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"My Sexuality…It Creates a Stress": HIV-Related Communication Among Bisexual Black and Latino Men, New York City

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Abstract

Men who have sex with men and women (including bisexual men) comprise 35% of all men who have sex with men (MSM) in the U.S. It is estimated that 121,800 men who have been bisexually active within the past year are living with HIV in the U.S. Communication about HIV may result in risk-reduction behaviors. However, little is known about the nature or context for HIV prevention communication among bisexual men, particularly for blacks and Hispanic/Latinos who are disproportionately at greater HIV risk. Therefore, we explored patterns and contexts of HIV-related communications occurring within personal social networks among bisexual black and Hispanic/Latino men. Using respondent-driven sampling methods, we conducted semi-structured interviews from 2011 to 2012 among 36 participants living in New York City. We examined interview responses from participants for main themes using computer-assisted thematic analyses. The three main themes identified were: (1) communication strategies (e.g., "You can tell a lot from how a person responds just by the tone of their voice"), (2) barriers (e.g., "My sexuality…it creates a stress"), and (3) motivations for these communications (e.g., "I know that's a(n) issue in the black community…if I could help another brother, I will do it"). Our findings can inform HIV prevention efforts such as social messaging campaigns and other risk-reduction interventions designed for bisexual men.

Keywords

HIV; Prevention communication; Black/African-American; Hispanic/Latino; Bisexual men

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflicts of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

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

Introduction

In the U.S., men who have sex with men (MSM) accounted for approximately 2% of the U.S. population (Grey et al., 2016; Purcell et al., 2012) and 66.6% of all HIV diagnoses in 2016 (Centers for Disease Control and Prevention, 2017). Among the approximately 4.5 million MSM in the U.S. (Grey et al., 2016), black and Hispanic/Latino men who have sex with men (BLMSM) made up 65.8% (38.1 and 27.7%, respectively) of persons diagnosed with HIV, compared with non-Hispanic/Latino white MSM, who comprised 27.5% of HIV diagnoses in 2016 (Centers for Disease Control and Prevention, 2017). In New York City (NYC), MSM accounted for approximately 74% of all HIV diagnoses in 2015 (New York City Department of Health and Mental Hygiene, 2017). HIV-related racial/ethnic disparities also persisted; black and Hispanic/Latino MSM represented 72.5% (38.6 and 33.9%, respectively) of HIV diagnoses in NYC compared with 21.3% in white MSM (New York City Department of Health and Mental Hygiene, 2017).

Approximately 1.5 million men (1.4%) in the U.S. identify as bisexual (Gates, 2011). Bisexual men comprise a subgroup of MSM who are at risk of HIV infection. Data from the National Survey of Family Growth (2002, 2006–2010, and 2011–2013 cycles) suggest that about 35% of MSM are bisexual men (McCree et al., 2017); about 121,800 bisexual men are living with HIV (Friedman et al., 2014b). Research shows that bisexual men engage in less HIV risk behavior compared with other MSM. Compared with men who have sex with men only (MSMO), bisexual men are less likely to have condomless sex with a male partner (Shadaker, Magee, Paz-Bailey, & Hoots, 2017). In addition, bisexual men report similar rates of insertive (condom use unspecified) anal sex (Williams, Mackesy-Amiti, McKirnan, & Ouellet, 2009), and they report lower rates of receptive anal sex (Zule, Bobashev, Wechsberg, Costenbader, & Coomes, 2009) with condoms or not. However, black bisexual men reported the highest percentage of condomless vaginal or anal sex with female partners compared to all other subgroups of MSM (Centers for Disease Control and Prevention, 2016).

Unique social and contextual factors are associated with sexual risk behaviors of bisexual men. Bisexual men may experience stigma from both heterosexual and gay/lesbian individuals (Friedman et al., 2014a); bisexual stigmatization can contribute to psychological stressors and subsequent HIV risk such as condomless anal sex, substance use, and avoidance of prevention services (Jeffries IV, 2014). Studies also suggest that bisexual men may be more fearful of disclosing sexual identity to others compared with other MSM subgroups (Dodge, Jeffries IV, & Sandfort, 2008).

HIV-Related Communication

Enhancing HIV-related communication within a community can be an important strategy for promoting HIV prevention behaviors, particularly among black and Hispanic/Latino bisexual men (Horvath, Oakes, & Rosser, 2008). Enhanced HIV-related communication can be effective for promoting sexual safety negotiation between sexual partners (Widman, Golin, & Noar, 2013). However, there are limited data regarding HIV-related communication occurring within personal social networks, particularly for black MSM. Data suggest that despite general positive attitudes toward HIV prevention communication, actual

conversations within black MSM networks are infrequent (Tobin, Yang, Sun, Spikes, & Latkin, 2014) and HIV-related communication prior to sexual engagement may not occur within some black MSM partnerships (Aholou, Nanin, Drumhiller, & Sutton, 2017). This discrepancy highlights an important HIV prevention issue; sexual relationships with less communication correlate with increased serodiscordant/serostatus-unknown condomless sex (Hickson et al., 2017). Additionally, correlation between lack of sexual identity disclosure and riskier sexual behavior further magnifies the need for understanding communication patterns of black and Hispanic/Latino bisexual men (Bingham, Harawa, & Williams, 2013). To date, no evidence-based interventions have addressed the HIV prevention needs for bisexual men in general and black and Hispanic/Latino bisexual men in particular (McCree et al., 2017). However, research literature includes only a dearth of analyses on HIV-related communication patterns specifically about bisexual men (separate and distinct from analyses of MSM in general) to inform such interventions. Therefore, the purpose of this qualitative study was to explore HIV-related communication patterns of black and Hispanic/Latino bisexual men with their personal social networks to inform HIV prevention interventions and strategies.

Method

Participants

Data were collected from spring 2011 through summer 2012 as part of a larger study known as Brothers Reaching Out to Talk about HIV Awareness (Project BROTHA). Project BROTHA explored interpersonal communications about HIV prevention and HIV testing among MSM who identify themselves as black/African-American or Hispanic/Latino and their social networks (ages 18–64 years) in the NYC area; study design details have been previously published or presented (Aholou et al., 2017; Nanin, 2013; Nanin et al., 2009). The concept of interpersonal HIV prevention communication entails the naturally occurring communication strategies (i.e., conversations, emails, texting, social media posts and messaging, and other strategies) that MSM and others may engage in with their friends, peers/associates, and sexual partners to discuss HIV risk, HIV prevention strategies, and other related topics, including HIV testing (Nanin, 2013). The study was conducted in NYC, led by the Center for HIV Educational Studies and Training in partnership with other community-based organizations that provided services for gay-identified/same-gender loving men of color, including Gay Men of African Descent.

A purposive sampling strategy was used to recruit black and Hispanic/Latino bisexual men. The research team used structured outreach recruitment that combined active and passive strategies online and offline (i.e., banner ads on websites, such as Adam 4 Adam, Manhunt.com; distribution of palm cards with study contact information at community events; and large gay-focused events such as NYC Gay Pride Parade). In addition, the team used respondent-driven sampling, a network-based recruitment method (Heckathorn, 1997). Eligible participants were men who met the following criteria: born male, ages 18–64 years, reported oral and/or anal sex with a man at least once within the past 3 months, had no HIV antibody test within the last year, were able to communicate in English, and were able to identify two other MSM from their social network. After signed consent, participants were

enrolled and asked to complete an Audio Computer-Assisted Self-Interview survey, which obtained demographic information (i.e., age, sexual identity, educational background) and assessed psychosocial and behavioral issues. After survey completion, research staff invited participants to complete a 45–75-min semi-structured interview (Appendix). Sample interview questions included “How often do you have conversations about HIV prevention?”; “How does the type of person influence the kind of conversation you might have with them?”; “When you talk to people about HIV, how knowledgeable do you feel about HIV prevention?”

For this analysis, we included only self-identified black and Hispanic/Latino bisexual men. We focused on the interview narratives that were responsive to questions about general HIV-related conversations among black and Hispanic/Latino bisexual men with members of their personal social network (i.e., sexual partners, relatives, friends, and peer/acquaintances). Upon completion of survey and interview, participants received $60 for their time.

Kingsborough Community College and Hunter College (CUNY) Institutional Review Boards reviewed and approved the study protocol. In addition, the study protocol was reviewed and approved by the CDC’s National Center for HIV, Viral Hepatitis, STD, and TB Prevention’s project determination process.

Data Analysis

All interviews were audiotaped and transcribed verbatim. We coded the interview transcripts for all participants who met the inclusion criteria ($n = 36$). Two analysts (KH and KD) used applied thematic data analysis (Guest, MacQueen, & Namey, 2011). The analysts read each interview independently. Both analysts then collaboratively reviewed and constructed a preliminary codebook based on emergent themes. Next, each analyst independently coded the first third ($n = 12$) of interviews using NVivo 11 software (QSR International Pty Ltd., version 11, 2015). All codes with a kappa score less than 0.80 were reviewed and discussed until consensus was reached; this strategy has been shown to be sufficient in achieving data saturation and acceptable intercoder reliability (Guest, Bunce, & Johnson, 2006; Hruschka et al., 2004). The codebook was finalized upon completion of consensus discussions. The analysts independently coded the remaining 24 transcripts ($n = 12$ transcripts each). Descriptive analyses were conducted using SPSS 21 software. Emergent themes from the analysis are discussed below. Pseudonyms were given to participants to protect their confidentiality.

Results

Of 37 potential participants, one was excluded due to missing demographic data, leaving a final sample of 36 bisexual men; 83% self-identified solely as black/African-American, 11% solely as Hispanic/Latino, with 6% identifying as both black and Hispanic/Latino. Forty-seven percent were aged 45–64 years; 81% reported having at least a high school diploma or higher; 58% were unemployed; 31% lived below the poverty level; 25% reported being homeless during the past 3 months; and 78% reported having either public or private health insurance coverage. Regarding condomless sex, 19% of participants reported having had vaginal sex, 44% having had condomless insertive anal sex, and 31% having had receptive

anal sex during the past 3 months. Approximately 17% of black and Hispanic/Latino bisexual men reported exchanging sex for food, drugs, shelter, or money. Demographics and other quantitative data for participants are summarized in Table 1.

For the qualitative analyses, three main themes emerged that identify communication patterns of bisexual black and Hispanic/Latino men: (1) communication strategies, (2) barriers, and (3) motivations for engaging members of their social networks in HIV-related communications. Related themes and subthemes are illustrated next with exemplars from the transcripts.

Communication Strategies

Twenty-one participants (58%) utilized cues to aid in starting HIV prevention communications with sex partners, friends, and family. They described that HIV was a difficult topic to broach, so context was often a factor in initiating HIV prevention communications. To increase comfort with engaging in such a sensitive topic, certain familiar locations (i.e., nightclub) and situational aspects (i.e., before having sex or during dinner) aided in creating a relaxing environment to initiate discussions about HIV. In addition, physical items (i.e., billboards, fliers, and posters) and media (i.e., TV shows and movies) sometimes facilitated discussions about HIV prevention, as one participant stated:

> I don’t think we ever brought up HIV, AIDS, I think we just end up stumbling into it (giggles). Real, I don’t know, you see something on TV and we might have a discussion but it’d be so brief, it’d be really brief…I’d even say for me, HIV, that’s a touchy topic. (“Alex”: Black, 38)

Participants sometimes felt that bringing up a conversation about HIV could offend others. One participant found it easier to ask sex partners about other health indicators rather than asking about HIV directly:

> We may talk about it but then disguise it in some kind of way…”how many times you been in the hospital? You been in the hospital a lot?” “Oh, word, I ain’t call you yet then. You got a cold. Aww. Night sweats? Alright, I ain’t messin’ with you.” (“Alex”: Black, 38)

One participant implied that he would not necessarily trust a “person’s word for it” when it comes to HIV status, and he attempted to decipher it based on social cues such as inflection and tone of voice. When asked where conversations about HIV prevention typically took place, he stated:

> Normally, face to face. Over dinner, or sittin’ in the park, or the phone. Never internet. I’m not typing all that (laughter)…plus you can’t hear inflection in their voice and things like that. So I like to hear inflection because you can tell a lot from how a person responds just by the tone of their voice. You can’t get that through a text…sometimes, when you’re asking about HIV status and you can hear a little (pause) in their voice. So, you know, there’s some cues that—that I pick up on. (“Bill”: Black, 32)

Humor was used as a strategy to accompany conversations about HIV prevention. One participant described how he utilized humor with a sex partner:

> How do you feel about using protection? Because I use protection all the time, you know. Have to be aware that HIV is prevalent, that it's out there. I mean you can have fun, but you also wanna protect yourself…You gonna die anyway, so, you know, you try to stay here as long as you can…You know you try to put a spin, you know a comical spin on it so it's not so serious, like the sky gonna fall, you understand what I'm saying? (laughter). ("Charles": Black, 48)

To protect privacy of their discussions, participants used code words as a communication strategy. One man described how he and his friends talked in code and used alternate words to reference topics like HIV so that others would not be able to decipher what the conversation was about: "We made new words up so people don't understand where we comin' from. Cuz we don't want nobody nosey…we use codes cuz they nosey real hard… you use a metaphor…you're using it to sort of express they might have HIV…" ("David": Black, 30).

A strategy for some participants was using a persuasive approach—convincing friends and sexual partners to test for HIV and other sexually transmitted diseases (STDs), use condoms, and discuss HIV status with sex partners. Several of the persuasive methods with sex partners involved condom negotiation. If a sex partner refused to use a condom, they refrained from having sex, as one man recounted, "We ran out of condoms… they wanted to have sex with no condom. And I was like, 'Oh no we're not. Like hell we're not…you can wait.'" ("Eric": Black, 22). Many of the persuasive conversations that participants had with friends regarded heterosexual partnerships; few involved homosexual relationships. One participant advised a friend to get an HIV test after he had condomless sex with a female:

> I had a conversation with my best friend. Because he goes around and having sex damn near everyday with different females. And you know, and the last female that he had brought over, she didn't look too safe. I'm like yo, did you have sex with that? And he said yea, and he-I was like unprotected or protected? And he said both. I'm like you got to get yourself checked out because she don't look too healthy herself…I'm like I'm just looking out for your well being because you're my friend. ("Frank": Black, 23)

Another participant felt that a careful approach was an effective HIV prevention communication strategy with children in his neighborhood, including his own children. He discussed how he gathered information from attending group sessions regarding HIV and applied his knowledge to facilitate communication with youth:

> When I grab some of the information I get from these groups, I take it back and I do share it. You know, and listen, this is what I learned today…I watch their movements and how they, you know, but I try to keep the focus on me. I make it look like, you know, this is comin' from me so that they wouldn't feel like I'm attackin' them or, you know, they drawin' back from me…I don't push it up on 'em every day. Because I don't want them to just get bored with this topic. ("Gordon": Black, 53)

Barriers

Fifteen participants (42%) identified various barriers that either prevented or hindered HIV-related conversations with members of their personal social network members. Three subthemes characterized barriers to HIV-related communication: fear, presumed trust, and stigma.

Fear—Six participants specified fear as a potential barrier to engaging in HIV-related conversations within their networks, including potential sex partners. For example, one participant expressed concerns that talking about HIV would ruin the sexual mood; the fear ultimately contributed to the participant engaging in "risky" sexual behavior:

> You know, because that can be kind of a turn-off. Because we hadn't seen each other in a while and we were pretty hot and then to bring up the subject, uh, he didn't want to talk about it much. I don't know if you can understand that…and we left it at that, it was short. We just wanted to have a good time and like I said, risky, we didn't want to think about, uh, too much of the consequences…Should he have said something, then that would have raised, very sensitive, my sexuality…it creates a stress. ("Harvey": Black, 47)

Some men also believed that discussing HIV would lead to anger, emotional rejection, and possible violence from their partner. The possibility of a volatile reaction dissuaded some participants from engaging in these conversations. One participant living with HIV described how his fear prevented him from disclosing his HIV status to his partner prior to having sex:

> I didn't share with them. But I did use a condom. I was kind of afraid to share with them. Because I didn't know their status and they didn't know mine. So I was kind of afraid to let them, tell him because I was afraid they might look at me funny and got up and walked out. You know, try to hurt me or something. ("Issac": Black, 49)

Some participants indicated that the difficulty with having such communications with an intimate partner is that one may be accused of infidelity. One participant expressed concerns with having an HIV-focused discussion with his girlfriend:

> …like if I say something about it, she's like, "What are you trying to tell me? You're doing things?" You know, so, you know I'm kind of like terrified to even really, you know talk about it if I don't have to keep doing it, you know. ("James": Black, 52)

Men also described how privacy-related fears influence the settings in which HIV-related communications take place. One participant described the locations and circumstances that his friends prefer for conversations:

> A lot of my conversations with friends are either over the phone or at home…a lot of my friends are, you know, are a little bit, you know, skeptical, a little bit of worry about letting the world know. We rarely do anything like online. We definitely stay away from Facebook, stuff like that…We'll talk about stuff in general, you know, like any propositions, yea we do that, but personal information just stay away from like, you know, group sizes and such…Just personal emails. ("Kevin": Black, 36)

Presumed Trust—Presumed trust also emerged as a subtheme related to barriers of HIV communication involving black and Hispanic/Latino bisexual men. Four participants believed that the significant bond between themselves and trusted individuals preempted the need to have any HIV-focused conversations, particularly with other gay or bisexual men. One participant discussed how his conversations and sexual encounters with other men were limited to a very small circle of trusted bisexual friends:

> I usually I know the people I'm, I'm intimate with. You know, and I've known them for a very long time. I know how their lifestyle is…'cause I'm bisexual, so I still sleep with women too. But um, you know just lately I just prefer to sleep with men, or just a few men that I, you know, interact with. And, we don't really speak about that because we know, ya know, more or less the other aspects of our lives, what we do to keep, ya know, safe, ya know to keep not have too many partners is the main thing…we're a very tight circle. Very small circle…And we've been that way for a long time. So you know. And none of us has gotten sick, so. Well, none of us have gotten any of our family members sick, you know, wives, girlfriends, whatever. ("Louis": Hispanic/Latino, 44).

Even when faced with considerable doubt, some participants avoided having in-depth conversations based on presumed trust. One participant decided against having detailed conversations about HIV prevention with a male sex partner; opting instead to "take each other's word for it":

> I asked him, "Are you clean?" "Yeah" He's clean, and I'm clean, and that's it. We took, uh, each other's word for it…Even though I haven't been tested and I don't think he's been tested. It's like we took each other's word for it. ("Harvey": Black, 47)

Another participant also indicated that he did not initiate HIV-related communications because he assumes that a potential sex partner who is HIV-positive would be forthcoming with their HIV-positive status:

> I usually, you know, you ne-you never know but, like I said, hopefully if I met somebody and if whatever happened, if I came onto them and they said "You know what, I'm HIV-positive" I would hope, or "I have AIDS" I would hope they'd tell me. ("Melvin": Black, 50)

Stigma—Four participants also expressed concerns that stigma (i.e., gay or HIV-related) can hinder potential communications about HIV within their social networks. One participant articulated how social stigma contributed to his discomfort discussing HIV with his heterosexual friends:

> Gay friends, bisexual friends…well a lot more in depth, you know, you don't feel as uncomfortable talking about it as if, you know, my straight friends do…you know, in this day-in-age, you know, we live in a very liberal state that a lot of these misconceptions of all, you know, being gay and such and being bisexual. People are worried, you know, especially that this climate's changing now, you know, this climate's getting a little more red. ("Kevin": Black, 36)

Some participants also revealed how gay-related stigma prohibits general conversation and acceptance of LGBT persons in their communities. One participant stated:

> Well, I know what it is. Um, in my community, in general, it's, it's, it's somethin' that um, that is frowned upon. I don't, I don't talk to anybody like about this. I don't consider myself to be a homosexual, per-se. Um I do know I have fetishes and I don't know if I'm in denial, whatever, but I don't consider myself as an individual who has actually slept with men. Um, I like transgender, transsexuals, but that's still a man. Um, as I'm going through it I'm like I'm kind of offended by the "when was the last time you slept men?" I've never slept with men but when I think, you know, but that's the game that I play in my head. Um, but we don't talk about it in my community, um, so it's not a hot topic. Now, as far as heterosexual, it's more of something, but as far as um, the people that I've, you know, experimented with, it's not something that, nobody cares, everybody's just havin' fun. ("Nelson": Black, 37).

Men also revealed the emotional struggle associated with gay-related stigma. This made some participants reluctant in discussing the issue with members of their social circles. One participant shared that he had challenges discussing his sexuality with his social circles and sought help from formal support groups:

> It was hard for me because I realized that I had to acknowledge something about myself I've never really acknowledged, because I've always been more or less in the closet, so that ultimately led to my, uh, well, going back into therapy to deal with that. 'Cause at the time I was in therapy 'cause I-I'd been having some problems with depression, my father died and, you know, dealing with this relationship and career stuff. It led to that night, for the first time in my life, I actually openly talked about it in therapy, which led to my going to the center to get into these groups. But the whole thing with the groups is I felt as though I had very little in common with most people in the group-the groups I was involved in, aside from the fact that I was bi and they were. ("Oscar": Black, 64).

Motivations

Twelve participants (33%) discussed various internal drivers that motivated them to have communications about HIV prevention with others. For example, one participant shared that they were motivated by a personal responsibility toward their own health, their loved ones' health, and the health of their community. "I mean that's really up to you, that's your choice" one man stated regarding HIV prevention techniques, "but I can just express my point of view and say that I think it would be a wise decision to uh, you know try to protect yourself. And to protect other people also." ("Charles": Black, 48).

One participant discussed the difficulties he experienced returning to a "normal life" after being released from prison and how that motivated him to change certain health behaviors. After struggling to find employment and housing and finally obtaining both, he began to develop the necessary self-esteem to want to have conversations about HIV prevention with his sex partners:

> I got more serious about my life…I got my little place… my self-esteem rose back up…when I did have to deal with somebody sexually, you know, I mean I would literally bring it up even though it wasn't so sexy to do it right then, but I was very concerned. ("James": Black, 52)

Some individuals indicated that having friends living HIV increases their motivation to engage in HIV prevention communications with others (i.e., only with close friends and loved ones or according to level of intimacy in relationships with sex partners). For example, one participant explained, "I have a very good friend of mine, he's HIV-positive. So, I try to, ya know, get the word out. To prevent other people from getting it." ("Peter": Black, 25).

For other men, motivation to engage with HIV prevention communication was predicated on any physical indication that his sex partner may be HIV-positive:

> The conversation doesn't come up if I don't think I have a relationship with them. It would not come up at all. Unless, you know, they physically look sick or something, I tell them you know, "You don't look too well, do you, have you ever got tested?" or something like that. ("Ramon": Black and Hispanic/Latino, 51)

One man utilized a "no glove, no love" approach to HIV prevention (i.e., no sex unless a condom is used) and was motivated to have conversations with sex partners because, "… honestly there is way too many diseases out there and HIV is one of them at this time they didn't find a cure for HIV and I'm not trying to risk trying to get HIV from no one. I don't care how beautiful you are." ("Eric": Black, 22). The same participant also felt a strong sense of responsibility to have conversations with others within his community, especially those who are younger than him. His motivation to have these conversations stemmed from a lack of mentorship during his youth:

> I felt like it was kind of my responsibility because in a way I'm just 22 but sometimes I feel older than a lot of these people…a lot of them were like 18, you know 17, 18, just coming into adulthood…I was just like them when I was 18. I swore I knew everything I swore, you couldn't tell me nothing…I never had somebody that was there to really sit me down and tell me what was going on I pretty much had to look on my own…I never had a mentor or somebody to like lead me to my path I had to lead myself in a way. ("Eric": Black, 22)

Men also felt it was particularly important to have discussions within their communities, as one participant stressed the importance of having HIV prevention conversations within the black community:

> …especially black male, you know, I try my best to give them the knowledge I got 'cause I know that's a(n) issue in the black community, man. If I could help another brother, you know, I will do it…I try to help them if they want to hear it. ("Scott": Black, 51)

Some participants indicated that their perception of the other person's risk motivated them to initiate conversations. For example, one bisexual participant chose to engage in an HIV-related conversation with a gay-identified person primarily because he believed that being "fully gay" (i.e., men who have sex with men only [MSMO]) is at greater HIV risk:

> I initiate it because he's fully gay. He not bisexual. And I'm very worried about his well being because a lot of people don't let their partner know what their status is. And then they be like ok you look clean, oh I'll sex with him unprotected ("Frank": Black, 23).

Discussion

We explored HIV-related communications among black and Hispanic/Latino bisexual men in NYC and found major themes related to these discussions: (1) communication strategies, (2) barriers, and (3) motivations. All of the themes have a subtext of the men being selective regarding when and with whom to have HIV-related conversations; this underscores the complexity and delicacy with which these conversations occur, and also the contexts in which HIV-related research with behaviorally bisexual men take place. Therefore, researchers must consider this context and remain mindful and culturally aware when conducting research and program/intervention activities with bisexual men.

For communication strategies, several black and Hispanic/Latino bisexual men described physical cues, humor, and persuasion as ways to approach often difficult and awkward HIV-related discussions. Though not specific to bisexual black and Hispanic/Latino populations, some other studies of MSM indicated that exposure to guided strategies (e.g., as presented on TV or social media), like video vignettes of real people with HIV-related stories, may help persons looking for ways to have conversations (Lippman et al., 2015); this approach is aligned with some of the conversation strategies described by the men in Project BROTHA. HIV prevention was a sensitive topic of discussion for many of our participants; they sometimes used indirect strategies to facilitate communication by asking partners about other health indicators, listening for verbal cues such as inflection and tone of voice, or using code words known only among members of their social networks. Other qualitative research has shown that black MSM who used implicit cues were more likely to default to condom use; black MSM who engaged in condomless sex relied more on an explicit decision-making process (Campbell et al., 2014).

Regarding barriers to HIV-related communications, several sub-themes for the men centered on fear, presumed trust, and stigma. These subthemes remain common threads throughout HIV prevention and education efforts with MSM, especially MSM of color and bisexually active MSM of color (Wohl et al., 2013). In fact, as it relates to HIV status disclosure, some studies suggest that compared with white HIV-positive MSM, black and Hispanic/Latino MSM are less likely to disclose their HIV status due to perceived homophobia and cultural attitudes in some communities of color (Garett, Smith, Chiu, & Young, 2016). Similar to other studies (Mavhandu-Mudzusi & Sandy, 2015; Schrimshaw, Downing, & Cohn, 2018), we also found that various forms of stigma (e.g., HIV or sexuality related) affected their approach or reaction to HIV prevention communication, particularly in socially conservative communities. Our analyses further expand this knowledge area by illustrating the various nuances of how stigma influences HIV communication among bisexual men. These findings could enhance communication strategies that improve HIV prevention efforts designed specifically for bisexual men. Though most of these reports are not exclusive to bisexual black and Hispanic/Latino men, they underscore the importance of developing interventions

that reduce homophobia and stigma in an effort to encourage more HIV-related dialogue in some communities of color as an additional HIV prevention tool (Winter, Sullivan, Khosropour, & Rosenberg, 2012).

Motivations described by the men included increased self-esteem and perceptions about others' HIV risk. We found that these motivations for HIV-related communications also mirror those for engaging in regular STI testing and safer sex behaviors among MSM (Heijman, Zuure, Stolte, & Davidovich, 2017). We also found that many self-identified bisexual black and Hispanic/Latino men in our study were motivated by a sense of personal and social responsibility. Further investigations are needed to understand these motivations as potential facilitators for engaging in HIV conversations. We also found challenges in defining clear correlations between somewhat nebulously-defined sexual relationships (i.e., monogamous vs. casual) and its subsequent impact on HIV-related communications. These findings are consistent with research data (Serovich, Laschober, Brown, & Kimberly, 2017) revealing inconclusive associations between relationship status and HIV-related discussions among MSM; further examination is needed to clarify this dynamic for bisexual men.

Strengths and Limitations

There are some limitations to this study. First, our small sample size and focus on bisexual men in NYC limit the generalizability of our data to other black and Hispanic/Latino bisexual men; engaging larger numbers of bisexual men, including men residing in rural areas and in the southern U.S., is vital for future studies. Second, our results have limited generalizability due to the purposive sampling methods in a single urban location. It will be important to examine the HIV-related communication among bisexual black and Hispanic/Latino men in other parts of the country and in non-urban areas. Third, the research study might have volunteer bias; the presence of a $60 participation incentive might have skewed the sample toward men of lower socioeconomic status. Fourth, our study consisted of mostly black bisexual men; future studies should include larger numbers of bisexual Hispanic/Latino men to obtain additional insight for bisexual men of color.

However, an important strength of this qualitative analysis is providing rare data to better understand HIV-related communications between bisexual black and Hispanic/Latino men; these data can inform HIV prevention efforts with bisexual black and Hispanic/Latino men. The results also suggest that prevention programs in NYC may benefit from incorporating more communication skills building, in combination with stigma reduction efforts specifically designed for non-disclosed bisexual men of color. Furthermore, the communication patterns identified in this study can inform HIV prevention researchers and professionals on strategies to recruit and engage bisexual men who are more reluctant to disclose their sexuality and discuss HIV prevention. Our findings can be incorporated into outreach efforts for bisexual men to facilitate activities that address the programmatic needs and research gaps for bisexual men.

Conclusion

Understanding the communication patterns among bisexual men will contribute to strengthened HIV prevention strategies for bisexual men of color, who are disproportionately affected by HIV in the U.S. Our findings can inform prevention efforts such as risk-reduction messaging campaigns, and other prevention and care interventions designed for bisexual men, especially men of color. These efforts are vital as we work toward decreased HIV-related disparities and improved health equity consistent with national HIV prevention goals.

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Appendix

Semi-Structured Interview Guide for Project BROTHA, 2011–2012.

Interviewer: "In this first section, we want to hear about the kinds of conversations you have with people about preventing HIV. Conversations may happen in person, on the phone, online, or in a variety of other ways. These conversations could be about any aspect of HIV prevention, such as testing, using a condom before sex, discussing ways to have sex that don't involve fluid exchange, among other aspects."

1. How often do you have conversations about HIV prevention?
    - With whom do you typically or most often have conversations about HIV prevention (friends, sex partners, social workers, doctors, acquaintances, peers, etc.)?
    - How does the type of person influence the kind of conversation you have (content, initiator of the conversation, etc.)?
2. Where do these conversations typically take place?
3. What kinds of things do you talk about when you have conversations about HIV prevention?
    - How does the type of person influence what kinds of things you talk about when you have conversations about HIV prevention?
4. Now we'd like to get some stories about specific conversations you've had about HIV prevention.
    - Please tell me about the last time you had a conversations about HIV prevention with a friend.

- Please tell me about the last time you had a conversation about HIV prevention with a sex partner.
- Please tell me about the last time you had a conversation about HIV with a peer or acquaintance.
- Were these conversations typical for you in terms of the kinds of conversations you have about HIV prevention?
  - If yes, how so?
  - If no, why not?

Probes:

- Who is this person to you?
- Where was this conversation taking place?
- What else was going on at the time of the conversation (e.g., was there drinking or drug use involved, were there other people in the conversation)?
- How did you feel about having this conversation with (***)?
- Did you feel like you were knowledgeable about HIV prevention? What about the other person?
- What are some of the things that were discussed in this conversation?
- What was the outcome of that conversation, if any?

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Table 1

Demographic characteristics of black and Latino bisexual men in New York City, Project BROTHA, 2011–2012 (n = 36)

	***N* (%)**
Age (years)	
18–24	4 (11)
25–32	4 (11)
33–44	9 (25)
45–64	17 (47)
Missing	2 (6)
Race/ethnicity	
Black/African-American	30 (83)
Latino/Hispanic	4 (11)
Both	2 (2)
Highest level of education completed	
< Grade 12	7 (19)
Grade 12 or GED	9 (25)
Some college, associate's/technical degree	10 (28)
Bachelor's degree	7 (19)
Postgraduate degree	3 (8)
Current employment status	
Employed full time	3 (8)
Employed part time	12 (33)
Unemployed	21 (58)
Living below poverty level	
Yes	11 (31)
No	25 (69)
Health insurance coverage	
Yes	28 (78)
No	8 (22)
Homeless in the past 3 months	
Yes	9 (25)
No	27 (75)
Condomless sex in the last 3 months	
Vaginal	
Yes	7 (19)
No	29 (81)
Anal insertive	
Yes	16 (44)
No	20 (56)
Anal receptive	
Yes	11 (31)

	***N* (%)**
No	25 (69)
Exchange sex—food/drugs/shelter/money	
Yes	6 (17)
No	30 (83)
Result of the most recent HIV test	
Negative	30 (83)
Did not get results/unknown	1 (3)
Missing	5 (14)

GED general equivalency degree (or degree)