-centric HIV-focused organizational entities, such as the AIDS Healthcare Foundation. This overlap also facilitates a similarity in expectations of an individual's behaviors, such as those pertaining to "safer-sex practices" and promiscuity. What arises from this are discourses about HIV risk as grounds for social exclusion due to an individual's likelihood of infection grounded in behavior and identity. The schemata driving these discourses reflect the racial and social inequalities that can make reducing infection difficult for Black and Latino MSM. As such, respondents make use of these discourses to determine the potential bodily and social costs of HIV with respect to their own lived experience.

HIV Legacy

The four decades since the height of the epidemic has provided the time for advancements in treatment and prevention to radically change the experience of HIV. It has, however, also provided the space for newer generations of individuals whose first knowledge of HIV's early ravages comes not from lived experiences but rather from what they learn through secondary sources. Respondents' interactions with parents, friends and members of the gay community are important sources of knowledge about the history of HIV that inform how they give meaning to their current and possible future relationship to it. In the previous chapter, for instance, Peter describes how her mother's friend who became positive in the 1990s continues to have an "amazing disposition on life" that has changed his own outlook on what it means to live with HIV, albeit with "problematic" views he associates with his generation's experience of the HIV epidemic. With respect to his HIV-positive friends within his age range, Peter shares how their

livelihoods provide a more contextualized sense of what it means to live as a “poz” person. What this suggests is that there are enduring aspects of initial responses to the epidemic that are brought to the fore when compared to how younger generations are presently experiencing HIV.

Sam’s discussion of generational differences, for instance, bring to light how the legacy of the HIV’s impact on the gay community has endured in its general orientation towards HIV as an ongoing epidemic that must not be forgotten:

There's a very interesting age of people who care more. It was so interesting. I think people my parents' age ... People who lived closer to the epidemic are a lot more conscious and cognizant of the realities of everything, and I haven't watched those documentaries, which I need to do, on the whole epidemic and stuff. People are out here telling me, "You need to get your gay education on and watch this and know about what the community went through," and I feel like, yes people are educated on it, but given PrEP and everything, I feel like people are a lot more passé about really being in the know.

Reflecting on the degree to which others like himself care about HIV, Sam notices a particular form of apathy that has arisen among his peers due to advents in treatment and prevention. He thinks of people like his parents who were old enough to actually witness the impact HIV had on society when little was known about the virus and how much more indifferent people his age are in comparison. PrEP, a preventative pill regimen that is discussed throughout this work, is one such innovation that Sam understands to have quelled much of the fear and concern of HIV due to its effectiveness in HIV prophylaxis. Sam wonders if contemporary medical innovations may have reduced the urgency to be more knowledgeable about HIV, but nevertheless acknowledges that HIV’s historic disproportionate impact on men like himself is part and parcel to the history of the gay community.

The acknowledgement of HIV as “no longer a death sentence” is remarkably prevalent across a majority of the respondents’ interviews and is indicative of how respondents understand the disease to presently affect the gay community. Given the age-range represented by the

interviewees, this statement represents an acknowledgement of the past they never lived, and the progress that makes up their current reality. Black and Latino MSM's shared experience of this reality, however, differs from the general public's given HIV's ongoing characterization as a problem only pertinent to this population. Part of this stems from what Moseby (2017) details is a significant transformation in public discourses and medical research that first characterized HIV as a White middle-class gay male disease and then later as mostly pertaining to impoverished Black and Latino populations. The impact of this can be seen in how Black and Latino MSM are often excluded from the broader gay community because of their assumed proximity to HIV risk, a topic that is discussed further below. Despite these challenges Freddie, a 29-year-old working-class Latino gay man, is hopeful that such perspectives will change:

... It [HIV] sucks, but it is not a death sentence anymore. And people can live with it. And actually a lot of people who are taking their medication and are healthy, you are safe from them. It's actually easier to catch other diseases, and it's less likely that you're gonna get diseases from someone who has HIV, because they take care of themselves and they are usually more aware of that than you are, because they have to worry about those things. ... Society has done a very good job of scaring me, growing up thinking it was a gay monster, it really only affects gays. I mean, it does have a big impact on the community, because of promiscuity, but yeah ...

Freddie is aware that while HIV still introduces complications to life, a positive diagnosis is no longer the death knell it once was during the early years of the epidemic. Offering more insight into the previously discussed undetectable status, Freddie describes how consistent adherence to treatment within the HIV care continuum can ensure both a long life as well as prevent the spread of the virus to others. He also suggests that an HIV positive person is likely to be more cautious about sexual health in general as they are enrolled in an on-going system of medical and self-surveillance. This supplements previous research on HIV-positive people who are proactive in their use of protection during sex over concerns of reinfection with drug-resistant strains of

HIV (Adam et al. 2005).

Of particular note is Freddie's acknowledgement of societal influences that led him to believe HIV was a "monster" that only haunted gay men like himself. In his view, promiscuity can explain disproportionate rates, but he is aware that anyone regardless of sexual identity could potentially become HIV-positive. Freddie's focus on promiscuity reflects a discourse in his sensemaking tool kit that is germane to the gay community: HIV persists within the community because of individual sexual behaviors that must be tempered to stop the spread of the virus; to do otherwise risks the health and integrity of the individual and the community as a whole. This is exacerbated by previously discussed associations of Black and Latino identity with sexual prowess and promiscuity.

In many ways, this discourse exists as a vestige of the rhetoric of immorality employed during the Reagan era. During his presidency, the Reagan administration did little to address the "gay plague" of HIV despite the countless lives that were increasingly being lost, as it was fashioned as a consequence of personal promiscuity (Shilts 2007). Additionally, the conservative Christian concerns over the threat of sexual immorality that preceded the AIDS crisis undergirded the view of HIV as a consequence of improper or unacceptable sexual behavior (Barlow 2015). What arose during this era in lieu of effective health policy was messaging rooted in fear that produced a damaging stigma surrounding HIV and the lives it impacted.

This fear surrounding HIV continues on in the gay community's efforts to mobilize treatment and prevention initiatives, which can often do more harm than good. Lucio, the Latino gay man who grew up in a Roman Catholic neighborhood in Florida, brings up an important point regarding this when he reflects on HIV stigma as it relates to both condom and PrEP use:

The shame is that a lot of that stigma comes from organizations that are supposed to be helping queer people. Like, the AIDS Healthcare Foundation has

traditionally been on the other side of all these condom laws. Because they keep spitting out these incorrect facts and all this stigma. They purposefully skewed the data about the efficacy of PrEP on materials they were distributing... They often rely a lot on language that doubles down on stigma and fear regarding HIV. So I absolutely respect what they did at the beginning of the epidemic. I know that I'm a young person who didn't have to live through that and didn't have to live through that trauma. But if we're gonna do anything about this shit... it's not just scaring people into using condoms.

Over the years, the activists at the heart of these organizations have assumed prominent roles that shape contemporary discourse around HIV treatment and prevention. Most recently, however, the AIDS Healthcare Foundation in particular has been criticized because of its concentrated efforts to undermine PrEP use. Michael Weinstein, the president of the AIDS Healthcare Foundation, has gone on record to say that he believes PrEP to be a “party drug” that will lead to increased levels of unprotected sex (AHF 2016). Apart from detracting from the viability of PrEP as a preventative tool, Lucio takes issue with how such discourse can unfairly conflate sexual identity with promiscuity and HIV risk. Such a schema can, in Lucio’s perspective, support discrimination against men like him on the basis of their sexuality, both within and outside of the gay community. Lucio’s concern with the tactical use of fear by organizations is not unwarranted, as the AHF’s (2014) “PrEP Facts” ad campaign played up the purported unreliability of PrEP, cautioning against a wide-scale increase in its use. Lucio’s gratitude for the efforts of the countless individuals who lived and died through the early years of the epidemic comes paired with a request for a more holistic approach to HIV prevention that looks beyond condom use.

“We also keep projecting on other people’s identities”: The Persistence of HIV Stigma

Despite HIV no longer carrying the same gravity as it did in the early years of the epidemic, HIV stigma persists within the gay community in such a way that it forms an axis of

exclusion. Leading a full and healthy life as an HIV-positive person entails a drastic change in routine that is governed by the demands of the HIV care continuum. Beyond changes to daily schedules, however, comes a shift in how individuals familiar with the gay community are expected to present themselves to and interact with their peers. Lawrence, the Black and Asian gay man who learned about the HIV lived-experience through his friends, reflects this in his descriptions of the particular anxieties he holds about the potential difficulty of dating within the gay community were he to seroconvert:

I would say the other thing that comes to mind, to be extremely frank, is the potential for being able to ... find and develop a relationship with someone ... I think that's something that's in mind in general for a number of people, and definitely me. And I feel like that added aspect of being HIV positive would be something where I'm like "Oh, crap, who's gonna love me?" And maybe if there is someone, am I gonna love them? But there is this stigma that is within ... In general, one, and two, within the LGBTQ community, where I'm like, great, you know, now having to account for that and also navigate the ... "not-so-normal" waters of dating, I would say. So, it's an added variable that adds some complexity to it.

As discussed previously, the potential negative social ramifications of being HIV-positive looms large in the stigma framing of HIV and in respondents' partner selection strategies. Here Lawrence illustrates how this extends to the broader gay community he and his potential partners are a part of. Specifically, he worries that being HIV-positive would further complicate what he believes to be an already difficult process of finding and establishing romantic partnership within the gay community. Lawrence describes a fear of being isolated or excluded because of his status. Prior research has illustrated HIV-positive people are treated as a dangerous "other" within the gay community, an idea that is enforced by gay men's screening of each other's HIV status and safe sex practices (Robinson 2018). As such, Lawrence makes use of this discourse in his perception of HIV not just as a threat to his social standing, but also a risk to his ability of finding a partner due to social exclusion.

In many ways, the persistence of HIV stigma is indicative of the gay community's paradoxical messaging about the illness. On the one hand, a significant portion of the social movements that unified members of the gay community were in response to the ways in which the epidemic disproportionately impacted this population. Those lost to the initial years of the epidemic, the survivors, as well as the newly diagnosed are to be embraced, honored, and supported. On the other hand, an aim germane to the gay community is disabusing others of the notion that HIV is strictly a "gay disease," endeavoring for health equity through the expectation that individuals view HIV as a risk and do everything in their power to prevent infection. Respondents' views on targeted HIV awareness campaigns bring to light how the gay community reinforces a belief of HIV as an integral component of Black and Latino MSM's experiences that must be eradicated. These advertisements also serve as tangible manifestations of the overlap between biomedicine and the gay community, as they typically promote the use of some pharmaceutical treatment or prophylactic technology. For instance, one ad campaign spread across the city's subway system featured colorful backdrops and images of people from various backgrounds in loving embraces, all with the aim of promoting the use of PrEP. Despite the visible diversity in people represented in the ads, respondents noted that those who appeared Black and Latino MSM were the most prominently featured. Lawrence in particular took issue with this, as he found it promoted the idea of PrEP as only being important for individuals such as himself, thereby further entrenching associations between HIV and this population.

Respondents note, however, that efforts to remove the association of HIV risk as solely pertaining to the gay community can lead to the social exclusion of HIV-positive people. This presents a unique tension, which Victor, the Black gay man whose family helped him seek medical care after potentially being exposed to HIV, grapples with when relaying his hopes for

the future:

... I pray that it's the ending of the stigma, so for those who have [HIV] can still live a full life. They can still find love, they can still find reconciliation within themselves, within the community, within their partners. I think the only way to do that is for communities to be more accepting of people, for the gay community itself to be more accepting of their members ... And I think that's what anybody and everybody wants in this world is connectivity. It's like literally to find that they are connected to somebody, that they belong. And I think a lot of it stems from like the LGBT community, or a community that like tried to find its identity, and we keep trying to find an identity, but we also keep projecting on other people's identities.

Victor clearly describes the fears at the core of HIV stigma as it exists within the gay community, namely that HIV would preclude someone from living a healthy life full of love. The ways in which members of the gay community internalize these fears can lead to views about and behaviors towards HIV-positive people that are dismissive. In Victor's view, the gay community must openly accept and support the HIV-positive individuals in order for the stigma to truly end. By focusing on how people are “projecting on other people’s identities,” Victor highlights the fundamental paradox of a gay community that at once embraces HIV-positive people while also actively shuns them due to their serostatus. This push-and-pull results from competing discourses of HIV as integral to the cultural identity of the gay community while also antithetical to its aims. Drawing upon these discourses with respect to his own lived experience, Victor finds it more common that members of the gay community would sooner disparage than accept him were he to ever seroconvert, reaffirming his stigma framing of HIV.

“People think it’s a Black or a gay thing, or a Latino thing:” Essentialist Notions of HIV Risk

Respondents’ discussions about the gay community point to the existence of a racial divide resulting from frequent associations of Black and Latino MSM with HIV. In the previous chapter, I showed how certain respondents worried about appearing undesirable to potential partners due

to presumptions about HIV status based on their racial identity. Black and Latino MSM face disparities in access to and quality of HIV-related care due to ongoing structural inequities, and discourses about this reality can serve to further crystalize essentialist notions about HIV risk and identity. Respondents highlight how such views are propagated by the gay community in ways that work to exclude other Black and Latino MSM. In this way, the individual experiences of such discrimination are intimately tied to pervasive institutionalized inequality that impact Black and Latino MSM. Matt, 22-year-old Black working-class gay man who wished to move to Atlanta in search of a community with a higher concentration of Black MSM like himself, lends insight into this when he states:

I don't know the statistics, but perhaps maybe that [HIV] hits that [Black and Latino MSM] community the most, because Black health care is the least, I'd say. Things like that. A lot of the organizations and commercial links I see involve people of color or people who are gay ... I'm not really sure about New York [HIV rates] but I would think maybe because it's such a big gay community and it has been for almost 30 years [in] New York City ... people think it's a Black or a gay thing, or a Latino thing, or it's certain cities that you'll catch it and whatnot. Where people will use it as a way to be racist, to say, "Oh, I don't want to go to Africa and catch HIV."

Matt, despite not fully knowing all the details of the latest epidemiological reports on HIV, demonstrates an awareness of the illness disproportionately affecting Black and Latino people, especially those who are gay or MSM. In offering an explanation, he like other respondents, touches upon the shortcomings of healthcare in communities of color due to persistent racial and social inequalities that systematically limit Black and Latino's access to quality medical care and insurance (Smedley, Stith, and Nelson 2003). He draws his insights from the advertisements he sees around NYC, as well as what he knows about how the epidemic specifically impacted NYC in the 1980s, suggesting that these objects and occurrences contribute to an almost default association of HIV with Black and Latino MSM, in particular those who live in big cities. The

harm this can have is made clear in Matt's observation of people still resorting to outdated and harmful racist stereotypes that weaponize the illness's impact on hard-hit communities through explicitly negative connotation. Despite the decades of research and public health communication making clear that HIV can affect anyone regardless of their identity, what prevails is an idea that HIV is still predominantly a Black and Latino MSM problem that is exacerbated in particular geographies.

Black and Latino MSM effectively can understand themselves to be viewed as stigmatized beings within the gay community itself due such essentialist thought. To acknowledge this is not to discount the research that clearly points to the disproportionate rate at which new HIV infections occur among Black and Latino MSM in comparison to their White peers. It does, however, bring to light how discourses from the gay community can impact their HIV risk perception formation. Lawrence, the Black and Asian gay man who wonders who would love him were he to seroconvert, offers a clear example of how this reality affects how he gives meaning to his relationship to HIV when discussing how racial segregation in New York City extends into the gay community he considers himself to be a part of:

My anecdotal observation of ... the gay community, is that it's segmented by race and ethnicity. So if you keep all the black people together, then that means that if there is an illness, or if there's a situation that's a health epidemic. It's going to spread within that particular community. I think the landscape would look completely different if there was no race ... But if we are the highest risk in the community, and other ethnicities, other races don't find people of black and brown color to be desirable. White people may have certain perceptions, they may not wanna date someone Black ... Then I think that's when it becomes very insular to a community. ... So I would imagine that social aspect of it almost ... it's sad, but it sounds like the social divisions keep the rates up there...

Lawrence's words reveal the essentialist schema that characterize discourses associating Black and Latino MSM with HIV risk within the gay community. In attempting to explain the racial disparity in HIV diagnoses, he explores how social divisions can facilitate the disproportionate

spread of the virus by creating insular racial groups within the gay community. Joe, a 28-year-old Black gay man from Queens, shares a similar observation when he shares that “white gay guys are not into Black and Latino guys as much ‘cause they feel like they might get HIV.” Both of these accounts speak to the theoretical underpinnings of the REF’s institutional and cultural components. The institutionalization of intersectional inequalities and the interpersonal experiences of discrimination are interdependent social forces that individuals internalize. Culture serves the vehicle through which individuals enact what they have internalized, thereby reconstituting the very structure of their social environment. As such, discourses that link Black and Latino MSM with HIV risk inform individual perceptions of HIV as posing proximate and distal threats. This can be seen in Lawrence’s stigma framing of HIV, where HIV is perceived to threaten his membership in the gay community and, as a result, place him in a position that contributes to the disproportionate spread of the disease along racial lines.

Racism functions in a variety of ways that are specific to the context of life as a Black and Latino MSM within the gay community, with race-based HIV stigma simply being one of them. Race, for example, figures into how potential partners can view an individual as a mere object of their fetishizing fantasy, as discussed in the previous chapter. Social life within the gay community, however, has been reconfigured to accommodate and uphold racial segmentation. This is due largely in part to the existence of discourses about HIV within the gay community pertaining to both race and sexuality. Nightlife is perhaps the most visible form of this social divide. Peter, the ideal type respondent who invokes the stigma frame, highlights the significance of these spaces in his understanding of nightclubs to be the core of the city’s gay life. At the start of our interview, Peter tells me of the party he had just attended the night prior, where there was a “a good mix of fun, cute, fashion gays, but then also hot, muscle, muscle gays.” While Peter

pinpoints a variety physical appearance and aesthetic among the men in attendance, Lawrence highlights nightclubs and other party spaces in the city are from diverse:

... instead of it being as segregated, it's almost more of a spectrum...when there's a hip-hop night and that's seen as the black club ... I'm just trying to think, I forget the name of the bar. But it's in like Midtown, Downtown. Somewhere in like 20s Chelsea, somewhere. And they changed ownership, and they're like, they don't want people of color there, or they don't want black people there.

In describing the current state of nightclubs that cater to MSM in New York City, Lawrence shows how racial divides are upheld even without explicit mandates of racial segregation among attendants. The “hip-hop night” Lawrence mentions refers to a popular theme that many nightclubs utilize to signal not only the kind of music they will play during the event, but also the type of people they hope to attract. Implicitly, hip-hop nights are designed to attract Black and Latino individuals, and while everyone is welcome to attend regardless of race or gender, these events are almost exclusively racially homogenous. In Lawrence’s view, however, these curated spaces uphold racial divides within the gay community by keeping Black and Latino MSM separate. He also touches upon how gay clubs in NYC can exclude Black and Latino MSM on their regular, non-hip-hop nights through racist door policies. In the above excerpt, Lawrence is referencing an April 2017 incident in which a popular gay club the Chelsea neighborhood denied entry to a large group of Black men citing issues with capacity, despite the club itself being rather empty. At the time, the club also had a “no baseball hat” policy, which many felt was a way to implicitly exclude Black and Latino men implicitly through a dress code (Katz 2017).

Despite these occurrences, it must be noted that racially homogenous places are not inherently harmful to the experiences of Black and Latino MSM. Given the existence of racial division, hip-hop nights at a popular gay club can offer spaces where Black and Latino MSM can feel safe from racism and discrimination from others. There once was a time when New York

City was host to several gay clubs that catered specifically to the interests of the Black and Latino gay community, yet today they have all but vanished due to outside forces like rising costs and gentrification. They have instead been replaced by hip-hop and “Latin” nights, as well as other periodic parties like Papi Juice and Trappy Hour that are organized by and for LGBTQ people of color. These spaces can offer a sense of belonging. Larry, the Black gay man introduced in Chapter II who moved to New York City from the Midwest, relates this when he states that he loves living in Harlem because “some of the gay places in Harlem I'm like, oh my God this is the first time I've ever actually been to a bar where it's Black gay men. . . . All the bars I've been to in the past have been, it's white, predominantly white.”

Given what has been discussed about the assumptions made about Black and Latino MSM's HIV status due to their social locations, the insularity of racial sub-groups sustained in ways that affect how respondents understand HIV risk and its impact on their ability to belong. Larry's mention of Harlem is important, as the gay community's racial divide can be geographically traced across the New York City's many neighborhoods. These are so engrained into the social life within New York City's particular gay community that individuals are often categorized by the neighborhood they typically frequent nightclubs in, such as being “Harlem girls” or “Hell's Kitchen girls.” Harlem, a historically Black and Latino neighborhood, boasts a gay nightlife that is starkly different from that of Hell's Kitchen, which houses popular gay nightclubs whose attendees are noticeable non-Black and Latino save for on the occasional hip-hop night. Bushwick, a neighborhood in Brooklyn, has its own nightlife that is conceived as the alternative to the mainstream current of gay community social life that can be found in Hell's Kitchen. That the “alternative” spaces are noticeably more populated by Black and Latino individuals further demonstrates how racially segmented the gay community is. In this way, the

values of the gay community can uphold exclusionary divides that further cement associations between HIV risk and Black and Latino MSM's identity.

Sexual Subcultures

Culture enables and constrains action (Swidler 1986). As has been discussed thus far, there exist racialized discourses that conceive of HIV as detrimental to the integrity of the gay community. Arising from this are expectations that Black and Latino MSM engage in safer sex practices and refrain from "promiscuous" sexual behaviors that may otherwise be conducive to HIV infection. The language of fear that characterized the initial national responses to HIV painted promiscuity as a kind of moral misbehavior that begat infection (Crimp 1987). Several respondents note that there is an unspoken pressure for individuals to have learned from HIV's legacy and take personal responsibility for maintaining both their own and the community's overall wellbeing. At the same time, respondents also acknowledge the existence of subcultures based on sexual behavior that push against to the expected norms of the broader gay community.

By nature, a subculture presumes a dominant culture from which it diverges from in some form or another, such as in its perceptions and accompanying actions. Tim Dean's *Unlimited Intimacy* (2009) covered the subculture of "barebacking" among gay men, or sex without condoms, which arose in the wake of the HIV epidemic. Self-identifying members of the barebacking community cite diverse reasons for barebacking and the potential for HIV transmission, most notable among them being the idea of HIV-infection as a form of kinship building. This is related to a similar group of individuals who purposefully seek HIV-infection,

commonly identified as "bug-chasers⁸." Victor, the Black gay man who believes the gay community is still trying to find its identity, comments on this subculture:

I've heard of like bug catchers, is what they're called. I mean, I think it speaks back to the mental health crisis that's happening in this country. Because to seek out something that is unhealthy, to seek out something that is like... I mean I don't understand like why they would find it sexy. And to say that is not to judge them, but ... I cannot understand the reason why. ... ultimately, you're looking to seek out a virus that will attack your immune system ... That doesn't add up mentally. ... Sometimes I think it's they do it to get it to be over with the fear. I've heard that before ... it's almost like facing death in a way. And that's the only like intellectual reason that I can almost be like 'all right, I see where you're coming from,' but it still comes from a place of like a lack of mental health. Because it's ultimately like a constant living in a fear, and I can say that because that's what I experienced when I went through my own [HIV scare]...

The phenomenon of bug-chasing has been well-studied for some time, with research focusing on the psychosocial dimensions of purposive seroconversion (Moskowitz and Roloff 2007). In the excerpt above, Victor's sentiments mirror the dominant view of bug-chasing that is characteristic of both the gay community and biomedicine; that is, "to seek out something that is unhealthy" is incomprehensible and irrational behavior that goes against what the institution understands is best for the individuals it hails. In his attempt to make sense of it, he acknowledges the role fear may play in this process, relating it to the psychological distress he experienced during his own HIV scare, which was discussed in the previous chapter. That he views bug-chasing as a consequence of poor mental health is significant as Victor and other respondents make mention of the role mental health plays in preventing HIV infection.

Biomedical researchers have long investigated and found evidence for linkages between mental well-being and susceptibility to HIV exposure. In the case of bug-chasing, however, it is crucial to note that individuals who engage in this activity may be doing so not out of mental

⁸ Bug-chasers, as Gauthier and Forsyth (1999) describe, are a subculture of gay men who share a desire of contracting HIV. Bug-chasers engage in sex without any form of prevention with men who are either ambiguously or certifiably HIV-positive.

illness but out of their own set of beliefs and desires that clash with those of the institutions they are hailed by. In a similar example, Benjamin sheds further light on purposive seroconversion and subcultures within the gay community when he states:

I've definitely heard about conversion parties. And they exist... They tend to be really meth-y ... it tends to be in the white bear community. But they're basically these really ... fisting parties and whatever. But it's basically a whole bunch of HIV positive guys having bareback sex with HIV negative people ...

Benjamin describes the concept of the "conversion party," or a planned gathering in which HIV positive men, colloquially known as 'gift-givers', have sex with HIV negative men with the purpose of seroconverting. Prior research in the social sciences have found conversion parties to be sites where certain groups of MSM establish bonds to one another through shared meanings and behaviors that are otherwise viewed as deviant by others (Groves 2004 ; Reynolds 2007). Conversion parties deviate from what the gay community understands to be normative and acceptable sexual practice.

In sharing what he's learned about conversion parties, Benjamin also points to the role race can play in subculture membership. He specifically describes the typical conversion party attendee as a "white bear" who also engages in opioid use during sex. Gay men who identify as "bears" are individuals who root their sexual and gender identity in hypermasculinity characterized by their large and hairy bodies (Hennen 2005). Bears are typically simultaneous members of other subcultures within the gay community, such as the leather and kink communities, as well as others that valorize drug use during sex. The bear community is predominantly represented by White men, and while there do exist non-White bears, accounts of overt racism and discrimination point to White identity being central to bear group membership in certain subsets of the population (Rawles 2018; Shea 2013). Though it cannot be said that conversion party attendees are strictly White men, Benjamin's observations shed light into

another dimension through which Black and Latino MSM may further be subjected to exclusion within the gay community.

Given the persistent fear surrounding HIV, the prospect of behaviors that openly embrace the potential for HIV infection reveals a tension that outlines the worldviews of the gay community. If it is wholly unacceptable and abhorrent to actively seek HIV, then the accepted and expected behavior is the outright prevention of HIV transmission. The existence of subcultures is a testament to both the diversity of perceptions among individuals that fall under the broader gay community, as well as an established and understood set of cultural norms and expectations. Though the gay community and biomedicine diffuse schemata linking HIV risk with sex among men, sex can also take on additional meanings serve other purposes, such as establishing intimacy in long-term partnerships, a topic that is discussed further in the following chapter.

Conclusion

In this chapter, I have analyzed the cultural and institutional moorings of respondent's risk perception formation. Race, class, and sexuality are intersecting social institutions that structure the HIV-relevant discourses, beliefs, and rhetoric culturally made available by religion, biomedicine, and the gay community. Underlying these sensemaking tools are schemata that associate HIV risk with Black and Latino MSM's social locations. Respondents draw upon this cultural repertoire to construct meanings about they relate to HIV. Religious beliefs, for instance, conceive of HIV as divine punishment for non-heterosexuality, which respondents can then incorporate into their understanding of the self as being at-risk because of their sexual identity. Biomedical rhetoric of risk support essentialist notions of HIV's impact on Black and Latino

MSM. Racialized discourses and exclusionary practices within the gay community can make clear for respondents how their HIV infection is an individual potentiality with public implications.

Moving focus away from action and towards perception about whatever may await on the other side of risk lays bare the breadth of the risk ecology individuals are conceptualizing and confronting. Analyzing the institutional and cultural dimensions of risk perception illustrates how risk perception is a social process influenced by more than just human agency. Rather than focus on how individuals consider the costs and benefits of “taking a risk,” the risk ecology framework offers insight that illuminates how individuals can even come to consider their intended actions as viable and possible. To that end, the following chapter serves to demonstrate how adopting the socioecological approach outlined thus far can deepen sociological understandings of the link between perception and behavior.

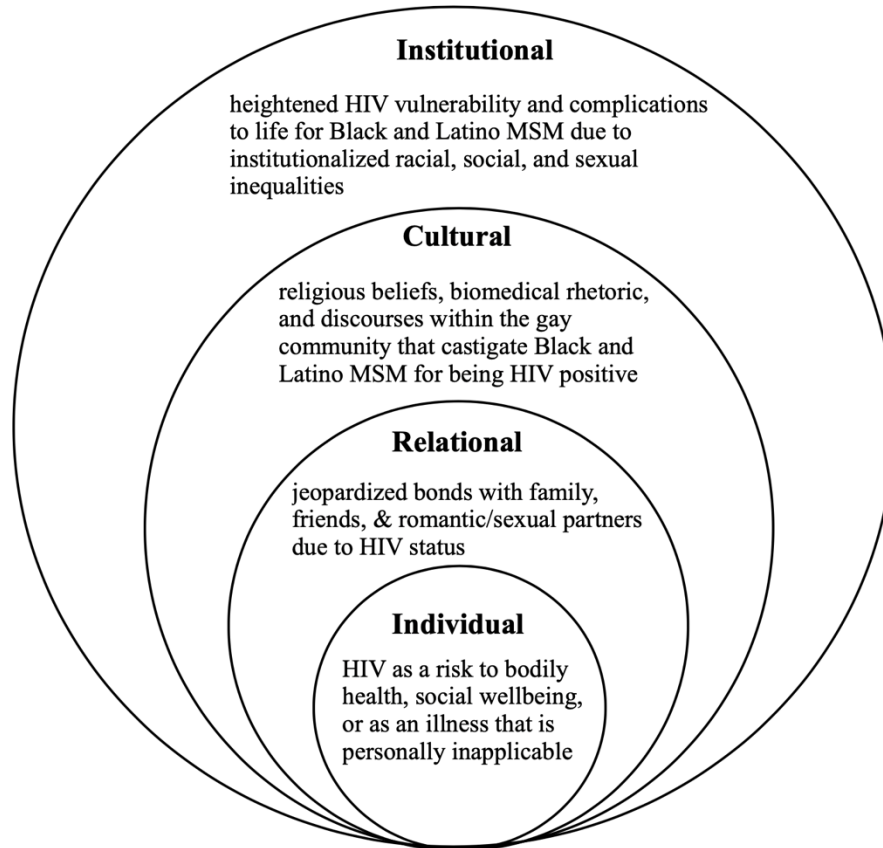
CHAPTER V

Passion / Peril: On Perception, PrEP, and Sex

Our lives tremble / between pathos and seduction / Our inhibitions / force us to be equal.

— “Between Pathos and Seduction (For Larry),” Essex Hemphill

Figure 2. The Risk Ecology Framework - HIV Risks and their Ecological Origins



The previous chapters have respectively described the individual, relational, cultural, and institutional levels of analysis that comprise the risk ecology framework. Focusing on each dimension of an individual’s social environment, I detailed the breadth of threats Black and Latino MSM are confronting when considering HIV’s place in their lives. Figure 2 above illustrates the ecological origins and types of risks that arose from the analysis of respondent interviews. In directing analysis away from *how people perceive the risk of HIV* and towards

how they *give meaning to their relationship to HIV*, I have also demonstrated that risk is not an inherent quality of HIV but instead a multifaceted potentiality of it. How and in what ways people perceive HIV as a relevant concern in their lives is dependent on how risk comes to be associated with their social location across ecological levels. As a whole, the REF departs from existing risk frameworks in its consideration of intersectional race, class, and sexuality as central to understanding the socioecological forces that structure how people form their perceptions of risk.

The insight offered by this approach also enables fuller comprehension of the link between perception and action. Here I articulate how a comprehensive application of the REF can provide a contextualized understanding of Black and Latino MSM's health-relevant behaviors. Specifically, I focus on respondents' use of PrEP medication as well as their sexual practices. Sociological research at the intersection of health and risk has predominantly focused on how people assess the riskiness of a certain behavior and the social reasons for engaging in it. Taking up from this work, I argue that an individual's HIV risk perceptions correlate with their *intended* behavior, but do not necessarily correspond to whether or not these behaviors are realized. Just as an individual's HIV risk perceptions are influenced by social forces in their environment, so too are the meanings they find in prophylactic technologies and sex. Due to the variety of meanings PrEP medication and sexual practices can have, along with the fact that sex is not always rational, how respondents act upon their perceptions is also dependent upon unpredictable factors and unforeseeable circumstances.

This chapter explores these points further. It begins by centering on the life of Don, a 28-year-old Latino working-class gay man, and analyzing his relationship to HIV. Next, the chapter turns to the topic of PrEP medication and demonstrates how the REF reveals the multifaceted

barriers to medications uptake and acceptability among Black and Latino MSM. Lastly, the chapter focuses on how respondents' HIV risk perceptions structure the meaning they find in sexual interactions. I pay particular attention to intended and realized sexual behaviors to highlight how respondents reconcile with the uncertainties of sex.

Making Sense of a Risk Ecology

Don was one of the last people I interviewed before concluding my study. A working-class New York City native, Don proudly proclaims having lived in four of the five boroughs, with the Bronx being his present home. Don describes himself as being of Caribbean ethnic heritage, with a Puerto Rican father born in the United States and immigrant Dominican mother. Don resides with his mother and younger sister, with his father living elsewhere. Though his parents were initially together for most of his adolescence, violence would soon cause the family to split in a way that had intense financial ramifications for all in the household. Don shares having a middle-class upbringing because the family jointly owned a successful business together, but “things got really ugly” when domestic abuse created an irreparable rift between his parents. Don is grateful to still be living with his mother, as he feels that he had always been closer to her side of the family, but does not deny the difficulty of the poverty he endured after their separation. There were months he would go without a pair of shoes and only an air mattress to sleep in.

With great effort, Don's family was able to mostly recover from their losses, so much so that Don now had the time to pursue his college degree. At the time of our interview, Don was a first-generation rising college senior at a public university and was anxious about his next steps

after graduation. A musical person at heart, Don majored in performing arts and aspires to be on a stage or screen in the future. A lack of progress in this pursuit initially lead him to consider alternative career paths, but when those proved unfulfilling, Don decided to double down on his passion for theatre albeit with supplemental training in marketing. Don describes having a “great career” as being an important life-long goal, especially given the prior financial hardships he hoped to never experience again. Don did not consider his finances at the time to be particularly stable, but with the governmental assistance he had been receiving, along with the job prospects that come with possessing a bachelor’s degree, Don was hopeful that his situation would only improve.

I met with Don one afternoon in early June, the waning springtime sun mirroring the tone of what would first be a warm, and then intense, conversation. As I greeted him outside of the office space I had reserved for the interview, Don seemed relaxed, though I noticed he would rarely make eye contact with me. He was dressed in a light brown leather jacket and orange Henley shirt, paired with an everyday denim jean and sneaker combination. We sat across from each other as I introduced myself and explained the interview process. When Don expressed his excitement about participating, I noticed that he spoke in a voice that wavered between a slow murmur and boisterous, hurried speech. This vacillation would carry on throughout our discussion, never reaching a steadiness but instead flowing with emotion. When we spoke of home, his words were hushed and, at times, pained. But when we spoke of HIV, fervor and conviction filled every utterance.

How Race, Class, and Sexuality Matter

Figure 3 below summarizes Don’s personal risk ecology that is made visible through the

analysis of his experience and social location. This risk ecology encompasses the considerations Don weighs to apprehend his relationship to HIV. At the individual level, Don serves as an example of a respondent whose HIV risk perceptions are characterized by both the corporeal and stigma frame. Elements of the corporeal and social frame appear in his sensemaking about his relationship to HIV. To reiterate, risk perceptions are typically characterized by combinations of distinguishable frames of varying salience. Analytically, these frames help to not only understand the range of threats individuals perceive HIV to pose, but also how these threats relate to the lived experience of their social location. As is discussed further below, Don and Shane both arrive at framings of HIV as detrimental to corporeal health, but differences in their social location affect the process by which this occurs. Shane, for instance, comes from a relatively wealthy family of doctors who exposed him to biomedical rhetoric about HIV's impact on men like him. Don, on the other hand, comes from a working-class background and was exposed to similar sensemaking tools at the community health center he would visit to escape family life.

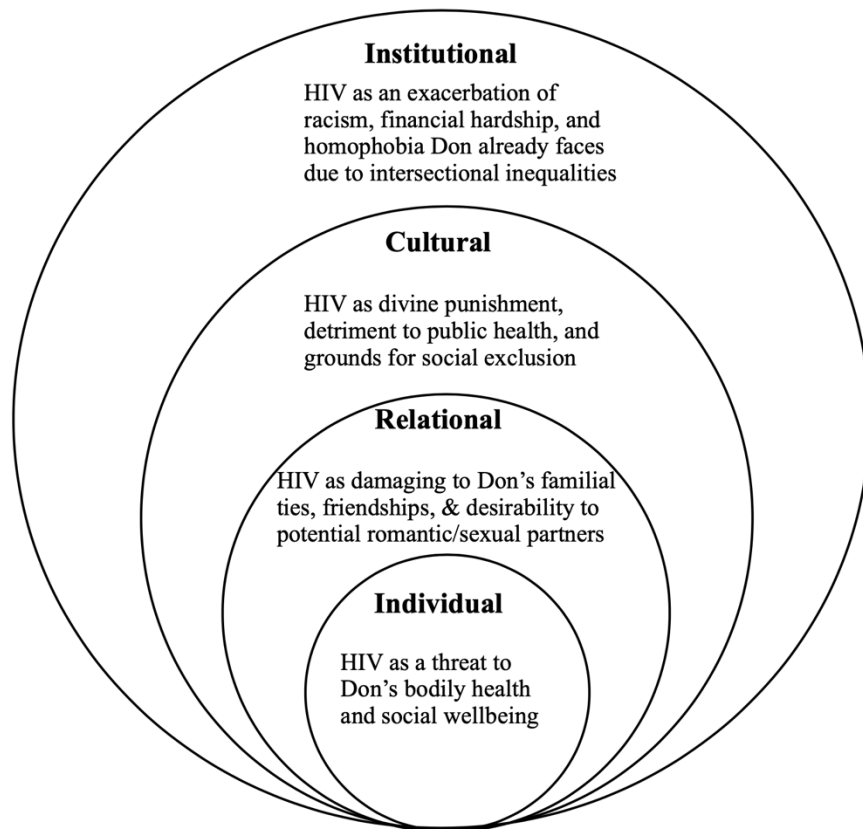
The hybridity of Don's framing of HIV is reflected in his general definition of risk as existing in several different forms:

It [risk] means taking a chance to do something you really want to do and knowing that it's not completely safe ... It's like trying to jump down the window and to land in the pool, but there's a chance that you could either land on the pool or you could land on the concrete. ... But then again, there's also educated risks, that you know that you've done all the math you have to and you've checked out the variables and you know that it's a risk that you will likely succeed in. And there's sexual risk that is risky like that. You don't know if you're gonna land in the pool or you're gonna land on concrete, so you just have to really be careful.

Above Don describes risk in ways that align with the conceptualizations highlighted by prior risk scholarship, such as a risk being "leap of faith," but also a rational calculation of circumstances as a means of reconciling with uncertainty (Brownlie and Howson 2005). However, it is interesting to note how "sexual risk" represents a unique phenomenon for Don for which it is

impossible to estimate the possible outcomes; all one can do is to be deliberate in their precaution, but ultimately there is no way of fully knowing what engaging with sexual risk may bring. As is discussed, sex encompasses several potential threats that can be acknowledged but never fully anticipated. For Don, the potential of HIV infection is one such threat that he understands as detrimental to various aspects of his lifeworld.

Figure 3. Don's Perceived HIV Risk Ecology



Don's reflections on the CDC report referenced throughout this dissertation further clarify how he frames HIV as a threat to the many dimensions of his life as a Latino MSM. He describes the report's projection of 50% Black MSM and 25% Latino MSM contracting HIV as "heartbreaking, but it's unfortunately a reality," one which he is presently living in. When asked to describe his major concerns about HIV, Don first highlights the bodily impact it can have that

echoes Shane's concern about general corporeal well-being:

I want to be healthy, I want to make sure that I don't have to go through the issues that my friends are going through, in terms of having to seek medication, having to constantly go to the doctor's for check-ups and routines, and just because I feel like it's better for my overall health to not contract it.

Additionally, Don focuses on the social aspects of living with HIV, sharing concerns similar to Peter's:

Also, the stigma that surrounds it, because of people think that because you have it, that means that you can't live a healthy life. Now a days you can, you can just take the proper medication, visit your doctors ... And yeah, there's also just because, since it's looked down upon, most people don't wanna disclose their status a lot of the time. ... unfortunately one of the stigmas was that it's a gay disease, because the LGBT community is the community that unfortunately gets affected by it the most as well as people of color. Because of incarceration and because of unprotected sex, and unfortunately in a lot of minority communities, it is a big issue there.

Don's HIV risk perceptions are comprised of both the corporeal and stigma frames, as he understands HIV as a potential threat to his bodily health and well-being. The biological impact of HIV coupled with the experience of stigma jeopardize what it means to be "healthy" for Don. This also relates to his awareness of broader issues, such as incarceration, which has disproportionately affected communities of color due to racism and socioeconomic inequality (Wildeman and Wang 2017). How Don understands himself to be "at-risk," however, is a result of the ways in which he interfaces his race, class, and sexuality with what he knows about HIV. This is seen partly in his statement about HIV being a "gay disease" that disproportionately affects people of color. In discussing the CDC report further, Don's reflections begin to touch upon the broader risk ecology he confronts in navigating his uncertainties about HIV:

...it has to do with the funding, because mind you, a lot of inner cities are in red states, and unfortunately a lot of red states are very homophobic in their views. They don't give the proper funding, so therefore it's much harder to get the medicine to take care of yourself. ... So a lot of people are trying to get money so they can get the medicine, because it's not as easy as getting it, say, somewhere

here. But also, I guess it's challenging, because this is such a large LGBT community here in New York, it also takes months to see a doctor sometimes, so it's very difficult to get the medicine and I do think that that plays into it, just because of the lack of resources that black communities get, and also how long it takes to get the proper help and the knowledge.

Don's words demonstrate his awareness of how socioeconomic inequality exacerbates the HIV-related difficulties racial and sexual minorities face in their lives. Even in a well-resourced place like NYC, Don knows that while he may be in a comparatively better situation than many other places in the United States, the same structural forces that place Black and Latino MSM at particular disadvantage also affect him given his identification with this demographic. Just because New York City has the resources does not mean they are doled out equally and efficiently in an accessible manner. In Don's eyes, becoming HIV positive would entail a severe complication of the life he has led thus far.

At the same time, Don's sensemaking also highlights how risk perception is temporally situated, with certain framings taking prominence over others depending on the respondents' reality at the time. This is exemplified in how Don's understanding of being at-risk has changed and can change again depending on the actions he takes:

I really, unfortunately, for a while thought I could have. I mean, if I was more sexually active, it could have easily been me. Because it happened to my friend, so it totally could happen to me. It's why I'm taking, I'm trying to do what I could to take the steps necessary to make sure that I'm taking care of myself and I'm preaching the self-care that I talk about. I practice what I preach.

Reflecting on whether or not he feels represented by the CDC report, Don explained that while he viewed himself as belonging to the demographic at the center of the CDC report, he did not at the time of the interview consider himself to be among the percentage projected to contract HIV in their lifetime. He explains this in terms of a noted change in his behavior; "it could have easily been" him were he not presently taking "the steps necessary" to prevent HIV infection. Don's

view of HIV as an illness that can be kept at bay echoes aspects of an irrelevance framing of HIV similar to Benjamin's, who placed part of his sense of exemption in his reduced sexual activity and use of protection. Don's retrospection also brings to light that while others may ascribe a permanent at-risk status because of his social location, being at-risk does not always characterize how he gives meaning to his relationship to HIV.

The Role of Friends, Family, and Partners

Friends, family, and partners play a major role in how Don gives meaning to his relationship to HIV. The portions of his narratives discussed thus far already begin to demonstrate the impact friends have had on his HIV risk perceptions. One of the major reasons why Don feels he could have easily become HIV-positive is because he saw it happen to some of his friends. What he has heard about HIV's impact on the body and social life is concretized as a potential reality for himself given his friends' experiences. In another example of this dynamic, Don shares how social media interactions with his queer friends of color have been particularly influential:

I've seen posts from my Facebook from my queer friends of color who live in the South who are also working in the medical field ... a lot of them talked about how a lot of their friends passed away before 30, they don't really make it as far as undergrad because of HIV ... One of my friends who's in Mississippi who's a black gay man living HIV positive had his medication cut off because it was too expensive.

Don knows what life could be like through his friends. His previously discussed concern about the difference between NYC and southern states is in reference to what his friends have shared. Don trusts their perspectives not just because they are his friends, but also because these are individuals with medical expertise that he values. Of note is how different this is from Peter's case, whose stigma framing of HIV risk was dependent on how he would be viewed and

potentially judged by his friends. The presence of HIV-positive people in Don's friend group makes it so that he knows he would be socially supported despite potentially being stigmatized by the broader society. What is most alarming to Don is his friend's inability to receive medication because of affordability. Though Don frames HIV as a threat to his bodily health and social well-being, class plays a prominent role in Don's realization that he may encounter issues accessing the care he needs should he ever seroconvert. Don sees through his HIV-positive friend's eyes the linkages between social location and HIV risk, and gains an idea of what his own life chances could be like were he to ever seroconvert.

Family acts as a focal point for what Don understands HIV to threaten in his life. Don's family is extremely disapproving of his sexuality and explicitly view HIV as directly associated with his sexuality. As will be discussed in further detail in the next section, Don's family has consistently exposed him to homophobia rooted in religion ever since he came out. Don explains that while his family still "supports" him enough to not kick him out of the home, "they're still not as open-minded and they still have a stigma about" homosexuality that is explicitly associated with the risk of HIV. Though he would not describe his mother's side of the family as "really religious," he explains how they still have a general faith that is not accommodating of non-heterosexual identity. While his family has come to tolerate his sexuality to a degree, HIV would completely jeopardize his social standing among his relatives. This is made clear in Don's discussion about why he would never bring an at-home HIV testing kit (AHTK) to his house:

I would rather have a professional do it [test for HIV], just because at least I could have ... If, God forbid, I ever got tested positive, I would have someone to talk to and I could get services. Especially if I would still be living at home, it just wouldn't happen.

As a college student without steady employment, much of Don's sense of stability was dependent on the housing and other resources his family provided. Were he to find out he tested

HIV-positive at home through the use of an AHTK, Don believes he would lose that familial network of social support. For Don, becoming HIV positive is a realization and affirmation of his family's disapproval. It is evident here, then, that he perceives HIV as a threat to his well-being precisely because it also threatens to alter how his family views him, highlighting the import of the relational dynamic.

Like all the other respondents, interactions with romantic/sexual partners also figure into Don's HIV risk perceptions. In thinking about what relationships mean to him, Don believes them to be a "two-way street...for getting to know someone...that I can have a good time with... that I am attracted to." These bonds serve as a space for Don to cultivate both pleasure and passion, his potential partners being sources for sex but within the context of a lasting and loving union. Don, however, has faced difficulties in finding either romantic or sexual prospects that he understands to be a result of his identity. Specifically, Don states that there are "a lot of struggles that a Latino gay man has to go through" that arise when using gay dating apps Grindr, where people openly state their preferred physical attributes with statements like "no fats, no femmes." Don finds that he does not get a lot of attention because of his feminine presentation and body size, but also worries that people may be assuming he's HIV positive because of his race. Don states that he does believe people try to discern who is HIV positive by their appearance, and states that "unfortunately, a lot of times, they think people of color have it." Such interactions serve to solidify an association between HIV risk and identity that inform Don's view as a real threat in his life.

Of note is that Don is among the few respondents to openly state that they take no issue with their romantic/sexual partners being HIV-positive. Don finds that with the existence of condoms and PrEP, he can have a fulfilling relationship with an HIV-positive person that still

protects both of their well-being. Don asks his partners about their HIV status not as a means of excluding them from the potential of sex or any other interaction, but in order to foster a sense of openness and set healthy boundaries. Don's vigilance also stems from a prior experience with a former partner who unfortunately died of AIDS-related complications a year before our interview took place. While Don and this individual were separated for some time prior to his death, upon hearing the news he felt "such a panic about it" and immediately went to the doctor to seek testing and treatment. Don had never openly discussed HIV with this person but has made it a point to do so with his potential partners moving forward. Don relates how this experience brought HIV close to home, with the risk of infection never being outside the realm of personal possibility.

Don's Sensemaking Tool Kit

In considering the cultural and institutional level components of the REF, analysis of Don's narrative thus far has already begun to demonstrate the influence religion, biomedicine, and the gay community have on his HIV risk perception formation. Don both alludes to and explicitly pinpoints how the social institutions of race, class, and sexuality intersect in ways that make Black and Latino MSM vulnerable to potential infection. Racial, social, and sexual inequalities undergird how he makes sense of HIV as threatening to exacerbate the difficulties of a life marred by ongoing experiences of racism, financial hardship, and homophobia. Don's individual framing of HIV, along with his interactions with the people in his life, indicate the deployment of discourses and rhetoric that serve to cement his perception of HIV risk as a reality in his life.

Religion figures prominently in Don's risk perceptions because of the central role it has

played in his family life. Don's family, as previously mentioned, disparages his homosexuality because of its association with HIV risk. Don expands upon this when describing the difficulties he faced when he first came out to his family about his sexuality:

They really just don't like that about me. I mean, they accept it. They accept that's who I am, but they just don't like it 'cause they'd rather have me into females ... They want grandchildren... They worry about me a lot too, so they want me to fit into the hetero norms as much as I could, as much as they could get me to.

Don had known he was not sexually interested in women for quite some time, and his family had their suspicions about this as well. When he came out about his sexuality, he was met with conditional acceptance that was overshadowed by abject disapproval of his sexual identity. Part of their disapproval was predicated on a worry that his sexuality would bring him harm, with HIV being the most concerning. Don's family possesses a view of HIV as part and parcel to the experience of being homosexual, a perspective that stems from religiously-rooted beliefs of HIV as divine punishment for sin. Don takes this to heart, so much so that he does not feel safe bringing home anything associated with his sexuality, including HIV-related resources. For instance, part of the reason Don did not feel comfortable using AHTK, Don explains, is because he doesn't want to "bring HIV care around my parents or around my little sister. I just don't, because they're gonna go "Oh, this is your life now" and they're just gonna go in my business."

Don details having attempted to come out several times in his life, but his family was firm in their religiously-based disapproval of his sexuality, so much so they subjected him to sexual assault and abuse. Don explains this when he states:

I'm gay... I'd tried being straight. ... even though my mom and my family do support me, they're still not as open-minded and they still have the stigma about it [HIV], because my family in the Dominican Republic, it's very Catholic over there. ... At one point, I had sex with not one, but two prostitutes, with two female sex workers, I should say. One for my dad when it was New Year's when I was 17. Me and my father, we both had sex with the same woman. It was very awkward and uncomfortable as it sounds... and then the second time it was kind

of like a high school graduation type thing that my mom's ex got for me. And I just really didn't ... I tried.

Don emphasizes how his family's view of HIV are influenced by Catholic beliefs about homosexuality, which are especially prominent in the Dominican Republic. This is similar to both Shane and Benjamin's discussion of homophobia as being almost a part of the language of their families from Jamaica. His parents were so staunch in their disapproval that they forced Don to have sex with female sex-workers in an attempt to discourage his interest in men. This is not unlike the experiences described in research on the controversial and highly contested process of conversion therapy, which often recommends sexual interaction with the opposite sex as a proposed "remedy" for homosexual thoughts and behavior (Robinson and Spivey 2007). In Don's case, this violence served to reinforce the idea his sexuality was inherently flawed because of its associations with HIV.

Seeking refuge from his abusive household, Don found comfort in community health centers that offered HIV-related youth programming for low-income LGBTQ individuals such as himself. It was in these spaces that Don was able to acquire the resources and information necessary to address what he understood to be an ever-present risk of HIV infection. It was also here that Don came to be exposed to biomedical rhetoric that further associated HIV risk with his social location. His family's concern about his sexuality were substantiated by medical practitioners who emphasized the importance of HIV testing and prevention for Black and Latino MSM. Rather than feel disparaged, Don took it upon himself to learn as much as he could about HIV and how best to prevent it, adopting a biomedical rhetoric of risk that he deploys in his own framing of HIV as risk to bodily health and social well-being. An example of this can be seen in how Don discusses broader attitudes about HIV in comparison to the initial years of the epidemic:

I do know that people don't care, are more loose about it, just because of PrEP and stuff that they think that it won't be as big of a deal. And it's like, no, you don't stigmatize against those who have it already, but you also do take care of yourself because it's not something you just want to get. You want to make sure that you're healthy, you're using condoms, or if you're going to go out and have multiple partners, that you're constantly getting checked and you're making sure that you're doing your best to not catch it, because we have the technology. But, you know, things happen, unfortunately. It can still happen...and that's why you've got to take care of yourself.

Don possesses a familiarity with HIV that mirrors Shane's despite not coming from an upper-middle-class family of doctors. He shares the same view of HIV a public health problem that individuals are personally responsible for containing through deliberate efforts to reduce the likelihood of exposure. Recalling his broader discussion of risk at the beginning of this section, Don touches upon the unique space sexual risk occupies; the a sexually active individual is always at-risk of HIV because "things happen." There's an incalculable aspect of sexual risk that makes it impossible for Don to view HIV risk as a matter of rational action alone. Don understands himself to be capable of reducing the likelihood of infection, but nevertheless perceives HIV risk as inescapable.

The gay community also plays a part in Don's sensemaking tool kit about his relationship to HIV. During his time at the community health center, Don became an HIV outreach worker to increase knowledge about and awareness of HIV in underserved neighborhoods. It was through this line of work that Don learned about the history of HIV/AIDS and its stigmatization as a "gay disease" that mostly affects people of color. Don sees the enduring nature of this stigma when discussing how gay people come to be associated with the likelihood of being HIV positive:

I will see more discrimination, like say, they will be like "Oh, well they're gay ..." they think that most gays, a lot of gays are bottoming. But there are gays that top. Like there's certain aesthetics that go with it, they'll assume that most effeminate guys are bottoms and most masc guys are tops, when it's a whole spectrum. ...There's so many different sexual positions out there. Like, you can't really have the same structure as, say, the straight community does.

Here Don describes how people outside of the gay community associate HIV risk with gay people by way of feminine presentation and anal sex. Research has identified bottoming, or the act of being the receptive partner during anal sex, as “highest-risk sexual activity for getting HIV” due to the increased potential for tearing the thin lining of the rectum (CDC 2018). As previously discussed, feminine-presenting MSM are often associated with being the receptive partner in anal sex which, in turn, leading to assumptions about their degree of sexual activity and likelihood of HIV infection. Don finds that this association with HIV and sexuality also occurs within the gay community, which upholds a binary idea of “bottoming” and “topping” as the primary means of sexual interaction among men.

For Don, the primary issue is the heteronormativity at the root of this framework for sex which he finds to be pervasive in the gay community in ways that affect his sense of belonging within the gay community:

...For some reason, our community, ... it's trying so hard to follow the hetero norms and like the white ... the beauty norms and white norms that hetero society follows which is frustrating...Because a lot of times I feel like I'm misrepresented or misunderstood.

Don, like many of the respondents discussed throughout this dissertation, has had several experiences where he was fetishized, tokenized, and discriminated against because of his race. He shares several accounts of his attempts to interact with other gay men online and in person, only to feel out of place, his attempts at platonic and romantic connection being completely ignored or rejected. Don also shares the worry that perhaps others may be making assumptions about his HIV status due to his identity. Don has hope that, with time, everyone will understand that HIV “can happen to anybody” and not just individuals like himself. For the time being, however, Don finds the contemporary HIV epidemic to encompass a breadth of risks that

complicate how he navigates his social world.

PrEP Use

PrEP medication has been proven to effectively reduce the probability of HIV transmission when used alongside condoms. However, despite an increase in the availability and access to PrEP medications like Truvada, adoption and adherence are particularly low among Black and Latino MSM (Murnane et al. 2013; Lelutiu-Weinberger and Golub 2017). Drawing on insights from the REF to show the relevance of this perspective to our understanding of health relevant behaviors, I demonstrate how Black and Latino MSM's PrEP use is dependent on social factors that extend beyond awareness about, access to, and affordability of the medication. I argue that a respondent's decision to take the PrEP pill involves confronting challenges to their relationships, experiences of medical racism, and stigmatized promiscuity. These barriers align with the threats respondents perceive HIV to present across the dimensions of their social environment. They also are manifestations of the ecology-spanning influence of race, class, and sexuality as intersecting social institutions.

Experiences of discrimination in medical settings, for instance, can deter respondents from seeking a PrEP prescription. These individual experiences, however, are derived from and shape institutionalized inequalities that have historically impacted the healthcare and treatment of Black and Latino MSM. In this way, the sensemaking tools respondents use to understand their relationship to HIV also inform their use of PrEP. I focus on Don's experiences, along with those of other respondents, to illustrate how Black and Latino MSM reckon with these challenges. I show that while a respondent's HIV risk perceptions cannot neatly predict whether they will go on to seek and use PrEP medication, they do underscore how the respondent comes

to view taking PrEP as a personally acceptable and viable action.

“When we were together, we stopped taking PrEP:” The Significance of Relationships

Don’s experiences with PrEP illustrate how taking the medication may compromise important relationships in a person’s life. As the previous section demonstrated, Don makes sense of HIV as real threat in his life that can potentially jeopardize more than just his own well-being. Don is a strong proponent of PrEP and any other medication or technology that can help to protect his bodily health against HIV, which resonates with his corporeal framing of HIV. This is related to yet fundamentally different from Peter and his stigma framing of HIV, who views PrEP as removing social anxieties about the potential for HIV that can interfere with the pleasure of sex. Don also makes use of a stigma framing of HIV, albeit in a way that concerns his inability to acquire and adhere to the medication due to his family’s disapproval. An aspect of this was seen in his reluctance to bring home and use an AHTK. Don expands upon this further when he relates how his parent’s linking of homosexuality with HIV has complicated his ability to use his PrEP prescription:

My mom found out about it [PrEP prescription]. She thought that I was hiding that I had HIV, and it's just like, they really like misunderstand what it's for, it's to protect me when I'm having sex, if I was to have a relationship with someone who does, so I don't get the disease...

Don had acquired his PrEP prescription some time ago but had not been using it consistently because he was not particularly sexually active. This is much like Benjamin, who had an interest in PrEP but ultimately found it to be unnecessary as he did not feel HIV to be relevant to his circumstances. Don’s mother’s discovery of his prescription, however, evolved into a heated argument that ended in his discarding of the medication altogether. Don first explains how his mother immediately assumed that his PrEP prescription implied he was HIV-positive. This was

due in part to his mother lacking awareness and knowledge about PrEP, as well as alarm upon seeing the term “HIV” on the prescription itself. What led to the immediate assumption of HIV-positive status, however, is his mother’s association of homosexuality with HIV.

In the Dominican Republic, where Don’s mother was raised, homophobia in the household is often expressed through customary views of homosexuals as morally corrupt individuals that can infect others with illness (Caraballo-Diéguez 2008). The idea that homosexual men are perverted and ill stems from the Roman Catholic beliefs at the center of Dominican conceptualizations of masculinity and the family (De Moya 2004). This experience constitutes a set of relational interactions with Don’s family that have made it impossible for him to use a vital preventative tool. Don states that he always preferred condoms, so he did not view his inability to use PrEP as a major setback. Nevertheless, because Don lives with his mother, he is also discouraged from keeping condoms of his own and therefore must rely on his romantic/sexual partners to supply them.

In further consideration of religion’s influence on PrEP use, it is worth noting that traditional religious beliefs about sex rarely involve or consider the use of prophylactic technologies. As respondents like Benjamin note, the religious views of their relatives often focus on sexual abstinence or celibacy until marriage as methods individuals should engage in to protect themselves. What religious doctrines state people are protecting themselves from, however, differs by religious system. In Christian traditions, for example, abstinence is required of all faithful believers, as sex is understood to be reserved for those in marriage seeking to procreate. All other sexual activity indulged in for other ends is, instead, viewed as immoral or sinful. Children born out of wedlock and STDs/STIs are subsequently viewed by believers as consequences of such immorality. There are no references to be found in religious texts about the

use of condoms or any other inanimate tool barrier people can employ as a preventative barrier in sex. Aside from the fact that such tools did not exist at the time, their use would otherwise suggest an uncharacteristic acceptance of premarital or non-procreative sex.

A result of this can be a lack of acknowledgement or conversation about PrEP and other HIV-prevention tools within a respondent's family. This can be seen in Saul's reflections on growing up with religiously conservative parents in the rural south. A 27-year-old Black upper-middle-class queer man, Saul recalls an inability to have open conversations about sex with his parents due to his sexuality:

Being queer and being Black or Latino is also super hard. Just being able to have open conversation about your body and about sex. If you have a mom and a dad who are straight, your parents at some point might have a talk with you... you have a conversation with dad where you all are talking about sex, right. But are you talking about sex and does your dad actually tell you make sure you use condoms and stuff like that? Probably but I don't know. But even those types of conversations can't really happen as authentically. So, most of the time you probably hear people say, "Well, be safe." "You're gay, be safe." But what does that actually mean? If no one is talking about that. No one's actually saying, what does it mean to be safe.

Saul describes how growing up with his racial and sexual identity can come with added challenges because parents are unable to offer crucial information about sexual health and safety. Growing up in a Baptist and Methodist household, discussions about sex and the use of protection were never had. In this particular case, Saul could not gain knowledge about preventative technologies from his parents during his adolescence because religious views limited the range of conversations they could have together. What Saul learned about prevention came from his later sexual experiences in college, where he realized that condoms were the accepted norm for sex among men on campus. The research surrounding PrEP was still developing during that time, so while Saul had a vague understanding of it, he never considered it as an option. Due to not being out about his

sexuality, Saul also did not have the opportunity to speak candidly about sex with his parents, nor the particulars of what safe sex might look like for someone such as himself. That Saul mentions a reticence around what it means to be safe is significant, as it relates to his perception of a breadth of risks Black MSM like him can face. For Saul, vague warnings “to be safe” are not only passive associations his sexuality with HIV infection, but also simplifications of the complexity of threats individuals like him navigate due to their identity.

At the relational level, the use of PrEP can also bring affect the status of romantic/sexual partners. The most common theme that arose was a view of PrEP as being a tool that can signal the conditions and configurations of the relationship. Some respondents like Gary, the Black gay man who feels “anxiety” about his prior sexual partners’ HIV status, believes that PrEP has no place in long-term relationships because it can bring established trust into question. This is similar to findings from previous research concerning the ways in which condom use can be perceived as a breach of intimacy and trust between partners (Tavory and Swidler 2009). Gary, however, finds that condoms and PrEP are two different things. Gary enjoys sex with condoms and does not find them to hinder the pleasure or intimacy between himself and his partner, regardless of how long they’ve been together monogamously or otherwise. However, Gary feels that if his partners were to use PrEP, they would be signaling not only their distrust in him, but also that they are having sex with other people outside of their relationship. In Gary’s eyes, PrEP communicates that “this person has sex with a lot of people,” and as such is “immediately turned off” by potential partners who disclose their use of the medication. Given his corporeal framing of HIV as a health hazard associated with sex, Gary views

these individuals as more likely to have an STD/STI.

Several other respondents shared Gary's view of PrEP use as signaling frequent and non-monogamous sexual interaction, though some, such as Nolan and Jackson, mobilized this to the betterment of their romantic relationships with long-term partner. Nolan, the Latino gay man who finds that sex is "too easy" within the gay community, decided to open up his relationship with his boyfriend to include other sexual partners. They sought a PrEP prescription together as a way to protect one themselves and each other. Though they never use condoms when they are alone together, Nolan makes it a point to request his other sexual partners use condoms. Even so, Nolan stated that PrEP gave him and his boyfriend the freedom to have sex with other individuals who may or may not be amenable to condom use "and still feel safe knowing that we won't accidentally infect one another." In this case, PrEP use that is negotiated between individuals can serve to bolster trust and intimacy, as it symbolizes an act of care for the self and for the partner. In a similar case, Jackson, the Black gay man originally from Pennsylvania who considers himself health-conscious, describes how PrEP has helped him and his partner navigate their tumultuous relationship:

We would go through periods of exclusivity and then periods where we wouldn't see each other but would see other guys. When we were together, we stopped taking PrEP. When we'd temporarily break up, we'd get back on it. We were on and off like for a long time.

In this example PrEP served as to delineate the present status of their fluctuating relationship configuration. Jackson said that PrEP allowed them to "continue trusting one another" even in times when they were no longer having sex with one another. For Jackson, PrEP threatened the "intimacy committed partners share" and so was viewed as unnecessary when he and his partner were exclusively with one another.

“I just don't like having to constantly be on the lookout:” Medical Surveillance and Racism

Resistance to PrEP use among Black and Latino MSM can also be understood as arising from institutional and cultural factors that shape their risk perceptions. While PrEP medication such as Truvada is indeed as simple as ingesting a daily pill, adherence to the treatment requires frequent routine visits to primary care physicians to ensure the individual is healthy enough to continue with their prescription. Apart from the discomfort of temporary side-effects many respondents recall enduring after the first weeks of treatment, some like Don find the required doctor visits to be both inconvenient and traumatic:

I've been hesitant to take PrEP, just because of the side effects that it has, because you have to constantly check in with your doctors, get tested and all of that, and it just honestly in a way feels a bit traumatizing to have to constantly be having to check on that, check your health ... You have to get blood tested every three months once you're on the PrEP and stuff, so I just don't like having to constantly be on the lookout and having to go to the doctor a lot because it feels like worrying because it's a lot to deal with when you're busy and also you're just trying to be there and be safe and stuff, so I ended up, after a while I didn't take PrEP.

For Don, PrEP makes HIV out to be an ever more real and proximate risk to his life. The constant surveillance through frequent testing means that Don is always vigilant about potentially contracting HIV, even though the medication significantly reduces the likelihood of infection. This is in stark contrast from Peter, who is a strong proponent of PrEP and also enjoys being able to get tested regularly given how sexually active he is. In Don's case, however, PrEP is not just a matter of taking a pill in the morning and forgetting about it for the rest of the day. It requires that he expend the mental bandwidth to accommodate testing in his already busy schedule, in a city where it can, as Don previously stated, “take months to see a doctor.” Testing for HIV, as prior research has shown, can be distressing for individuals, as it asks that they sit with and confront their fears of possibly testing positive (Blas et al. 2011). Don's sensemaking

already is such that HIV risk is a fixture in his social environment, but taking PrEP would make its presence more visible in his day-to-day life.

Respondents also highlight historical and personal accounts of medical racism and discrimination as major deterrents to PrEP uptake and adherence. A common sentiment across respondent was circumspection about PrEP's potential long-term effects given how relatively new it is. Benjamin, for instance, does not take PrEP because "I just don't like putting things in my body that I don't need...It's not completely innocuous, it can have effects on your body, especially if you're drinking and doing other things." Benjamin has friends who takes PrEP and has witnessed the nausea and other short-term side effects the medication can cause, which is enough for him not to take medication he understands to be unnecessary given his low degree of sexual activity. Some respondents like Nick, however, are averse to PrEP because it brings to mind the legacy of medical racism against people of color in the United States. Nick is a 29-year old Black and Latino queer man who is not a strong proponent of western biomedicine, which he understands to be driven by the idea that every symptom and illness can and must be treated with a pill. Nick does not trust PrEP because he describes "having seen" the impact of relatively new drugs, making explicit reference to the ongoing opioid epidemic, which has ravaged communities of color in his neighborhood. Nick also likens the overt marketing of the medication to Black and Latino MSM to the targeting of poor Black men during the Tuskegee Syphilis Study, one of many historic incidences of racist research practices that inspire ongoing medical mistrust among Black people (Epstein 2007). Nick views seeking HIV-related care as presenting potential threats as significant as those that may come with HIV infection, which speaks to how he incorporates broader structural forces into his risk perceptions.

On a more individual level, many respondents also cite being discriminated against by

primary care physicians and other medical personnel who made acquiring a PrEP prescription difficult. Joe's experiences provide an example of this:

I go to the free clinics, cause I went to my actual doctor and that costs a lot of money. And my doctor ran a whole bunch of tests, that I did not ask for. He drugged test me for a bunch of different drugs. Including cocaine and THC...I was like "I did not ask for this." It was very expensive...It's harder to get it [PrEP] from straight, older doctors cause they don't really know what it is. I've had two doctors say that they didn't know what it was and didn't really feel comfortable prescribing it. And they just assume that you have HIV and they're like, "Oh, I'm not a HIV specialist."

Beyond issues of accessibility and affordability, Joe, a working class Black gay man from Queens, highlights issues that arise from doctors' biases about their patients. The doctor's testing for THC and cocaine during a routine HIV screening without Joe's express consent in particular exacerbated his financial concerns as well as his mistrust in the doctor. Joe also identifies an ignorance about PrEP from other medical professionals, a concern that is shared by several study respondents. A majority of the individuals I spoke to explicitly prefer to receive medical care from medical practitioners who specialize in or explicitly accommodate the needs of LGBTQ people, which can be difficult to find or low in availability. Prior research has shown that positive interactions and communication between individuals and their primary care providers are crucial for the purposes of HIV treatment and prevention, especially for Black and Latino MSM (Crepaz et al. 2007). While knowledge and awareness about PrEP is steadily increasing, it is not uncommon for health care providers to not recommend or prescribe PrEP as an option. That Joe has had doctors assume he was HIV-positive based on his identity also indicates how biomedicine has cemented associations between risk and Black and Latino MSM. Doctors typically look to contemporary research, especially statistical epidemiological reports, to inform their medical practice over time (Altman and Bland 1991). Joe's narrative demonstrates how the disproportionate rate of HIV infection among Black and Latino MSM can affect how doctors

view and subsequently treat such individuals who seek their services.

“The ‘ho’ pill:” PrEP and Promiscuity

While PrEP has played a pivotal part in changing the HIV landscape, it is frequently associated with heightened promiscuity and, consequently, heightened HIV risk that many respondents find to be off-putting. Don, for instance, has noticed an overall decreased worry about HIV among his peers, stating that his friends and partners have become “loose about it.” For Don, despite current advancements making it possible for people living with HIV to lead full and healthy lives, infection is “as big of a deal” as it seems and should not be taken lightly. Don, much like Gary, worries people on PrEP may be having more sex than usual, oftentimes without condoms, thereby increasing their likelihood of infection. Roger expands upon this when he describes PrEP medication as “the ho pill:”

The ‘ho pill, the ‘ho pill that's what it is. Cause people be like, "Oh you smashed my cunt, you let him-" you know all this stuff. “He on PrEP, it's like a hug.” But then even then, you telling me, I'm putting faith and trust that you're actually on PrEP. . . . I think it's great for couples, they're like one person has HIV, and the other one is like, "I'll take this." I think it's perfect for that. . . . But when it's just like, out here popping pills to pop your puss, like. I'm sorry.

Roger has observed his peer groups use PrEP in a way that trivializes the risk of HIV that he associates with sex. Disclosure of one’s prescription is not enough for him to know that he would be safe from the potential of infection, especially when he is seeing an increase in sexual activity among his friends who use the medication. Though Roger sees PrEP as a useful tool for maintaining the health of individuals involved in serodiscordant relationships, he has no intentions of ever taking the medication for himself given its associations with promiscuity. At a time when Roger feels “like the world is set up against” Black and Latino MSM given HIV’s disproportionate impact on this demographic, he worries the promotion of PrEP may do more

harm than good.

Jackson's broader thoughts about PrEP use also sheds light on how the stigmatization of promiscuity has been present within the gay community even before the advent of the medication. Where some respondents worry PrEP may make others less likely to use condoms, Jackson finds that it can embolden a subset of men who have already been having condomless sex:

As much help as it [PrEP] has given the community, it also has exposed, I guess, a pocket of people within the gay community that, it's always been around, but that enjoy bareback sex, and that's fine, and stuff like that. But there's definitely consequences at times from engaging in that, and not knowing, necessarily, what your partners sexual history is, or their health is. Yeah, I just feel like in general, what it's shown is people always asking, "Are you on PrEP," and you know that the subtext of their question is just, "Oh, okay, I enjoy barebacking, that's why I'm asking if you're on PrEP," and everything.

In the above excerpt, Jackson is specifically referring to those individuals who are dedicated to not using condoms for diverse reasons, such as the bareback sex communities discussed in Tim Dean's *Unlimited Intimacy* (2009). What is notable is how the disclosure of one's PrEP taking can serve as an invitation to engage in condomless sex, which Jackson views as conducive to the risk of HIV infection. Certain respondents who held this view noted that PrEP, while highly effective, did not guarantee 100% protection against infection, sometimes citing the few cases in which men taking PrEP still tested positive for HIV (Ryan 2017). A concern therefore arises for these respondents where taking PrEP can be perceived as a kind of risky behavior, despite its uses to reduce the likelihood of transmission. This concern is further bolstered by the fact that PrEP does not protect against other STD/STI, as well as earlier reports on PrEP medication that warned it could lead to increases in STD/STI diagnoses among men who have sex with men in particular (Baeten 2012; Kojima et al., 2016). Recent scholarship, however, has cautioned against taking the claims of these reports at face value, calling for the scrutinization of using

exaggerated or incorrect data that can falsely demonize the populations that have endured the brunt of the HIV/AIDS epidemic (Harawa et al. 2017).

Some respondents like Peter, however, do not necessarily find the promiscuity associated with PrEP as a detriment. In his narrative, Peter brings up the pejorative stereotype of the “Truvada whore,” which describes an MSM who takes PrEP and as a result engages in frequent condomless sex without much caution or care. Peter has been called this term, but rather than take offense, he finds pride in the label because PrEP is his primary means of HIV prevention. Additionally, invoking the stigma frame, he finds that taking PrEP provides a means to talk about and engage in safe sex “without stigmatizing sex without condoms,” nor the people who enjoy condomless sex. For Peter, PrEP facilitates his experience of pleasure and human because it removes the expectation to, as Robinson (2018) describes, “do sexual responsibility,” a type of boundary work involving the sharing of HIV status and preferred sexual practices to filter out potentially positive partners.

In Peter’s mind, PrEP’s association with sex can be mobilized to promote uptake, which he discusses in his comments on PrEP advertisements in NYC:

It [the ad] was literally just someone's tongue and a PrEP pill on it, saying "Swallow this." I think it was so good because it got your attention, and it didn't shy away from it being something that had to do with sex. Because there's been a lot of respectability politics that have come about because of PrEP or whatever. I was like, yeah, this is the ad that says, "I'm taking PrEP because I wanna have sex." I was like, that's awesome, amazing, love it.

For Peter, these advertisements embrace the promiscuity often ascribed to PrEP users, transforming the stereotype of the “Truvada whore” into a reputable image of a sexually active person who is both healthy and responsible. Peter’s stigma framing comes to light here, as his concerns about HIV are exacerbated when his primary means of protection is also being stigmatized. The “respectability

politics” Peter mentions are in reference to discourses in biomedicine and the gay community about PrEP encouraging promiscuity among MSM and consequently facilitating to HIV infection. In Peter’s eyes, however, normalizing this medication has the potential to not only reduce transmission rates across at-risk groups, but also how such a reduction would radically transform what it means to live as a Latino MSM in the United States. In this way, how Peter conveys his stigma framing of HIV when considering PrEP depends on his use of these discourses as sensemaking tools.

Sex

As the narratives of study respondents have shown thus far, HIV is a potential consequence of sexual interactions that they often take into consideration in some form or another. However, their HIV risk perceptions also figure into the purpose they find in sex, as well as the means they go about fulfilling it. In this section, I demonstrate how insights from the REF can offer a deeper understanding of what sex means for Black and Latino MSM, as well as their condomless sexual practices. I argue that an individual’s sociocultural environment is instrumental to the formation of these meanings and how Black and Latino MSM act upon them. I show that while intentions surrounding sex can incorporate some aspects of a rational response to their avowed risk perception, the actual practices that constitute sexual interaction often involve incalculable factors that exist outside of the individual’s control.

Meanings of Sex

Sex can encompass a range of meanings for Black and Latino MSM, many of which are always explicitly tied to HIV risk. When asked to describe what sex meant to them, common themes that arose among respondents’ narratives were pleasure, building connection, and experimentation with the self and others. What counts as sex depends on the respondent, but a

majority described sex as involving different kinds of explicit sexual interaction between the self and one or more sexual partners. Don's description of the meaning he finds in sex serves as an apt example of this:

To feel joy, to get relief out, to have fun, and to get intimate, to know a person better. To know myself better. It's more enjoyable having sex than it is to masturbate ... it's something I could do any day, but sex is more special, because I'm with someone I enjoy being around.

In Don's eyes, sex is special precisely because it is something that is shared with another. The pleasure he finds in masturbation pales in comparison because it lacks the sharing of intimacy that comes with sex. For some respondents, most notably those who grew up in religious households, that intimacy comes to be understood in a decidedly spiritual sense. Some respondents find meanings in sex that reflect the influence of religious beliefs. Religious conceptions of sex are utilized as tools these respondents use to form their personal meanings of sex; these tools draw upon schemata that conceive of sexuality as intrinsic with HIV risk. For instance, Howard, the 28-year-old Black gay man living in Harlem, was always labeled as the "good child" in the family, but this image was partially tarnished once he came out about his sexuality. Howard experienced difficulties with his father's disapproval rooted in religious homophobia and concerns of HIV risk, but in time both his parents came to accept him fully. When asked about his views on sex, Howard's description of sex falls in between the spiritual and corporeal:

Well, to get philosophical, and to get technical, sex is merely a means of procreation...But for me, I think it is the, kind of the highest point of connection you can do with another person... If you're talking to someone, or there's that physical connection there, that lust for someone, it's what you do...Sex is the ultimate form of connection for the physical level. But, relationships are there for the emotional and spiritual.

Howard understands sex to be a form of physical interaction that can lead to pleasure. However,

Howard's perceptions incorporate some religious aspects, insofar that he acknowledges sex as a deeply meaningful form of intimate connection, as well as a means for procreation. For Howard, there is a clear distinction between sex in lust and sex in love, the existence of a relationship being the determining factor. Sex can exist as both a human behavior as well as an act that carries emotional and spiritual significance if it is with an established partner, which echoes religious conceptions of sex.

Roger's narrative, on the other hand, brings to light how individuals can find meanings in sex that exist in opposition to the religious views they were exposed to. Roger, the Black gay man who calls PrEP "the ho pill," highlights how religious conservatism in the Black community has made it such that Black MSM must confront "two layers of shame" because of their sexuality and its associated HIV risk. Despite this, Roger does not necessarily perceive sex to be a shameful act in the way his family does. In fact, Roger and several other respondents who had similar experiences came to understand sex as an innate human behavior that does not carry much meaning beyond bodily pleasure:

See, sex in the real sense is supposed to be having intimate connection between partners. Eh. It is like everything else. Pissing, pooping, sleeping, eating, it's just a normal part of life. This whole thing of I'm waiting till marriage, you know... Sex is gonna be sex... Sex is really supposed be this sacred thing but like -...I'm trying to get these rocks off, we ain't got time.

Here Roger specifically points to aspects of religious conceptions of sex, namely that it is a significant form of connection between partners that is to be reserved after marriage. Rather than adopt these views, he pushes against them and conceives of sex as akin to any other human process. Roger's experiences with his family were formative because they made clear to him how his engaging in sex with men was the root of their issue. Despite this, he takes pride in both his identity and pleasure, which he understands may

be at odds with what his relatives believe.

In a similar case, Peter, the ideal type respondent for the stigma frame, believes that more open conversations about sex for the sake of pleasure itself are necessary to remove the shame and stigma surrounding sex especially for Black and Latino MSM who cannot procreate:

[Sex is] for fun. Another thing is if we actually talked about it. It would help sexual health classes by a lot. It would remove a lot of the shame. Remove a lot of the stigma. Because, literally, we teach to have babies, and if you're not having sex to have babies, then you're not doing it right or for the right reasons. Or it's not because of love. I almost never have sex for love. I don't fucking know any of the people that I fuck mostly, so I don't love you. I don't even know if I like you, as in you're hot and it feels good and it's fun. That's why we have sex...Some of the best sex of my life has been some hot person, don't even know their name, in the club or literally walk in, have sex, boom, walk out.

Peter, like several other respondents, focuses on sexual health education courses as being sites in which respondents realize the sex they engage in is viewed as abnormal and even detrimental to their health. He finds that what he has been taught never accommodated the reality of his experiences with sex, which included experiences with strangers that were devoid of romantic implications. Stigma arises when people do not embrace the pleasure and enjoyment of sex as a valid reason for engaging in it. As analysis of Peter's narrative throughout this dissertation has shown, much of that stigma as it affects Black and Latino MSM explicitly relates to HIV. What Peter understands to be a basic part of being human is, as a result, imbued with fear.

Risk and Prophylaxis

Persistent associations of HIV risk with sexuality have also informed how respondents view sex as a health-relevant behavior. Don, despite understanding sex to bring release and intimacy, also believes that “condoms are a must. It's no glove, no love.” Don's understanding of

sex as requiring the use of preventative tools partly stems from his training as an HIV outreach worker, in which he drew from the biomedical rhetoric to emphasize the bodily risks of HIV transmission through sex. As mentioned earlier in this chapter, Don has begun to notice a decrease in concern about HIV when compared to the initial years of the epidemic. It is for these reasons that Don's intentions involve demanding that his partners use condoms before sex. Don's views are similar to Shane, whose corporeal framing of HIV is reflected in his consideration of sex as a health behavior first and foremost. Shane's upbringing in a family of doctors has exposed him to the biomedical rhetoric of risk, which he uses in his description of the kind of sexual practices he refuses to engage in:

If the condoms are not there, there is no sex happening...I don't have risky sexual behavior practices either...I don't have any unprotected sex. I know all of my partners. I...that's a big one, I know all of my partners. And yeah, I don't have any unprotected sex and we don't exchange fluids and there's no blood.

Shane still finds meaning in the pleasure and emotional connection sex can provide.

Shane, however, requires condoms because he understands unprotected sex as a threat to his bodily health. Shane shares Don's previously discussed concern about an increasing sense of apathy towards HIV that is starkly different from the alarm of at the start of the epidemic. This sentiment relates to their common worry that the existence of PrEP may be downplaying the gravity of the illness, as encouraging condomless sex. As such, even though sex can hold meanings that escape the bounds of the risk of HIV, the existence and use of prophylactic technologies can reaffirm associations between sexuality and risk.

Individuals like Peter, however, have a drastically different view on how PrEP has affected the experience of sex, particularly among Black and Latino MSM. In Peter's view, condoms have existed not only as a reminder of the fear that underlies his sexual

encounters, but also as a physical barrier between himself and the fullness of pleasure he wishes to experience. Peter expands upon this when he describes how the advent of PrEP has granted him, along with other members of the gay community, a sense of liberation:

I don't live in fear. I don't live in fear. That's one of the most beautiful things about it. It's liberating. It's so important to me as a gay man because just as gay men in general, I think we don't have to live in fear of having sex and expressing ourselves sexually the same way that we used to do. The AIDS crisis ravaged the community as far as sexual liberation and sexual freedom. It's just revolutionary in that sense. We do not have to have sex in fear.

Here Peter explicitly identifies sexual liberation as a casualty of the AIDS crisis, something he feels is now being restored due to PrEP. In Peter's view, AIDS changed the way men who have sex with men lived their sexual lives, and now PrEP is offering a means to return to what he views is a more natural state of being. For the gay community, however, Peter's views are controversial as they challenge the idea more sex can lead to greater rates of infection. Peter understands himself and men like him to be viewed as a concern to the broader gay community because their sexual behaviors do not align with homonormative expectations. While the gay community mobilizes the history of HIV in its valuation of prophylactic technologies, it also does so to disparage promiscuity, thereby engendering stigma. Peter laments that "unfortunately risk is used to describe people who have its of sex" and believes there are "better ways to go about" talking about HIV risk, because "nothing is ever changed in positive ways" through stigmatization.

Condomless Sexual Practices

What people say they do, as well as how they think they'll go about it, often differs from what actually happens, especially when it comes to sex. For all of Don's perceptions of HIV risk and his intentions to always use condoms, he, like many other respondents, admits to having had

bareback, or condomless, sex. Recalling the previous section on Don's sensemaking about his relationship to HIV, Don emphasizes several times that sex represents a unique kind of risk that is notably unpredictable. While sex can be planned for and intended to occur in certain ways, actual sexual interaction and the circumstances surrounding it involve a degree of chance and irrationality that can never be fully calculated. It is for these reasons that Don draws a distinction between the times in which he purposefully had condomless sex and the moments in which condom use felt out of his control. In the first case, Don had been with a monogamous partner for a few months who he knew to be HIV-negative, so he felt comfortable with phasing out condom use. In the other instances, however, Don cites a lack of condom availability, as well as an unwillingness to tarnish the sexual experience, as deterrents to his condom use when he states that "...sometimes I don't always bring condoms with me, so I really don't want to spoil the night. That's what happens a lot of times, also, just because sometimes I don't always have and sometimes my partner don't have."

When asked to describe the difference between sex with and without a condom, Don, much like Peter, describes condomless sex as inspiring a greater sense of openness with his sexual partners, "like you're giving yourself more just because there's no barriers in between, even if it is just to protect." Don does not deny the allure of such an experience, hence why he has had moments where sex continued when condoms were not available. Unlike Shane, Don doesn't always bring condoms, and recalling his living situation, it is rare for him to have any prophylactic technologies at home given his family's vigilant disapproval of his sexual. Don's experiences show that just because an individual understands themselves to be at-risk of the bodily and social costs of HIV does not mean they will or are able to act in ways that prevent exposure. In considering the linkages between perception and action, this brings to light the

significance of intentions and how they cannot always be reconciled with the unpredictability of the realized behavior itself.

An individual's assessments of their partners also figure into their decisions to engage in bareback sex. Prior research has shown that MSM are more likely to have condomless sex with partners they are in a serious relationship with, such as what happened with Don when he actively chose not to use condoms with his long-term partner (Mustanski, Newcomb, and Clerkin 2011). What the REF brings to light, however, is how individuals consider the social location of their potential romantic/sexual partners with regard to HIV risk to determine whether or not - sex is "safe." Respondents worried that associations of HIV risk with their race would reduce their desirability. Some respondents, however, made similar assumptions about their partners to ascertain whether or not the person presented a genuine risk of infection. Freddie, the Latino gay man who grew up viewing HIV as a "gay monster," shares an experience of having sex with a man in his neighborhood that highlight this point:

There was this dude who I used to talk to. ...He was a doctor, going into dentistry... And then we were intimate and went to his place. His place was cute, he was really well put together. His place was, he was one of those people who was kind of a neat freak, because everything was in its place ... for that time, that was the time where he was the top and I was the bottom. And that was probably my first time bottoming in 2-3 years, so I hadn't done it in a while. ... It did freak me out a little bit after, 'cause I realized, you know, I was like "Oooh, that was unprotected." And I was like "He's a dentist, he must know about himself." Of course I got tested.

Freddie is someone who considers himself to be "part of the statistic" of Black and Latino MSM who are at-risk of HIV, but at the same time understands that he can lead a full life were he to ever seroconvert. He says HIV is something he doesn't want but also "is not afraid of," because he is aware of prevention and treatment options available. Freddie identifies condoms as his primary means of prevention, despite sharing that he does not actually like using them because of

the discomfort they present. His lack of condom use in his narrative above, however, was less about discomfort and more about his partner's socioeconomic class. Freddie does not mention whether or not an explicit conversation about condom use was ever had, but he does share his internal reasoning that his partner, who is training to be a dentist, must be aware of his health. In this way, Freddie draws upon associations of class and HIV to determine bareback sex as a viable action to take. That he went to get tested after the fact also speaks to his understanding of the self as "at-risk," especially given an instance where his intended actions did not match his realized behavior.

"Chemsex," or the use of opioids and other recreational drugs during sex, is another sexual practice some respondents mention knowing about or engaging in. Peter views chemsex as "a certain way" to have sex and understands it to be wrongly associated with HIV risk, stating that "just because you're having sex on drugs doesn't necessarily mean you have an STD." Peter nevertheless highlights how there is a "big chemsex" problem in the gay community, which is indeed disproportionately affecting men who have sex with men (Mattison et al. 2001; McCall et al. 2015) The practice of chemsex is becoming more commonplace given the rise of online dating services where people can actively look for partners seeking to participate (Race 2015). As several study respondents mention in their interviews, it is not uncommon to hear a potential sexual partner ask if they are into "PnP" or "party and play," a term used to describe the use of opioids during sex. Jackson's narrative in particular illustrates how condom nonuse is typically expected during chemsex:

Well, the meth epidemic is very terrible right now, as well as the GHB epidemic...not enough people are talking about it... Being single in Hell's Kitchen-... it's just like, "Jesus, can't we just have normal sex?"... It's the same people that are asking me, "Are you on PrEP," and I'm just withholding that, 'cause then they're gonna be like, "All right, do you bareback?" Then the next thing they're gonna ask me, "Do you do chemsex," and stuff like that. I think that

they're so, "Those drugs aren't good for you, so we'll put your mind in a place outside of what is healthy," for the most part, and they feel, at times, invincible, and they at times feel that they just don't care. They're just like, "Oh, whatever. Life is life, we're existing, we're gonna have a fun time," and stuff like that.

The discomfort Jackson feels about disclosing his status as a PrEP user is notable. As previously discussed, Jackson finds the sharing of PrEP status to be another way to request bareback sex. Here, however, Jackson shows that it can also signal a request for chemsex, which he believes can inspire a harmful sense of carelessness. Recent scholarship has begun to find correlations between chemsex and PrEP use, supporting what Jackson and other respondents have observed (Drückler, van Rooijen, and de Vries 2017). As the gay community endeavors to distance itself from the HIV epidemic, that chemsex is associated with PrEP, condomless sex, and, by extension, HIV risk can contribute to the social exclusion of respondents who engage in all or some of these sexual practices.

An important aspect of condomless sex that respondents highlight is the significance of internal ejaculation during intercourse. Don and other respondents view ejaculation as a pleasurable “release” that can be intensified when shared with sexual partners. Apart from the pleasure that comes from the experience, ejaculation can also serve as a means of building intimacy and deepening bonds between partners. The desire for such connection can supersede an individual’s intentions to use condoms to prevent potential HIV transmission. This is especially notable among respondents who find a spiritual meaning behind sex. Colin’s description of the sex he has with his boyfriend offers an example of for this:

I think of ejaculation as a release and I think of it as a release of tension and as something that you can't help. So I actually think it's quite beautiful... I'm more a bottom than I am a top with him [his boyfriend], but in either sense whether that's

inside me or inside him I think it's [internal ejaculation] important. I think it's a great connection and I also think ... In a strange way it's ... I don't know, it's not baby making, but...It's kind of this attachment...this mirroring effect of straight people. This is the same action that's happening, and it's the same meaning, it just doesn't have the same result of babies.

Colin grew up in a religiously conservative part of Texas, the effects of which he felt most clearly in school where sexual education was severely limited. Open discussions about sex were rare, and even then, they were relegated to the concept of procreation without explicit detail on how this was achieved. Colin views sex as a form of physical connection with his partners, but internal ejaculation plays a significant role in solidifying their bond. Of note is how he compares this act with the way it occurs within heterosexual partnerships; despite childbirth not resulting from this process, internal ejaculating carries the same weight. His description alludes to the previous chapter's discussion of the mirroring of heteronormative values within the gay community, as well as the influence of religious beliefs about sex. Neither Colin nor his boyfriend are on PrEP, which they mutually decided was not necessary for their relationship. HIV or any other STD/STIs do not come to the fore as immediate concerns for Colin when he practices internal ejaculation.

Internal ejaculation is not a process that is necessarily limited to long-term or monogamous relationship configurations. Several respondents, such as Lucio, find it to be integral to the pleasure they derive from sex with the men, regardless of how long they have known each other. Growing up, Lucio was taught that sex was strictly reserved for procreation, or the act of "extending the Kingdom of God." As he grew into adulthood, however, he came to view his experiences with religion as both traumatic and formative to how he navigates the world as a gay man:

I think [sex is] about pleasure, and I have no shame in saying that...I will never forget when I discovered or came across the word “breeding.” I was 15. And I saw this dude cum in another dude...he didn't pull out and the orgasm looked so much more intense in the video... But I love cumming [ejaculating] inside people. And it's a lot more fun when you're not wearing a condom... For me it was more a feeling thing than meaning, I think. It's like to be fucking someone and have that feel so good and then take it out and put it in your hand. That's the biggest thing for me. I lose something. You know what I mean? It's like whenever I've pulled out to cum it's like it feels a little less good.

For Lucio, sex is primarily about pleasure, and internal ejaculation is part and parcel to that experience. He makes mention of the term “breeding,” which is a colloquial term among men who have sex with men for ejaculating into their partner’s anus. In this way, the pleasure Lucio receives from internal ejaculation does not hold the religious significance of procreation, nor is it centered on deepening a bond with his sexual partners. In considering Lucio’s irrelevance framing of HIV, the excerpt above lends further insight into why he believes himself to be a “fortunate outlier.” Lucio engages in what others would call “risky behavior” but has still managed to be HIV-negative. Lucio’s use of PrEP at the time of the interview was inconsistent because of issues with his health insurance. He has been consistent with HIV testing but never found fears of potential infection to deter him from having sex in the way that brings him the most pleasure.

Respondents also highlight the significance of topping and bottoming when engaging in anal sex. As Don previously mentioned, being the penetrative “top” and receptive “bottom” is often viewed as adopting the role of the man and woman during heterosexual sex, which Don believes can contribute to associations of HIV risk with sexuality. The gay community features a structural support of masculinity that extends into the sexual lives of men who have sex with men, shaping how they conceive of the sexual roles they take on. While several respondents

noted a view of bottoming as decidedly more of a “risky behavior” than topping, these respondents can also find deeper meaning in these sexual practices. Ricky, for example, finds that engaging in anal sex entails straddling the line between power and vulnerability:

I am definitely a top. I have bottomed in the past. It's not something that I actively seek. I've thought about it. It's just that it's still something that's pretty newish for me. I'd like to work towards being vers [versatile; able to both top and bottom]. I just don't ... it can be scary because you really have to know your body...I feel like it's just easier to be a top. There is a little bit of power in it, but I don't necessarily feel very dominant ... You have another person inside of you. I mean it's pretty vulnerable...In society and in mankind, being in that position is... considered weak... you're not in control and it's not masculine.

Ricky's narrative illustrates how an individual's intentions about sex are informed by their sociocultural context in ways that expand beyond individual assessments of a given sexual practice's riskiness. Prior research has shown that men who have sex with men negotiate and exert power during anal sex, both as receptive and penetrative partners (Kippax and Smith 2001). Ricky's description of himself as “definitely a top” illustrates how people can adopt their preferred position as a part of their identity. This is significant given his view of a patriarchal society that ascribes masculinity to being the penetrative partner, which consequently makes those who bottom out to be submissive and vulnerable. Ricky's decision to be a top, then, extends beyond his own personal preferences and reflects an awareness of broader schemata that imbue meaning to this sexual practice. Additionally, part of Ricky's framing of HIV as an irrelevance stems from his identity as a top, because as he mentions that “somewhere along the lines the thought came that you're safer if you're topping.” Ricky recalls only ever bottoming once in his life, which he describes attributes to being inebriated and lacking better judgement. Apart from the discomfort he felt during the experience, the sense of vulnerability is what overwhelmed him, not the potential for HIV transmission.

Some study respondents also highlighted how associations between race and masculinity

can negatively impact the sexual experiences of Black and Latino MSM in particular. Roman's reflections on the sexual propositions he has received on gay dating apps are indicative of this:

There is always this premium put on masc men, or masc-performing men. I'm 6'5, about 230 pounds. I am often solicited by White men who want to have like unprotected sex with me, like do a whole bunch of nasty crap with me. I'm just like, "I don't want this." ... What I will say, either way, is it just seems like whether you're masc or femme, I think black men are always just ... seem to be like somehow put in this category where they're gonna be like most targeted [for condomless sex]... Just like this fantasy of being with a Black or Latino man...people want to replicate what they sometimes see in porn. ... you're watching people's homemade porn and you're just like, "why are y'all having unprotected sex?" Or like, why does it seem all black, male porn stars, who have sex with men, have to have like unprotected sex with men? ... I guess people think that all gay black men are having sex without condoms.

Analysis of Roman's narrative makes clear how sex involves implicit and explicit considerations of HIV risk that are shaped by social forces across the individual's social environment. Roman's words reflect the previously discussed stereotyping and fetishization Black and Latino MSM often face within the gay community, which leads to assumptions of this demographic as being hypermasculine with an insatiable sexual appetite. These views are symptomatic of how race and sexuality are institutionalized in society. In Roman's experience, this translates to White men placing their fantasies about Black and Latino men onto him, which often involve "nasty crap" like condomless anal sex and other sexual practices Roman considers to be "risky behavior." That the "premium put on masculine men" is consequently foisted upon Black and Latino MSM in particular worries Roman, as his dealings with potential sexual partners can come with predetermined expectations of how he is to have sex. As an individual who primarily frames HIV as a risk to his bodily health, Roman describes now having an aversion to anal sex altogether because of these expectations and their potential consequences.

Conclusion

In this chapter, I have provided an articulation of the risk ecology framework. What the REF contributes that traditional risk frameworks do not is a comprehensive consideration of race, class, and sexuality as intersecting social factors that structure individuals' sociocultural context, the types of risks they perceive HIV to pose across ecological scales, as well as the means by which individuals conceptualize and confront these threats. A point I emphasize here and throughout this dissertation is that given the multifaceted nature of an individual's life, coupled with the multilevel nature of their sociocultural context, a comprehensive socioecological approach is necessary to identify how those deemed at-risk are actually navigating the landscape of an illness. Utilizing the REF to analyze a single respondent's HIV risk perception formation illustrates how it is a complex and socially mediated process that involves more than rational calculations of one's circumstances. Black and Latino MSM perceive HIV not as a singular risk, but as encompassing a range of interrelated and hierarchical threats across their social environment. The REF's focus on sensemaking is what allow for a fuller grasp of what people are actually considering when determining HIV's relevance to the reality of their lived experience. The risks HIV can present are not universally agreed upon, but are instead uniquely perceived with respect to a person's experience of their social location. This is made evident by the sheer variations in how individuals draw from their sensemaking tool kit to convey a plurality of framings of HIV.

The REF's utility is exemplified by its clarification of the link between HIV risk perception and health-relevant behavior. Where existing literature has explored why people act in ways that can place them at-risk of exposure, the REF illustrates how it is that people come to view such actions as personally possible and viable. These actions carry significant meanings

that are intimately intertwined with the structural influences of race, class, and sexuality, which is not fully considered by dominant conceptualizations of risk. In public health, for instance, Black and Latino MSM's non-use of the PrEP during condomless sex is considered an "unsafe" health behavior given their categorization as a high-risk group (Storholm et al. 2017). Apart from issues in access to and affordability of PrEP, missing doses or failure to adhere to the medication is attributed to the individual's own assessments of the riskiness of their sexual behavior. The REF adds depth to this perspective by considering the influence of social forces beyond just individual agency. A young Black gay man who perceives himself to be at-risk of HIV's bodily impacts, for instance, may draw upon their friend's experiences and biomedical rhetoric to determine that PrEP would be a viable option. At the same time, he may consider racialized discourses within the gay community about PrEP and stigmatized promiscuity, leading to considerations of the potential social costs of the medication. In the end, that individual may intend to seek PrEP but be unable to do so, as they are under their parents' health insurance; the prescription would inadvertently "out" the person to their religiously conservative family, presenting the threat of experiencing homophobic violence. The medication is also too costly to afford on his own. Underlying all of this are institutionalized inequalities that fashion and are upheld by the same circumstances that prevent this individual from acquiring a potentially life-saving medication.

The REF reveals that health-relevant behaviors like taking PrEP are not just a matter of planning and decision making. Instead, they are a microcosm of the constraints and freedoms individuals are afforded by their social ecology. How people give meaning to their relationship to HIV reflects both their intentions of and ability to seek a PrEP prescription. In the case of sex, the REF makes space for the irrationality of human emotion and unforeseeable circumstances.

Even the most knowledgeable and aware respondents who view HIV as an ever-present threat in their lives have engaged in what is traditionally considered “risky” behavior for reasons that surpass the limits of their agency. In treating sexual practices as neutral actions associated with the phenomenon of HIV, the REF elucidates how HIV risk is only but a portion of the meanings sex can have, and the role sociocultural context plays in imbuing such meanings.

CHAPTER VI

Projected Futures / Possible Realities: Policy Impacts and New Directions

*They're too busy / looting the land / to watch us. / They don't know / we need each other /
critically.* - "American Wedding," Essex Hemphill

In this dissertation, I have demonstrated the real importance of a socioecological framework that places risk in the broader context of people's lives. By focusing on the experiences of Black and Latino MSM in particular, I make significant theoretical and empirical contributions to the study of risk and HIV. The risk ecology framework I advance provides a comprehensive approach for understanding individual risk perception formation. Mobilizing the concept of sensemaking for the analysis of risk perception formation highlights the ongoing retrospective acts Black and Latino MSM participate in that allow them to interpret the reality of HIV risk's place in their life. They understand their place in the contemporary epidemic in starkly different ways because of risk's variable attributes within their resultant perceptions. Shifting focus to how individuals give meaning to their relationship to HIV allows for comprehensive and contextualized examination of the social dynamics underlying illness perception formation. The REF does not incorporate a presumption of risk's presence and, in so doing, enables a refinement of our understanding of risk by highlighting how, why, and in what ways it emerges. HIV's transition from terminal to manageable chronic illness over the last several decades provides a fruitful case for articulating this approach's applicability to other communicable diseases whose landscape is liable to change over time.

The REF clarifies how people bring in not only considerations of the risks associated with their conduct, but also an acknowledgement of a risk ecology embedded throughout their sociocultural context. Risk is conceived not as a singular, undeniable reality of disease, but

instead as encompassing a range of threats individuals perceive that pertain to associations between the disease and their social locations. Race, class, and sexuality therefore exist not just as constituent components of an individual's lived identity, but as social factors foundational to the ecological influences that shape how and why they view an illness to be relevant to their lived experience. In this way, the REF underscores how risk perception is a socially mediated process that extends beyond individual rational agency, making possible a more complete accounting of the relation between perception and action.

In Chapter I, I highlighted the enduring significance of risk in sociological analyses of health and illness. I focused specifically on the insights the sociocultural approach to risk has provided for understanding how people perceive and navigate health hazards in their life. In so doing, I also note areas in which this theorization can be bolstered, bringing into view the lack of sociological perspectives on risk perception formation. Given what is now known about how illnesses like HIV are experienced in drastically different ways due to fundamental causes like racism and socioeconomic status, addressing this gap in the literature necessitates a comprehensive consideration of social location that extends beyond the purview of the individual. In response, I introduce and outline the REF as a means to address this need in scholarship at the intersections of risk and health. Socioecological in its analysis, the REF synthesizes insights from Bronfenbrenner's ecological model, Douglas' sociocultural approach, and Weick's sensemaking theory to elucidate how people arrive at personal understandings of what it means to be at-risk of an illness.

In Chapter II, I documented and analyzed the HIV risk ecology Black and Latino MSM perceive, which deepens sociological understandings of how people may be navigating HIV today. The corporeal, social, and irrelevance frames represent the core patterns of thought that

govern respondents' sensemaking about a contemporary epidemic that has changed drastically yet retains much of its social and biological impact on society. The findings extend beyond considerations of how people reckon with their ascribed at-risk status. Black and Latino MSM arrive at and make use of these frames for themselves in ways that reflect the particularities of their lived experience and sociocultural context. As such, it is impossible to align a certain combination of race, class, and sexuality with specific framings of HIV, but it is possible to anticipate the potential composition of perceptions that may arise among hard-hit communities. The existence of an irrelevance frame in particular illustrates how the changes in one's sociocultural context, along with shifts in the disease landscape itself, can lead to unexpected developments in the kinds of perceptions people can hold. The respondents who understand HIV to exist outside of the realm of personal impact do so as a result of how they understand their lived experience to interface with what they know of HIV as a manageable chronic illness.

How a person gives meaning to their relationship to HIV suggests that there are other social forces that extend beyond the individual sphere. In Chapter III, I highlight how friends, family, and romantic/sexual partners are influential in Black and Latino MSM's risk perception formation. An individual's conversations and other shared experiences with these people can serve as sources of HIV-relevant knowledge that informs how an individual understands their social location to associate with HIV risk. These relational interactions also shape what individuals understand HIV as potentially threatening, such as their standing with relatives or their desirability to potential romantic/sexual partners. In Chapter IV, I showed how individuals and the people in their lives derive their sensemaking tool kit — that is, beliefs, rhetoric, and discourses concerning HIV risk — from religion, biomedicine, and the gay community. These cultural resources reflect how race, class, and sexuality function as social institutions in society. I

demonstrated how culturally available schemata constrain and enable behavior for Black and Latino MSM that emphasize how being HIV positive can lead to experiences of social exclusion grounded in homophobia and racism.

Chapter V exercises the REF's capacity to direct the multilevel analysis of risk perception formation by focusing on the narrative of one respondent. This articulation serves as an example of the breadth of insight to be gained from a socioecological approach. Centering on the link between perception and behavior, I underscore how understanding the origins of risk perceptions clarifies the significant difference between intended and realized actions. How people give meaning to their relationship to HIV relates to how they give meaning to their use of preventative tools and engagement in sex. However, this does not necessitate that certain perceptions neatly map onto certain behaviors. Analysis of respondent narratives reveals that health-relevant behaviors contain a degree of uncertainty, circumstance, and emotion that can never be fully cognized until they are experienced.

The socioecological approach I outline here is not without its limitations. Given the significance of race, class, and sexuality, the REF can be further developed by adopting a more deliberately intersectional approach to its analytical strategy. Race, class, and sexuality arise from the present analysis as important axes of comparison at the center of risk perception formation. Though I do emphasize similarities and differences between respondents, such as how Don and Shane possess similarities in their framings of HIV despite starkly different class difference, a more systematic intersectional perspective can highlight how an individual's positionality in a social context is shaped by the intersections of their social location (Crenshaw 1989, 1991). Sociological literature on identity has employed the intersectionality framework to show how members of social groups can have distinct experiences of social inequality due to

intertwining vectors of disadvantage associated with their social location (Goldberg 2009; Collins 2015). Incorporating intersectionality can generate further contextualized insight into the ways in which identity drives interpretation, as well as the scope of perceptions that result from this sensemaking process.

Nevertheless, the risk ecology framework serves as a significant expansion of existing sociological risk research in matters of health. Beyond the case of Black and Latino MSM's HIV risk perception, this framework offers an adaptable socioecological approach that broadens scholarly understanding of how people confront the innumerable uncertainties surrounding illness and disease. Much of the theorization in this area has centered its attention on examining people's engagement in behaviors that have the potential for harm. Recent research on social risk, for instance, has highlighted the interactional and institutional factors underlying the social reasons why people make decisions that may negatively affect their individual well-being (Khan et al. 2018), emphasizing the necessity of a broader ecological approach. The risk ecology framework takes up from this work by shifting its focus away from health-relevant behaviors and towards perceptions about associated health phenomena. Where the conventional risk framework provides a means of understanding how people give meaning to their actions, the risk ecology framework adds a means of comprehending how individuals arrive at the preceding perceptions that made such actions seem like viable or possible choices.

New Directions: Other Populations, Other Pandemics, Other Phenomena

A central motivation for this dissertation was to understand the experience of being at-risk of an illness and what that can tell us about health inequality. In selecting the strategic case of HIV and its historic disproportionate impact on Black and Latino MSM in the United States, I

did not seek to explain nor uncover the causal roots of this disparity, but rather begin an inquiry into why it can still persist after so many decades of progress. While statistically determined at-risk categorizations convey likelihoods of infection, the ascription of this label cannot measure the fullness of life for those who fit the demographic profile. In fact, such categorizations can inadvertently presume a homogeneity of experience among those deemed to be “at-risk,” with facets of identity like race and sexuality being reduced to risk factors. Given the moral debates in which HIV is embroiled, this can also potentially fuel harmful notions about identity and behavior that do not accurately capture the social origins of vulnerability. While public health approaches that operate from this perspective have been instrumental in the development of targeted health policy and interventions that serve hard-hit communities, it is clear that further contextualization is needed.

The REF stands to offer that contextualization. By analyzing how Black and Latino MSM form their risk perceptions, it becomes clear that race, class, and sexuality are more than just calculable risk factors. They are expansive social factors that organize how individuals experience life itself, including the ways in which they conceptualize and confront the uncertainties of health and illness. In looking to the ways in which Black and Latino MSM give meaning to their relationship to HIV, it becomes clear that risk is not inherent but rather a potentiality that is cognized with respect to the experience of race, class, and sexuality. Understanding this helps to explain how seeking affordable and accessible preventative care can still be difficult for certain groups in well-resourced places like New York City. Don’s experiences, for instance, show how a PrEP prescription can protect him from the bodily risks of HIV as much as it can expose him to family violence rooted in religious homophobia. These insights apply to all other populations affected by HIV in the United States as well. Race, class,

and sexuality are a part of social locations of all people, not just Black and Latino MSM, and so their significance still holds. What is likely to differ, however, is the ways in which social location matters across different demographic groups. Black women, another group disproportionately affected by HIV, may be considering a different set of threats not captured by the ecology of risks discussed in the present work. Future research that applies the REF to highlight these differences can help to unpack the enduring nature of HIV disparities.

The REF can be applied to the context of other infectious diseases as well, such as the ongoing global COVID-19 crisis. Sociological research on the topic is presently limited to early analyses and working papers, such as one study examining the causal relationship between recommended public health measure of “social distancing” and the spread of the virus (Sharkey and Wood 2020). Such work is crucial because while epidemiological research has helped to map the pandemic and shape responses to it, social scientific research is necessary to model what Sheila Jasanoff describes as “the social consequences of the preventative measures we’re taking” (Arjini 2020). A cursory glance at news headlines can already begin to hint at what a COVID-19 risk ecology might look like. The REF can aid in understanding the micro, meso, and macro forces that affect how people perceive and, consequently, confront these risks during a period of immense uncertainty. For instance, the impact of COVID-19 in the United States is most noticeable in low-income minority communities, such as in New York City where working-class Black and Latino people account for the majority COVID-19 related complications and deaths (Mays and Newman 2020). A troubling corollary is that social distancing measures have been unequally enforced by state and municipal governments, replicating racial and social inequalities such that this population also accounts for the overwhelming majority of social distancing arrests (Bates 2020; Wilson 2020). Long-standing socioeconomic gender-based disparities are also

currently being exacerbated, with women who already earned less than men losing employment or being tasked with simultaneously managing work, homeschooling, and childcare (Lewis 2020). For Asian-Americans, wearing a face mask outside can mean the difference between health or harm, not only due to the potential for COVID-19 exposure, but also because of the rise in hate-crimes against this population due to racist notions of the coronavirus' origins (Cheng 2020; Russell 2020). A risk ecology-based analysis of these and other related cases can illuminate how social distancing and face masks carry starkly differently implications for people that reflect how they make sense of COVID-19's place within their lifeworld. By bringing focus to the importance of social location, the REF can help to uncover the breadth of perceivable threats COVID-19 can present to and beyond the body.

The REF is also potentially useful outside of the domain of health and illness. As future occurrences and outcomes can never be fully predicted with absolute certainty, risk is present in nearly every aspect of everyday life. Risk, however, possesses greater relevance for phenomena associated with considerations of potential benefits and detriments. Debt is one such risk-related phenomena that many in contemporary United States society are deeply familiar with in a variety of contexts. Sociological work conceptualizes debt in relation to socioeconomic risk, centering on "risk-taking" actions, such as lending and borrowing, as well as the social dimensions of related inequalities (Addo, Houle, and Simon 2016; Wherry, Seefeldt, and Alvarez 2019). Attention, however, should be paid to how people are giving meaning to their relationship to the object associated with debt. There may be differences, for instance, in how people from varying social locations perceive homeownership as a possibility in their lives. Taking out a mortgage consequently may or may not be a personally viable option individuals are aware of due to ecological influences of their social environment. Homeownership may not be inherently

perceived as a socioeconomic risk for some, or it can encompass a variety of threats beyond financial strain, such as mental distress associated with the burden of debt (Selenko and Batinic 2011). Application of the REF can may uncover the types of risks homeownership can represent, as well as how and why individuals perceive them as relevant threats.

Health Policy Implications: Risk Ecology-Based Interventions

The day that I began my participant-observation work with Qatalyst, a health advocacy group organized by and for gay men, I was immediately recruited to assist with the organization's big annual summer event: the Qatalyst Fire Island Weekend. Every year, Qatalyst invites all of New York City's gay community, especially MSM of color, to a free weekend of entertainment and relaxation. The only thing attendees had to pay for was the price of the ferry fare. Held in in the first week of August, the event aims to foster new friendships and connections around open discussions concerning gay men's health. From Friday through Sunday, the Qatalyst Fire Island Weekend featured pool parties, fitness classes, and brunches, all which featured some informative component that related to health and well-being. All events take place at Qatalyst House, a lavish seaside property with a private beach boasting an open-bar and full-service catering. Beyond Qatalyst's volunteers and affiliates, anyone who had received a direct invitation, signed up via social media advertisements, or heard about the event through a friend were all welcome to attend.

In the preparatory phone conference that preceded the weekend, I was informed that I would be participating in a panel during Sunday's brunch. I got to meet my co-panelist, a nurse named Tom. According to Miguel, Qatalyst's president and brunch event organizer, our task was

to lead a discussion with attendees about anal sex and health. Part of Qatalyst's mission is to break the stigma surrounding issues of sexual health, and this event in particular sought to highlight the discomfort gay men have when speaking about anal sex. Tom was to provide practical medical knowledge surrounding safe anal sex practices, while I was tasked with explaining the social dimensions of the stigma surrounding the subject.

When I arrived at Fire Island, I followed Miguel's directions and after a ten-minute walk came across a white cement facade with two golden lion statues at the sides of a door. Unsure if I had reached the proper address, I called Miguel who almost instantly greeted me at the door. The external boardwalk continued into the house's private garden, complete with a small pond, fountain, and a garden with flowers and shrubbery. Miguel explained that I had come at the perfect time; Qatalyst volunteers had also just arrived and were in the midst of preparing for the brunch. Miguel summarized the day's scheduled events for me as we walked further into the garden until we reached the house itself.

A two-story building with a roof deck, in-ground pool, and personal beach, Qatalyst House was both large and inviting. Volunteers were busy setting up tables and seats, laying down tablecloths and preparing Qatalyst-branded drawstring bags filled with "goodies" for attendees, such as water bottles, pens, and condoms. Miguel stated that "this is how we get everybody informed, we want to keep it fun and sexy." He explained that even the previous night's pool party required that attendees visit the local 24-hour health clinic on the island in order to get an entry ticket, just so that people were aware of their services should they need them during their stay. Raymond, another lead organizer for the event, stated that "we know people come here to have sex, to have fun, that's the whole point, so we don't deny that. We like that actually, we're super sex positive."

After setting my things down, I assisted the event organizers by helping set up the tables and place goodie bags. Eventually attendees began arrive in steady waves, with about 40 or so people staying for the brunch and panel. At one point all the tables were filled with attendees who were busy talking to one another over drinks. A majority of the attendees were men of color, mostly Black and Latino. No women were in attendance, but Miguel mentioned that several of their friends had attended during the previous events that weekend. Some people came in groups as friends but had never been to a Qatalyst event before. One group of men I spoke to consisted of a couple and their mutual friend. They told me that they lived in Harlem but that this was their first time ever coming out to Fire Island. They heard about the event through social media and mutual friends, and were familiar with the Qatalyst name but not necessarily the work they did. They just knew there was a “fun free beach weekend event going on” and took them up on the opportunity.

Eating, dancing, conversing, lounging, and of course swimming were all activities that took place during the brunch. While leisure and play were emphasized, a closer examination of Qatalyst House and the event space they created revealed their central goal raising awareness about STD/STI treatment & prevention among men who have sex with men. Beverages ordered at the bar, for instance, were accompanied by napkins sharing facts about PrEP medication and a hotline number to learn more about affordable prescription options. Place settings at every table came paired with condoms, lubrication, and an informative pamphlet on safer sex practices. Beside the utensils sat laminated flyers on the do’s and don’ts of drug use, consent, and safer-sex practices. Jokes and platitudes shared by the host would include references to using condoms and getting tested. A large banner strewn about the rear of the house’s rooftop showcased almost-naked men of different shapes, colors, and sizes, either posing alone or intertwined with one

another. The words “Qatalyst NYC is building an aware community” are emblazoned just above the photographs, followed by messages of racial inclusivity, body-positivity, and overall sexual health and well-being. More than just a summertime escape from the demands of city life, the Qatalyst Fire Island Weekend is a concentrated effort to embrace the levity and pleasure into topics that are often fraught with discomfort and anxiety.

After some time, Miguel called me and Tom over to let us know that the panel would be starting soon. The event organizers began an icebreaker they titled “Bottoms Up” where a prompt was given and attendees were to flip a sign in response. For example, a prompt would be “I like to have anal sex” and all the attendees flipped their signs to say “bottoms up” or “bottoms down.” Other prompts included “I’m into threesomes” as well as “I know what an anal pap smear is / I have had one done before.” These health-centric prompts led into the actual panel presentation itself. Tom began by giving an overview about what an anal pap smear entails, which led into a short presentation about the STDs/STIs people are prone to when engaging in anal sex. I would step in throughout to answer questions concerning the social aspects of the topics Tom discussed. For instance, one attendee asked me why I thought there was such a stigma around anal health. In response, I led a conversation on homosexuality and religion, the conflict between competing views of cleanliness and profanity, and how social condemnations of “bottoming” and its associations with weakness reflected patterns of misogyny within and outside of the gay community. Tom also gave practical advice, such as how to find the right doctor, and also spoke on recent research that showed that people with undetectable viral loads could not transmit HIV to a partner.

An hour into the panel, many more attendees began to ask questions, creating an open discussion about topics that, as one attendee put it, “were never openly talked about like this

before.” People had questions about the safest way to have sex when using drugs, if there’s anything that can be done when not wanting to use condoms, and the viability of PrEP as a preventative tool. One attendee openly shared his HIV-positive status and offered his insight on how using condoms and PrEP has allowed him to maintain intimacy with sexual partners. The event was succeeding in its central goal: increasing sexual health awareness among gay men, but in an engaging and inclusive way. Once the panel concluded, Qatalyst organizers reminded everyone of their upcoming events for the fall season. Qatalyst’s Fire Island Weekend exists as a prime example of the kind of innovations Black and Latino MSM are deploying in their organizing around HIV as it exists today. On my way back to the ferry, I reflected on just how much has changed since the inception of the epidemic, and was hopeful that the work of Qatalyst and other community-driven organizations could continue to lead the efforts to end HIV and its associated inequities.

When I first decided to incorporate participant-observation in my dissertation research, my original goal was to supplement the interviews with ethnographic data that could better portray how Black and Latino MSM were making sense of HIV among themselves. During my concurrent data collection and analysis, however, it became clear to me that the events Qatalyst hosting were similar to what I imagined risk ecology-based interventions could look like. Qatalyst prides itself in taking a “holistic” or comprehensive approach to the health and well-being of the gay community it serves. One of the REF’s central contributions is the attention it brings to how illness is felt across an individual’s social environment, not just their immediate experiences. As analysis of interview data showed, there exists a stigma around anal sex due to its associations with HIV risk. The Qatalyst Fire Island Weekend panel tackles this in its focus on

breaking the stigma surrounding anal sex in hopes of inspiring open communication and safer practices. With anal sex being one of the primary methods in which HIV is transmitted, Qatalyst's event was an HIV-centered intervention disguised as an entertaining beach getaway.

Qatalyst does the typical work of raising knowledge and awareness about HIV treatment and prevention, but it is also unique in how deliberate it is about engaging with the structural forces that can facilitate vulnerability of exposure. One of these issues is the fragmentation of the gay community due to differences in race, class, and HIV status. Regardless of the particular topic of focus, every one of Qatalyst's events is designed to bring people from diverse backgrounds together under the common desire of improving well-being as a unified community. The Fire Island event is particularly impactful in this regard, given its lasting reputation as "the summer capital of homosexual America" which "continues to shape the public image of what it means to be gay: white, affluent, socially exclusive..." (Koppelman and Forman 2008:12). One organizer I spoke to mentioned how this weekend was the one time in summer where Fire Island was decidedly more racially diverse than usual. Qatalyst focuses on health as a grand unifier and emphasizing how all MSM can be affected by HIV but in ways that are presently unequal. As an organization with no physical home or central location, Qatalyst is reimagining NYC's gay community with every venue that houses its events and, in doing so, fostering inclusivity.

Risk ecology-based interventions should be focused on addressing the myriad threats individuals perceive in relation to HIV, but may not be as immediately noticeable. They should also function with respect to the ecological origins of these threats. This approach can offer crucial contextualization for HIV-prevention programs that, as Carrillo and Fontdevila (2014) note, treat their targeted populations as monolithic groups without accounting for the within-group diversity of their experiences. Don's narrative, for instance, highlights the significance of

maintaining familial ties, which seeking HIV care can potentially jeopardize. Many present HIV-related initiatives draw from the existing public health model in their goals to make treatment and prevention more affordable, available, and accessible. Such programs conceive of the individual as a deliberate actor who is inherently at-risk and, were they to have the resources they presumably lack, would behave in expected ways of reducing the likelihood of HIV infection. While this has been effective to some degree, the persistence of HIV disparities suggests there is a need for additional solutions. For Don and others like him, one option could be to have health policy support programs that actively teach family members how to support their relatives who may benefit from prevention. Apart from ensuring that the burden of confronting HIV does not fall on the individual alone, such an initiative could help relatives ameliorate Black and Latino MSM's capacity to seek care. In times as uncertain as these, the risk ecology framework may support the scholarship and policy necessary to make health equity an achievable reality.

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Appendix A – Semi-Structured Interview Logistics

Interviews with respondents were audio-recorded and were typically 60 to 90 minutes in length. All personal identifying information was removed from the interview transcripts and pseudonyms were given for every respondent. At the end of each interview, I exited the room and had respondents fill out a questionnaire that captured their demographic information and recapitulated their responses to certain questions from the interview. I wrote brief post-interview notes to summarize and describe the overall feel and experience of the interview, as well as my observations about the respondent's appearance and tone of voice. I also accounted for reflexivity by taking note of how my demeanor, self-presentation, and other affects may have shaped the conversation so as to improve future interviews. All participants received a \$15 gift card upon completing the questionnaire. Respondents also provided referrals to facilitate sampling and recruitment, thereby increasing access to individuals who may not notice or be compelled to respond to publicly placed flyers. Respondents facilitated the initial contact between myself and their referrals. Prior research on homophily has shown that while individuals are likely to know others of similar demographic background, there is still a notable potential for substantial variation among members of their social network (McPherson et al. 2001). As such, this respondent-driven sampling allowed for the recruitment of participants with greatly varying backgrounds and experiences.

The interview began with a general discussion of the respondent's background and interests, which I would then relate to my own. Participants were asked to introduce themselves as they would to someone they were meeting for the first time, with further probe questions regarding their employment, education, and their current living situation. For respondents who had spent a significant portion of their lives elsewhere or had recently moved to New York City,

probe questions were asked to explore their prior experiences and reasons for moving. The interview then moved onto the aforementioned sections of inquiry generally following the listed sequence, which contained questions of increasing level of potential discomfort or distress due to how sensitive they are in nature. For certain respondents who were more readily comfortable, the semi-structured nature of the interview allowed for deviation from the established order so as to accommodate deeper discussions of relevant topics that arose.

The open-ended questions about social and family life asked respondents to describe their relationships with friends and relatives, as well as how and with whom they liked to spend their free-time outside of work or school. The questions regarding the facts of HIV and prevention were designed to be more structured in order to gauge the respondent's degree of knowledge and awareness. These were followed by a broader discussion of the epidemic in the United States using data points from recent epidemiological reports from the CDC as talking points. The open-ended questions in this section of the interview were designed to motivate contemplative thought about the notion of risk itself, the complexities of the HIV lived experience, and how the respondents understand themselves to be personally affected. Probe questions further explored recurrent topics whenever they emerged during the course of the interview. The interview schedule was routinely updated to include novel probe questions and sub-topics that frequently arose during previous interviews. To protect the respondent's well-being, each interview concluded with a conversation about their hopes and dreams for the future, both in relation to the HIV epidemic and their own personal goals. This discussion provided further insight into the respondent's lived experience while also imparting a sense of levity to disperse the otherwise difficult emotions that typically characterized the later portions of the interview.