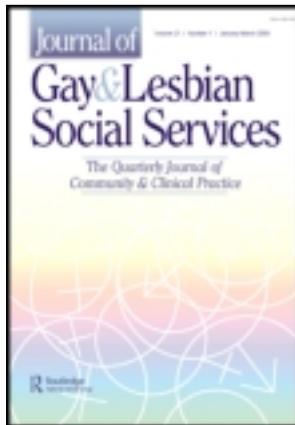


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Past Present: Discordant Gay Male Couples, HIV Infection History, and Relationship Dynamics

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Past Present: Discordant Gay Male Couples, HIV Infection History, and Relationship Dynamics

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Discordant couples are unique because partners do not share the same serostatus. Yet research overlooks how they became discordant, mistakenly assuming that they have always been that way and, by extension, that being discordant impacts the relationship in a similar manner. This study examines HIV infection history and its impact on relationship dynamics using qualitative data from 35 discordant gay male couples. Most couples were discordant when they met (69%); however, many were not (31%). Those couples that met discordant felt being discordant had a lesser impact on their sexual and relational satisfaction, while those that did not meet discordant felt it had a greater impact, reporting sexual frustration and anxiety over seroconverting. This suggests that relationship dynamics may differ for discordant couples depending on HIV infection history. HIV prevention and counseling services for discordant couples can be better tailored and more effective when differences in HIV infection history are recognized.

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KEYWORDS *discordant gay couples, disclosure, seroconversion, relationship dynamics*

INTRODUCTION

Unlike concordant negative and concordant positive couples whose partners are the same serostatus, discordant couples are unique because partners do not share the same serostatus: one partner is HIV-negative, the other HIV-positive. This difference is the focus of research that examines the effect being discordant has on gay male couples; however, this literature overlooks how couples become discordant and mistakenly assumes that they have always been that way and, by extension, that being discordant impacts the relationship in a similar manner. This potentially masks important differences between couples that have always been discordant and those that have not.

Previous research involving discordant couples clusters around two outcomes: the impact of discordancy on sex and the impact of discordancy on relationships. The first area of inquiry, the impact on sex, focuses predominantly on HIV, as discordant couples are at increased risk for HIV transmission from one partner to the other when they have unprotected anal intercourse (UAI) together (Bouhnik et al., 2007; Prestage et al., 2008). Despite the potential risks, studies show many discordant couples choose not to use condoms because of the sexual and relational barriers condoms represent (Davidovich, de Wit, & Stroebe, 2004; Moreau-Gruet, Jeannin, Dubois-Arber, & Spencer, 2001; Palmer & Bor, 2001; Remien, Carballo-Dieiguez, & Wagner, 1995). Instead, they negotiate safety agreements to reduce their risk, such as agreeing to have sex only when the HIV-positive partner's viral load (VL) is undetectable (Beougher et al., 2012; Prestage et al., 2009; Van de Ven et al., 2005). This, however, may be an unreliable strategy for determining how risky (or safe) a given sexual behavior may be, as actual and perceived VL can differ (Guzman et al., 2006; Hallett, Smit, Garnett, & de Wolf, 2011; Remien, Halkitis, O'Leary, Wolitski, & Gomez, 2005; Stolte, de Wit, van Eeden, Coutinho, & Dukers, 2004). Continuing with the same example, without adequate VL testing (current guidelines recommend every three to six months), discordant couples may make decisions that could directly affect the HIV-negative partner's health based on inaccurate or out-of-date test results (Hallett et al., 2011). Studies also show that men with favorable perceptions of their VL (i.e., they feel healthy and assume that it is undetectable) may have detectable VL. In other words, their perceived VL does not necessarily correlate with their actual VL, which only tests determine (Stolte et al., 2004).

The second area of inquiry, the impact on relationships, includes how discordant couples cope with the health-related and interpersonal challenges

HIV presents. Many HIV-negative men, for example, help their HIV-positive partners adhere to their antiretroviral therapy and monitor its side effects (Wrubel, Stumbo, & Johnson, 2008). Being discordant also impacts relationship dynamics by acting as a barrier to sexual intimacy and to sexual and relational satisfaction (Palmer & Bor, 2001; Remien et al., 1995; Remien, Wagner, Dolezal, & Carballo-Diequez, 2003). This may explain why many discordant couples rate their agreements about sex (e.g., whether they allow sex with outside partners) lower than other couple serostatus groups (Hoff et al., 2009). Research has shown that discordant couples report open agreements (i.e., agreements that allow sex with outside partners) more often than concordant negative or concordant positive couples (Hoff et al., 2009). Allowing sex with outside partners may be how some discordant couples reconcile their sexual frustration, as fears of transmitting HIV eclipse the partners' desire to have UAI with each other (Adam & Sears, 1994; Palmer & Bor, 2001).

A final area of inquiry that is unrelated to the outcomes just discussed, but has important implications for couples, involves the disclosure of HIV-positive serostatus to others. Some of this research addresses disclosure within relationships. For example, HIV-positive men are more likely to disclose to their primary partners compared to casual partners (Hays et al., 1993; Stirratt, 2005). HIV-positive men report a duty to inform as well as the need to establish trust and build intimacy as reasons for disclosure to primary partners (Derlega, Lovejoy, & Winstead, 1998; Derlega, Winstead, Greene, Serovich, & Elwood, 2002, 2004; Simon Rosser et al., 2008; Stirratt, 2005), which suggests disclosure plays an important role in relationships. Presently, however, there is little consensus as to how disclosure affects UAI. Disclosure has been linked to less UAI if the partner is known to be HIV negative, if the HIV-positive partner attends preventive counseling, or if consistent disclosure is normative (Bird, Fingerhut, & McKirnan, 2011; De Rosa & Marks, 1998; Parsons et al., 2005; Simon Rosser et al., 2008). Other researchers have failed to find any connection between disclosure and UAI (Crepaz & Marks, 2003; Cusick & Rhodes, 1999; Sullivan, 2005). Instead, it may be that disclosure has more to do with laying the foundation for a healthy relationship than with having safer sex. Regardless, the effect of disclosing to primary partners on relationships is important.

While these studies provide an increasingly detailed and comprehensive view of HIV's impact on discordant couples, none examine HIV infection history in relation to the partnership—that is, how a discordant couple becomes discordant. As a result, the analytical focus remains confined to the here-and-now, ignoring the past and any influence it may have on the present. Examining HIV infection history allows for a deeper understanding of why HIV risk and relationship dynamics for discordant couples may look the way they do. This study explores this history. Its aim is to uncover the different HIV infection histories of discordant couples and examine their

effect on HIV risk and relationship dynamics in order to provide further insight into HIV's impact on discordant couples and better tailor support for this population.

METHOD

This analysis utilizes qualitative, semistructured interview data from 35 discordant gay couples. The data came from three samples of discordant gay couples ($N_1 = 12$, $N_2 = 13$, $N_3 = 10$; $N = 35$). Each sample was collected at a different time: Sample 1 in 2002; Sample 2 from 2007 to 2009; and Sample 3 in 2011. Each sample belonged to its own larger, qualitative study of gay couples ($N_1 = 39$, $N_2 = 40$, $N_3 = 20$), with Studies 1 and 3 being independently recruited and Study 2 being a randomly selected subsample of a larger, quantitative study of gay couples, which was also independently recruited ($N = 566$; for more information about the selection criteria of this subsample, please see Beougher et al., 2012).

Our justification for pooling all three samples of discordant couples for this analysis is threefold. First, each study's methods were the same (further methodological detail is provided next). Despite data collection spanning nearly a decade, all three samples were recruited from the San Francisco Bay Area; conducted using the same recruitment, data collection, and analytical methodology; and executed by the same study team. Furthermore, each study constituted a separate phase of the same, ongoing, long-term study of gay couples (called The Gay Couples Study), the overarching objective of which is to examine relationship dynamics in gay male couples and their relationship to HIV risk behavior with primary and outside partners. Second, there were no meaningful differences in participant demographics across the three samples (further detail regarding participant demographics for the pooled sample is provided in the Results section). For each study, the mean age was 39 (range: 21–63 years), 47 (range: 21–70 years), and 35 years (range: 21–53 years), respectively, and the mean age difference between partners was 8 (range: 0–26 years), 9 (range: 1–27 years), and 5 (range: 0–21 years), respectively. The mean relationship length for all three studies was 7 years (Study 1 range: 5 months to 27 years; Study 2 range: 3 months to 34 years; Study 3 range: 3 months to 17 years). Note: Mean age and age difference between partners was lower for participants in Study 3 because recruitment efforts targeted younger men to balance out the older men from Studies 1 and 2. The racial/ethnic makeup of each sample was also similar (i.e., the ratio of White men to men of color was approximately the same); as was age and age difference between partners relative to whether couples met discordant or not; relationship length, HIV infection history, and reported relationship dynamics; and finally the age difference between partners and HIV status (i.e., the number of couples for which the older

partner was HIV positive was equal to the number of couples where the older partner was HIV negative; in several couples the partners were roughly the same age). Third, and most importantly, the point of analysis—HIV infection history for discordant couples—is an event that occurred in the past for each couple (i.e., participants discussed what had already happened) and remains unchanged by “present” events, such as the interview date or the time elapsed over data collection from study to study.

Our recruitment strategy was designed to produce a sample that reflects the diversity of the San Francisco Bay Area in terms of race/ethnicity and HIV status. Field research staff reached participants by handing out cards advertising the study at social venues, such as bars and cafés; community venues and events, such as nonprofits and sports tournaments; and at health and HIV/AIDS service organizations, such as hospitals, clinics, and social support groups. When unable to do this in person, field research staff left cards and hung flyers. They also recruited participants through advertisements in print media and online.

Those interested called a toll-free hotline for more information. Callers were screened over the telephone for eligibility. Eligibility required that participants be at least 18 years old, be in their relationship at least 3 months, and know their own and their primary partner’s HIV status. Couples that gave discrepant reports of partner HIV status and couples in which either partner identified as transgender were ineligible. For Study 3 only, eligibility criteria narrowed, excluding concordant positive couples so that resources and efforts could be focused on couples for whom HIV transmission within the relationship was a present, as opposed to a past, concern. Couples were eligible to participate if both partners met all eligibility criteria.

Couples were given scheduled appointments for 60- to 90-minute semistructured, qualitative interviews. All interviews were conducted in downtown San Francisco and informed consent was obtained from each partner before the interview. Partners were interviewed separately to encourage candid discussion of their relationship. Interviews examined the following topics: relationship history, agreements about sex, broken agreements, sexual behaviors with primary and outside partners, sexual and relational satisfaction, and the participants’ attitudes towards HIV. Discordant couples, in particular, were asked about their relationship history vis-à-vis their discordancy and its impact on their relationship and sexual behavior. Here, interview questions were designed to uncover details about how discordant couples became discordant. Questions started broadly and over the course of the interview grew more specific. For example, partners were asked, “How is it being negative/positive when your primary partner is positive/negative?” A follow-up question asked, “Have you and your partner always been discordant or did one of you seroconvert while you’ve been together?” Interviewers followed a guide that determined the questions and their order. Interviewers were trained to probe if further clarification or

detail was needed; for example, whether and how disclosure of HIV-positive serostatus occurred. Partners were paid \$40.00 each as incentive.

Interviews were recorded and transcribed verbatim. Transcripts were then cleaned to check for accuracy in transcription (e.g., mistakes, misspellings, or omissions). The process for generating codes remained the same across the three studies: Research staff members conducted an initial analysis of each set of transcripts utilizing a Grounded Theory approach (Denzin & Lincoln, 2003), analyzed the emergent themes, and distilled those themes into a unique set of codes. New codes from Studies 2 and 3 supplemented the originals from Study 1 as the scope of each successive study broadened. In addition, for Studies 2 and 3, this process was augmented by the study team's previous research (Hoff & Beougher, 2010; Hoff, Beougher, Chakravarty, Darbes, & Neilands, 2010; Neilands, Chakravarty, Darbes, Beougher, & Hoff, 2010).

Coding strategies were the same across all three studies: Research staff members worked in teams coding transcripts and achieved reliability by reviewing each coder's first two coded transcripts as a team, examining discrepancies in how codes were applied to the data, and discussing the meaning and interpretation of codes until consensus was reached. Codes for topics that dealt with HIV, sex, and relationship dynamics (e.g., attitudes towards HIV; HIV risk and seroconversion; disclosure of HIV status; sexual and relational quality and satisfaction, as well as changes over time; etc.) were included in a secondary analysis, conducted by the first author, for the development and refinement of the themes presented in this analysis and for the purposes of selecting quotations for their ability to illustrate and best support those themes.

Two software packages were used for coding and analysis: Ethnograph (2001) for Study 1 and Transana (Woods & Fassnacht, 2007) for Studies 2 and 3. Additional information about participant recruitment or selection, eligibility criteria, interview protocol, and data coding and analysis have been published elsewhere (Beougher et al., 2012; Hoff & Beougher, 2010; Neilands et al., 2010). Only data from the discordant couples in each sample were utilized for this analysis. Thus, results from this analysis reflect the pooled sample of discordant couples ($N = 35$) from all three studies.

RESULTS

The mean age for the pooled sample was 43 years (range: 24–68), mean age difference between partners was 8 years (range: 0–22 years), and mean relationship length was 8 years (range: 3 months to 33 years, 6 months). Of the 35 couples, 17 included partners who were both White, 3 who were both Latino, and 2 who were both Black; the remaining 13 couples were interracial.

Partners in all 35 couples discussed their HIV infection history—with all HIV-positive partners revealing how and when they became HIV-positive—as well as the challenges of being discordant. Couples that met discordant ($N = 24$) were discordant since the beginning of their relationship. Couples that did not meet discordant ($N = 11$) either were concordant negative when they first met and one partner later seroconverted (hereafter referred to as couples that “seroconverted discordant”) or were unsure of their serostatus at first and when they later tested found out they were discordant (hereafter referred to as couples that “tested discordant”). Note: All couples were discordant at the time they were recruited and interviewed. The data presented here concern an event that occurred in the past for each couple. Results are grouped by whether couples met discordant or did not to compare and contrast their experiences—their HIV infection history—and their effects on various relationship dynamics.

Couples That Met Discordant

Twenty-four couples met discordant (69%). These couples were discordant since the beginning of their relationship. Partners in every couple described how and when disclosure of serostatus occurred and its impact on their relationship. Eight HIV-positive partners disclosed their serostatus on the first date or before the first sexual encounter. One said, “It came up the first day, because he asked me my status. . . . We had a pretty frank discussion. So, from day one there wasn’t any beating around the bush” (White/47/HIV+).¹ Disclosure at the beginning of the relationship, participants noted, helped partners establish trust and togetherness by being honest and open with one another. Another said the following:

When I first met him I told him, I put it out on the table . . . I felt that if I’m going to have an open relationship, meaning openness to communication, I’ve got to be honest from the get-go. I can’t date this man and six months into it say, “Oops, I forgot to tell you: I’m HIV positive.” I don’t want that. I’ve seen that happen to people and it’s messed them up. . . . So, I was very up front and honest with him in the beginning. (Latino/33/HIV+)

And still another HIV-positive participant shared a similar story, saying,

I told him the day I met him that I was HIV positive. I wasn’t going to pull any punches, I wasn’t going to pretend I wasn’t and not say anything. . . . So, I told him three hours after I met him because I knew we were hitting it off. We obviously liked each other. (White/37/HIV+)

The HIV-negative partners' experiences were complementary. One added that disclosure brought him and his primary partner closer together:

It was during that first date that he told me he was HIV-positive. He said that if it meant I only wanted to be friends, or wasn't interested, he would understand. Without hesitating I said, "Well, I really wish that wasn't the case, but it doesn't make any difference as far as my interest is concerned. I still want to see where things go." And he broke down crying. So that was a really important first date. We made a tremendous connection. (White/55/HIV-)

The remaining four HIV-positive partners did not disclose before the first sexual encounter (exact times are unclear, as partners often described somewhat different timelines). Comments from these men reveal their anxiety about disclosing, as they cited concerns about privacy or fear of rejection as reasons why they waited. One partner stated, "I didn't tell him for at least two years. I had that terror, emotional and psychological terror in my mind and heart that he would just abandon me in the event that I was more forthright with him" (White/55/HIV+). His partner, who found out only after examining his partner's medicine bottles, said, "I was numb. I suppose I wondered why [he didn't tell me]. But then I knew. I had known all along" (Mixed Race/33/HIV-). He explained that his partner was secretive about personal health matters. Thus, while caught off guard, he was not surprised. The other HIV-negative men in this situation reacted similarly. One said,

It took him a couple of months before he told me. . . . He was, of course, very nervous, worried, and scared because not a lot of people knew about his status. Certainly, in his family, nobody knew at that time. It was a big burden. So, I didn't know. I feel a tiny bit betrayed; I feel that he should have told me. But at the end it didn't matter too much because I could see where he was coming from and [we] didn't cross any lines in the sense that I was put in any type of risk [for HIV]. (Latino/38/HIV-)

IMPACT ON RELATIONSHIP DYNAMICS

Couples that met discordant were less troubled by their discordancy. Most did not view it as a significant barrier to sexual intimacy or to sexual and relationship satisfaction. Two different participants said, "It didn't matter to me. I mean . . . I'm not gonna [avoid] sleeping with someone because they're positive. That's not fair to anybody and it's silly at this point" (Latino/32/HIV-) and "I just don't think about [my partner being] HIV-positive. . . . I don't care that he's HIV-positive. I know that he takes care of himself" (Mixed Race/42/HIV-). Both men were of the belief that while HIV was a part of their relationship, it did not define it. Another stated,

I've never thought of it as a difference between us. I do worry about him sometimes, when he gets ill...but that's usually the only time I think about it...It's kind of like [when] my mom contracted hepatitis...I don't think of my mom as a carrier, so I don't really think about it all that much. I know that it is a difference between the two of us, but it's just not something I think about. (White/31/HIV-)

His partner, who admitted that he originally wanted to be in a concordant positive relationship because he "thought that would be an ideal person to be with," said he was surprised by his partner's acceptance of their discordancy, noting that "this [relationship] turned out to be ideal because he didn't care about my HIV status" (White/46/HIV+). Echoing this sentiment, one participant said, "[T]he unusual thing about our relationship is that...[being discordant]...doesn't put any strain on the relationship at all. As a matter of fact, we don't even talk about it. It's not an issue" (White/58/HIV-). A different participant explained, "[I]t's something we don't talk about all that much anymore. It's a pain in the neck having to use a condom—I hate condoms—but, like everybody, it's a pretty easy choice" (White/47/HIV+). One participant articulated a more philosophical approach, saying, "If I had a choice, if he had a choice, HIV wouldn't be part of the relationship. But there's absolutely nothing we can do about it, so we accept it and do the best we can." He continued, "[It's] not a problem. It's a trade you do for somebody you love" (Latino/38/HIV-).

Partners discussed, matter-of-factly, clear boundaries around sex and risk so as to avoid HIV transmission from one partner to the other. One participant said, "I don't have any funniness about having sex with him because he's positive. I'm just not gonna let him fuck me without a condom. He doesn't want to and that's fine" (White/42/HIV-). Another participant explained that he and his HIV-positive partner monitor viral load. "If his viral load goes up then we use condoms" (Latino/32/HIV-). Transmission of STDs from outside partners to the HIV-positive partner was also a risk to avoid. One partner explained:

I've been HIV-positive for thirteen years now. I don't need [my partner] to have a sexual encounter and have to pay for it; meaning him...doing something that might put me in danger. I know and understand that could happen [and] I think I could deal with that...but I wouldn't be able to handle him being negligent [and] bringing something home... So that was addressed and agreed upon. That is the understanding. (Latino/34/HIV+)

Couples That Did Not Meet Discordant

Eleven couples did not meet discordant (31%). While these couples were already discordant at the time they were recruited and interviewed, they either were concordant negative when they first met and one partner later seroconverted (i.e., “seroconverted discordant”; $N = 6$) or they were unsure of their serostatus at first and when they later tested found out they were discordant (i.e., “tested discordant”; $N = 5$). Partners in every couple described the circumstances surrounding seroconverting discordant or testing discordant. For example, all who seroconverted discordant allowed sex with outside partners at the time seroconversion occurred (i.e., an outside partner was the source of their HIV infection). Most HIV-positive partners explained that they seroconverted because they “got careless” (Latino/42/HIV+) with outside partners or failed to clarify the details of the agreements about sex they negotiated with their primary partners. One man said, “[E]arly on, my concept of safety was not identical to his” (White/32/HIV+). Reflecting back on his primary partner’s seroconversion, a participant from a different couple claimed, “I think we both have different levels of what we consider risky behavior—mine being more conservative than his” (White/52/HIV−). The following is one man’s narrative of his infection, which was similar to some others’:

I remember exactly when that happened... When I was really high I had sex with this guy. He was a top... and in the middle of the night [when we were having sex] I remember that he came. I was so high and drunk; he came inside [me]. (Latino/28/HIV+)

Later, the participant contacted the outside partner to ask about his serostatus. “Hey, are you positive?” And he’s like, ‘Yeah, you’re not?’ I fucked it up. I was having unprotected sex with this guy who was HIV-positive.”

In the couples that tested discordant, the HIV-positive participants discussed both why they avoided testing for HIV as well as the circumstances surrounding when and why they eventually sought a test. These couples acknowledged that, when they met, they assumed they were concordant negative or admitted that they simply did not know. One couple explained that there was no HIV test when they first met. The HIV-positive participant in this couple stated the following:

I was probably positive from the beginning, but there wasn’t any testing when we got together. Neither of us knew. He’s such a bottom that when the tests came back and I was positive, and he wasn’t, it was a big surprise. Not that I hadn’t bottomed plenty of times... So it wasn’t a surprise that I was positive, it was a surprise that we were discordant. (White/52/HIV+)

HIV-positive partners in couples that tested discordant described their past anxieties around testing and voiced regret over not taking a more active role in maintaining their health. Some told stories of avoiding testing for HIV. One participant said, “[M]y first test was when I was in my twenties . . . and it was negative. . . . And I just moved along. I think I got infected when I was thirty-one . . . I didn’t go get tested [because] I was too afraid” (White/52/HIV+). Another HIV-positive man felt HIV was something other people dealt with, saying,

When [my partner and I] met, I had not tested for HIV in many years. [My partner] is in the field and it is something in his world that people discuss . . . he spends all day and all night talking about HIV, its ramifications, health consequences. . . . This is not something I deal with. . . . I’ve never retooled my perspective on it, which led me to being so fearful of learning of an HIV-positive diagnosis that I refused to get tested. (White/43/HIV+)

Couples that tested discordant waited to do so until the (as-yet-unknown) HIV-positive partner fell sick with an opportunistic or unusual infection, such as chickenpox, pneumonia, or, in the words of one participant, a “rare form of *E. coli*” (White/48/HIV–). He recalled the following:

We both thought we were negative and then he started getting sick . . . I was like, “It’s weird that you’re getting all these diseases. I wonder where you’re getting them from.” The doctor never once thought of asking [my partner] his HIV status or giving him a test.

Another participant, who was HIV-negative, shared a similar experience:

I took the test. I figured, [I’m] negative, he’s negative. Well, about a year later he got sick and had to go to the hospital. The doctors encouraged him to take the HIV test and then he found out he was positive. So, somewhere along the line—I suppose it could even have been before we met, I don’t know. When they first diagnosed him his T-cells were already pretty low, so I assumed he’d had it for a while. (White/45/HIV–)

Importantly, what these men experienced was not seroconversion illness, but an infection that was related, they said, to being already HIV positive and immunocompromised.

IMPACT ON RELATIONSHIP DYNAMICS

Couples that did not meet discordant reported struggling with the impact of HIV on their relationship. Some HIV-positive men, for example, described stopping all sexual behavior with their primary partners immediately

following their seroconversion. One partner said, “[A]fter I converted we didn’t have sex for a very long time . . . I didn’t feel like [having] it with him” (White/45/HIV+). His partner said, “It’s not something I wanted to live with, something I wanted to get. Early on, I didn’t want to be with anyone that was HIV-positive” (Asian/35/HIV–). For most, sex with their primary partner became a source of anxiety. One man said, “Sometimes, I’m just not interested in it because I’m afraid of infecting him even though I know the proper ways of taking care of ourselves” (Latino/42/HIV+).

Couples that did not meet discordant expressed feelings of estrangement, regret, and anxiety, comments in stark contrast with the sense of togetherness reported by couples that met discordant. One HIV-positive participant said,

He’s always on the other side of the river now. That’s the way I think of it. [We’re] on different shores, no matter what. . . . I also worry about him giving me some sort of complication, some sort of opportunistic disease . . . so, it’s a worry of mine, it’s a growing worry of mine. And at times I’ve gone into panic [about it]. (White/45/HIV+)

Another participant shared his experience of distance from his primary partner:

One of the negatives for me is that he is HIV-negative and I am HIV positive, which really is frustrating. . . . So, sexually we’re really not on the same page, especially to be in a long-term relationship. . . . We’ve been to couples counseling several times over the issue. (White/54/HIV+)

Many HIV-positive participants voiced regret over seroconverting. One said, “I always tried to be negative. I always used protection when I was having sex with people. It was a stupid thing that I did” (Latino/28/HIV+). Another participant’s comments were similar:

Sex is anxiety-inducing for me because we’ve never used condoms. . . . It’s impossible to have sex without being mindful of the fact that the person I love most in the world is in a position where he [may be] infected with HIV any time we have sex. So it’s not without its incredible stresses. (White/43/HIV+)

His HIV-negative partner explained, “After he tested positive we didn’t know how to deal with sex. We had not used condoms before, so trying to introduce them after . . . proved difficult and unenjoyable. I even went on antidepressants” (Black/48/HIV–). Similarly, an HIV-negative participant described the difficulties being in a discordant relationship presented his sex life:

Once we knew that he was positive and I was negative, then we started thinking about negotiating sex...[We] shifted from having whatever kind of sex we wanted to being more circumspect about it. We tried to use condoms; we tried to make them work for us. We experimented. There was abstinence for a while, which was awful. (White/51/HIV-)

One participant described being the opposite serostatus of his partner as a weakness. He said, "[My partner]'s been complaining about us not being intimate, not being sexual. Plus, he puts me down because I'm HIV-positive... So that's another part of the friction in our relationship" (White/31/HIV+).

Partners in couples that did not meet discordant also spoke about the inevitability of HIV infection. An HIV-negative participant said, "I know I'm doing things safely, or fairly safely. [But] in my heart, I don't always feel that way. I still have that doubt that the condom...[will] break" (White/48/HIV-). Along the same lines, one said, "[My partner] says I shouldn't be so clinical... Still, you never can tell. So, he says I'm over-protective when I'm sexual with him. He says he doesn't care, but I say no, I do care" (Black/46/HIV+).

DISCUSSION

Differences in how couples became discordant clearly have implications for their relationships and their sexual behavior. Most HIV-positive partners in couples that met discordant disclosed their serostatus to their HIV-negative primary partners before the first sexual encounter; a small number waited until later. Couples felt that disclosure was beneficial, brought them closer together, and helped cement their relationship during its early stages. In particular, those who disclosed before the first sexual encounter felt it important to be open and honest with their new partners, while those who waited until later were anxious about their new relationships and waited. As for couples that did not meet discordant, all couples that seroconverted discordant allowed sex with outside partners at the time it occurred, with every HIV-positive partner attributing his infection to UAI with outside partners. Partners in couples that tested discordant either assumed they were concordant negative or simply did not know each other's serostatus when they first met; they did not know for certain until they later sought an HIV test and found out they were discordant. The HIV-positive partners in these couples were anxious about testing and put it off until they became sick.

Overall, couples that met discordant were much less troubled by their discordance, while couples that did not meet discordant were much more troubled by it. For example, few of the couples that met discordant described experiencing discordancy as a barrier to intimacy as well as to sexual and

relational satisfaction. Couples that seroconverted discordant or tested discordant, in contrast, spoke of it often and struggled with being opposite serostatuses. When men in these couples discussed challenges in their relationships they ascribed them to HIV. The findings suggest that couples that meet discordant go into their relationships with a clearer sense of the challenges that lay ahead with respect to HIV (Remien et al., 1995), whereas couples that seroconvert discordant or test discordant find themselves caught off guard by HIV and, colloquially, felt they did not get what they bargained for (Adam & Sears, 1994). Importantly, and more broadly, the findings suggest that relationship dynamics may differ for discordant couples depending on HIV infection history.

Previous research involving discordant gay couples has identified unique relationship dynamics, such as having agreements about reducing the likelihood of HIV transmission from one partner to the other, partners seeing their discordance as an imbalance, and discordancy creating experiences of distress and dissatisfaction (Beougher et al., 2012; Hoff et al., 2010; Palmer & Bor, 2001; Remien et al., 1995; Remien et al., 2003). This study goes one step further and identifies differences among discordant couples based on HIV infection history, which could allow fine-tuning of HIV prevention or counseling services to gay couples.

Couples that met discordant expressed greater satisfaction with sex and their relationships and less concern about HIV transmission. Thus, couples that meet discordant may require less relationship counseling and more support around long-term HIV risk reduction and prevention within the relationship. Examples could include establishing regular VL testing for the HIV-positive partner and facilitating how he communicates the results to his partner or, simply, increasing condom use (Davidovich et al., 2004; Guzman et al., 2006; Hallett et al., 2011; Palmer & Bor, 2001; Remien et al., 2005; Stolte et al., 2004; Vernazza, Hirschel, Bernasconi, & Flepp, 2008). HIV-positive partners in couples that meet discordant, and who wait (or waited) to disclose their serostatus to their primary partners, could benefit from targeted counseling that explores their anxiety around disclosure with an aim to help them disclose earlier to future partners or to outside partners in an effort to reduce HIV transmission risk (Derlega et al., 1998; Derlega et al., 2002; Rutledge, 2009; Sheon & Crosby, 2004; Stirratt, 2005). Disclosure in and of itself proved to be a significant and beneficial event for these discordant couples; additional benefits may include increased social support, greater self-esteem, and lower levels of depression (Zea, Reisen, Poppen, Bianchi, & Echeverry, 2005). Couples that seroconvert discordant or that test discordant may find relationship counseling helpful as they work through any concerns about trust, fidelity, and responsibility, especially if a seroconversion or HIV-positive test result occurred recently (Derlega et al., 2002, 2004; Hays et al., 1993; Remien et al., 2005; Remien et al., 2003; Ware et al., 2012). Communication may be another area where couples that

seroconvert discordant or test discordant may benefit from additional support as sexual agreements should be revisited, broken agreements disclosed, and safety agreements—which may reduce HIV risk—clearly understood by both partners (Beougher et al., 2012; Gómez et al., 2012; Hoff & Beougher, 2010; Prestage et al., 2006). For HIV-positive partners in couples that avoided testing for HIV, counseling may help them resolve any lingering feelings about seroconversion that prevented them from testing in the past and that may still cause anguish in the present.

Knowledge of HIV infection history could also guide the administration of pre-exposure prophylaxis, or PrEP, to discordant couples as well as inform alternative uses for it such as ameliorating some negative repercussions of HIV infection history. PrEP, a biomedical tool to prevent HIV infection that involves the use of HIV antiretroviral medications by uninfected individuals, is currently FDA-approved and available by prescription in the United States and will soon be more accessible around the world. Research in the United States with same-sex male couples has shown that PrEP may significantly reduce anxiety about transmission for those that are discordant (Brooks et al., 2012). Research out of Uganda also demonstrates the potential benefits of PrEP to relationship dynamics for discordant couples. There, heterosexual couples that seroconverted discordant used PrEP as a way to repair the damage caused to their relationships when they experienced seroconversion (Ware et al., 2012). Perhaps, then, in conjunction with PrEP's use as a biomedical tool to prevent HIV infection, it could also be used more explicitly to reduce relationship- and HIV transmission-based anxiety for discordant couples regardless of their HIV infection history, with benefits likely to be most dramatic for couples that seroconvert discordant (Beckerman, Letteney, & Lorber, 2000; Brooks et al., 2012). Alternative uses for PrEP, such as those just outlined, are worthy of further exploration.

There are limitations to this study. First, despite allusions to seroconversion being distressing for couples, no causal relationship between seroconverting discordant, or testing discordant, and subsequent breakup can be inferred from these data. Previous research, however, hints that while seroconversion within a relationship, or an HIV-positive test result at the beginning of one, may not be the sole cause of a breakup it could be the catalyst for a relationship ending (Adam & Sears, 1994; Stephenson et al., 2011). While the purpose of this study was never to establish this link, our findings also hint at this possibility, underscoring the importance of providing tailored and intensive relationship counseling to couples experiencing stress or trauma as a result of seroconversion or HIV-positive test result. Second, while the results suggest an association between differences in relationship dynamics and HIV infection history, it may be the case that, for some, those differences preceded HIV infection. Third, the sample consisted of participants who were in current relationships. We did not interview participants who may have broken up because of, for example, non-disclosure

of HIV-positive serostatus, seroconversion, or an HIV-positive test result. Consequently, couples in this study may have reported more robust relationship dynamics, thus skewing our findings to reflect those that stay together despite the challenges being discordant presents. If this is the case, however, our findings offer compelling evidence of how discordant gay couples manage these challenges and proof that some overcome them. Fourth, couples from all three studies were recruited via a convenience strategy and all were residents of the San Francisco Bay Area. As such, this sample is not representative and may not reflect the experiences of other gay couples in other areas; generalizations should always be made cautiously. Fifth, the HIV status of participants was self-reported; no actual testing occurred. We forwent testing because we are interested in how perceived, rather than actual, serostatus guides sexual behavior.

Despite these limitations, the present study exhibits an important, core strength: Across nearly a decade of data collection from three, independent samples of discordant gay couples, all participants reported experiencing one of three distinct HIV infection histories that affected their relationships in remarkably similar ways—an important finding in and of itself. This suggests that the findings presented here may be a common experience for most, if not all, discordant gay couples. If this is the case, it further underscores the importance of understanding HIV infection history and its impact on relationships.

Assuming discordant couples have always been discordant may mask important differences between those that meet discordant and those that do not. This, in turn, masks important differences in the way HIV infection history impacts sexual and relational satisfaction as well as HIV risk. Investigation of HIV infection history via quantitative methods, with a larger sample of discordant couples, may flesh out these interactions and lessen some of the present study's limitations. Understanding how present relationship dynamics may differ depending on HIV infection history can provide for more effective and better tailored HIV prevention and counseling services for discordant couples.

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NOTE

1. The participant's race/ethnicity, age, and serostatus.

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