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The Influence of Culture on HIV Disclosure Among Gay Asian Males

David C. Doan
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Walden University

College of Health Sciences

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David Doan

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Walden University
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Abstract

The Influence of Culture on HIV Disclosure Among Gay Asian Males

by

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MBA, University of St. Francis, 2012

MS, University of St. Francis, 2006

BA, University of South Florida, 1999

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

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Abstract

HIV-positive, Asian Pacific Islander (API) men who have sex with men (MSM) experience triple minority stigma including HIV, sexual orientation, and minority ethnicity. To date, there is no research that examines the influence of cultural factors, level of acculturation, social determinants of health, and other confounding variables (e.g., age, education, level of income, and length of time since diagnosis) on HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners for API MSM. The theoretical framework for this study was based on Hofstede's original cultural values and Triandis's cultural dimensions. In this 2-phase, mixed methods, sequential explanatory study, 24 API MSM participants who are members of Fridae and other API organizations in the United States completed an anonymous online survey and 8 participants in Southern California completed in-depth semistructured phenomenological qualitative interviews. None of the regressions produced significant findings at the requested significance level (i.e., $p < 0.5$). The findings from the 2 phases of the study were integrated to facilitate a deeper, richer, and better understanding and explanation of those results than either approach alone. This mixed methods study was unique because it addressed an under-researched and poorly understood population of API MSM. The findings from this study have implications for positive social change for practitioners to incorporate culturally sensitive counseling strategies and for policymakers to develop or modify existing HIV preventive health education and health promotion programs for HIV-positive API MSM to negotiate safer sex behaviors, improve well-being, provide informed choice, and protect life that would promote competent quality care.

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Dedication

I dedicate my dissertation work to my family and close friends. I am grateful for my mom, Nina, who provided me with many home-cooked meals so that I could devote my time to writing. I am thankful for my two loving cats, Moulin and Rouge, who are smart enough to know that I have not neglected them. Finally, I dedicate this piece of work to my loving younger brother, Todd, who passed away way too young and left an amazing legacy behind in this world that I could never be able to fill.

I also dedicate this dissertation to my many close friends who have supported me throughout the process. I apologize for declining your numerous invitations to socialize through this academic journey. You have convinced me that my close friends are my chosen family.

I dedicate this work to those who have lost their lives or are currently afflicted with HIV/AIDS. I am convinced that there will be a cure to this unwarranted, unjustified, and stigmatizing disease (one day soon).

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This humble work is dedicated to the amazingly talented, brilliant, and incredible dissertation committee: Dr. Jacquie Fraser and Dr. Angela Prehn. You both have provided excellent and sound guidance and mentorship. You lit the fire in me when my candle was temporary extinguished. With your continued support, words of encouragement, and humanistic approach, you reignited my flame and motivated me to complete this dissertation while respecting my time, judgment, and opinions. I am forever grateful for your words of wisdom, kindness, love, and support. Most importantly, you have comforted my soul through the numerous personal losses and challenges that I have experienced throughout this dissertation journey. With much gratitude and appreciation, I promise to take what you have altruistically given me to guide and help others in their quest to achieve their goals, dreams, and ambitions. Through you and this dissertation journey, I am a believer that with desire, dedication, determination, discipline, concentration, hard work, perseverance, and faith, anyone can achieve anything they set their heart and mind to aspire.

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Chapter 1: Introduction to the Study

AIDS was first reported over 35 years ago in the United States on June 5, 1981, under the diagnosis of *Pneumocystis carinii* pneumonia in the *Morbidity and Mortality Weekly Report*, which described the rare disease that five young homosexual men had at the time in Los Angeles, California (Gottlieb, 2006; Gottlieb et al., 1981; Sepkowitz, 2001). On June 18, 1982, the Centers for Disease Control and Prevention (Centers for Disease Control and Prevention [CDC], 1982) reported a cluster of 19 cases of Kaposi's sarcoma (KS) and/or *Pneumocystis carinii* pneumonia (PCP) among previously healthy homosexual male residents of Los Angeles and Orange counties, California. One of the two hypotheses that the CDC offered at the time was that the infectious agents were being transmitted among homosexually active males and if true, sexual partners of these patients may have been at increased risk of developing KS and/or PCP (CDC, 1982). By the early 1990s, HIV infection and AIDS had become the leading and most common cause of death of Americans among persons aged 25-44 years, surpassing unintentional injuries as cause of death in this age group by 1994 (CDC, 1996).

The CDC (2015b) estimated that more than 1.2 million people in the United States aged 13 years and older are living with HIV infection, including 168,300 (14%) or almost 1 in 7 who are unaware of their infection. Even though gay, bisexual, and men who have sex with men (MSM) represent only about 4% of the male population in the United States, it is the population that is most profoundly affected by HIV, accounting for 54% of all people living with HIV infection in 2011, the most recent year from which these data are available (CDC, 2015b).

Of the various MSM groups, Asian Pacific Islanders (APIs) is an important population on which researchers should focus more attention in regard to HIV/AIDS for numerous reasons. First, the Asian population experienced the fastest rate of growth between 2000 and 2010, with an increase by 43%, or more than four times as fast as the total population (U.S. Census Bureau, 2011). Although the API population represents about 5% of the total U.S. population, this proportion is expected to increase to 9% by 2050, accounting for 16% of the nation's growth from 1995 to 2000, 17% from 2000 to 2020, and 21% from 2020 to 2050 (U.S. Department of Commerce, 1996). In fact, California led the nation with the largest minority population (22.3 million) by having a "majority-minority" population (i.e., over 50% of the population was minority) in part due to relatively higher levels of immigration in 2010 (U.S. Census Bureau, 2011). Second, the U.S. Office of Management and Budget's (OMB) *1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity* required federal agencies, including the U.S. Census Bureau, to collect race information using the following five minimum race categories: White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander (U.S. Census Bureau, 2011). This federal requirement supports the need to collect data and conduct HIV research for all racial groups including API as this group has historically been grouped in the "Other" category. Third, Asian Pacific Islanders collectively share unique characteristics compared to other racial or ethnic groups in the United States and are a heterogeneous group with many different ethnicities (roots in at least 29 Asian countries and 20 Pacific Islander cultures), languages (over 100 languages), and cultures (numerous religions; CDC, 2013; Ghosh, 2003; Joint United

Nations Programme on HIV/AIDS [UNAIDS], 2013). Fourth, a recent analysis of HIV data covering 2001-2008, which showed that APIs have the highest rate of increase in new HIV infections in the United States at 4.4%, the only statistically significant growth among any racial or ethnic group while other racial and ethnic groups have seen a decline in the rate of HIV infection (Asian & Pacific Islander Wellness Center, 2012).

Fifth, the API MSM group is of particular concern. Compared to other racial and ethnic groups, APIs continue to account for only 2% (950) of the estimated 47,500 new HIV infections in the United States in 2010 and the rate of estimated new HIV infections among this population actually decreased from 10.4 per 100,000 in 2007 to 8.4 in 2010 (CDC, 2015a). However, a closer examination of the numbers reveals that there are trends that raise public health concerns. For example, the CDC (2015a) reported that of the estimated 973 adult and adolescent Asians diagnosed with HIV infection in 2013, 82% (799) were men and of these men, 88% (703) had male-to-male sexual contact or were MSM.

Finally, race/ethnicity misidentification also confounds the low number of HIV cases among API and may not reflect the true burden of HIV that could lead to the underestimation of HIV infection in this population (CDC, 2015a). Medical record information does not necessarily reflect patient self-reported or self-identified race/ethnicity and is limited by the accuracy of the information obtained by providers, with the common example of the frequent misidentification of Filipinos as Hispanics/Latinos because of the assumptions made based on Hispanic surnames (CDC, 2013). For example, the top 10 of the 50 most frequently-occurring surnames for the Filipino ethnic group includes Reyes, Santos, Garcia, Cruz, Ramos, Delacruz, Mendoza, Bautista, Deguzman, and Fernandez

(Lauderdale & Kestenbaum, 2000). That is, patients who have one of these common Hispanic surnames may be erroneously classified as Hispanics or Latinos rather than correctly in the API group.

In addition to the growing population of API in the United States, there are many contributory factors why APIs are particularly affected by HIV. Nearly one in four (22%) API persons living with HIV does not know that they have it and therefore are unable to obtain the needed care, such as taking advantage of highly active antiretroviral therapy (HAART) to extend their lives and reduce the risk of transmission to others (CDC, 2015a; Koh, 2014). Cultural factors including language barriers, fear of discrimination, stigma of homosexuality and HIV, immigration issues, and fear of bringing shame to their families may affect the risk of HIV infection as some APIs avoid seeking testing, counseling, or treatment (CDC, 2015a). There is also limited research about API health and HIV infection resulting in few targeted prevention programs and behavioral interventions in this population (CDC, 2015a). English language fluency is also a barrier to many APIs, as 76.5% of Asian Americans reported speaking a language other than English at home (U.S. Census Bureau, 2011).

Despite much progress in addressing the healthcare inequity over the past few decades, the opportunity still exists to provide culturally relevant HIV services to the API population. Koh (2014), Assistant Secretary for Health, U.S. Department of Health and Human Services, offered 10 reasons why it is important for the Office of National AIDS Policy to address HIV/AIDS in API communities. One of these reasons is the critical need to deliver HIV prevention, care, and treatment services that are respectful of and responsive

to APIs' cultural needs (Koh, 2014). The CDC (2013) suggested that state health departments discontinue combining Asian Americans and Native Hawaiian and Other Pacific Islanders (NHOPIs) into an "Other" category and collect data on ethnic subgroups in addition to data on race to improve HIV surveillance data collection.

This recommendation has implications to researchers to explicitly include the API population when conducting research to ensure that the sample is diverse and representative. The U.S. Department of Health & Human Services (HHS, 2013) Office of Minority Health (OMH) initially developed the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) in 2000 and later enhanced these standards "intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services" (p. 1). The two overarching philosophies of social justice and standards of business encapsulated the main six reasons that guided the development of the National CLAS Standards (HHS, 2013). Two of these reasons include the need to respond to current and projected demographic changes in the United States and to eliminate longstanding disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds that have an estimated combined cost of health inequalities for minorities of \$1.24 trillion (HHS, 2013; LaVeist, Gaskin & Richard, 2009).

Even though it has been 35 years after the first case of HIV/AIDS was reported in the United States, there is an ongoing need to conduct research to better understand the influence of cultural factors on HIV-positive disclosure to casual sexual partners. The

findings from this study have direct implications for positive social change by addressing the cultural needs and other social determinants of health of the growing API population in the United States on the topic of HIV-positive disclosure to casual sexual partners.

Background of the Study

Advances in diagnosis, treatment, and care of HIV infection have transformed HIV/AIDS from a deadly disease to a manageable, chronic condition. Even so, people who are diagnosed with HIV/AIDS have the responsibility and burden of disclosing their HIV-positive serostatus to others (Lehman et al., 2014). Disclosure is a complex and emotionally charged burden for those who are infected with HIV (Iwelunmor, Sofolahan-Oladeinde, & Airhihenbuwa, 2014; O'Connell, Reed, & Serovich, 2014; Tshabalala, 2014). MSM are faced with the challenge and responsibility of disclosing their HIV-positive serostatus to others including casual sexual partners (Knox, Reddy, Kaighobadi, Nel, & Sandfort, 2012; Tang, Bensman, & Hatfield, 2013).

Factors that impact self-disclosure decisions include fear of: rejection and disapproval (Lee, Li, Iamsirithaworn, & Khumtong, 2013; Petrak et al., 2001), discrimination (Nachega et al., 2012; Patel et al., 2012; Petrak et al., 2001; Seid, Wasie, & Admassu, 2012), being criminally prosecuted (Cockerill & Wahlert, 2015), loss of confidentiality (Alemayehu, Aregay, Kalayu, & Yebyo, 2014), and of potential shame and loss of face following the disclosure process (Li, Holroyd, Lau, & Li, 2015). Other negative consequences of HIV-positive disclosure include anticipated disruption of relations, concern about insurance benefits and employment, loss of economic security, a desire to protect oneself and others emotionally, the possibility of verbal abuse, physical abuse, tension, and

anger, and the possibility of being disowned by family, friends, and society (Chaudoir, Fisher, & Simoni, 2011; Kang & Rapkin, 2008; Lee, Li, Iamsirithaworn, & Khumtong, 2013; Osinde, Kakaire, & Kaye, 2012; Seid et al., 2012; Suzan-Monti et al., 2011; Vaz et al., 2011; Vu et al., 2012). There are also political, psychosocial, economic, religious, moral, and cultural factors that persons living with HIV (PLHIV) need to consider when choosing to self-disclose their HIV serostatus to others (Henry, 2014; Kang & Rapkin, 2008; Phillips et al., 2013; Qiao, Li, & Stanton, 2013). The timing (i.e., recently diagnosed versus in advanced stages of AIDS or latency phase of the disease) and to whom PLHIV choose to self-disclose also plays in the decision-making process. For example, the degree of ease or difficulty of self-disclosing to a close friend, family member, spouse, sexual partner, child, sexual encounter, romantic interest, co-worker, healthcare provider, and acquaintance certainly differs for each party or constituency (Brohan et al., 2012; Hightow-Weidman et al., 2013; John-Stewart et al., 2013; Kiula, Damian, & Msuya, 2013; Shacham, Small, Onen, Stamm, & Overton, 2012; Serovich, Craft, & Reed, 2012; Vaz et al., 2011; Zhou, Zhang, Li, & Kaljee, 2013).

Even though there are many documented benefits for PLHIV to self-disclose their HIV serostatus to others, such as stress reduction from decreased psychological and physical burden, improvement in mental and physical health, and possibly increased lifespan and health status, self-disclosure is not easy given the potential real and perceived ramifications and consequences mentioned above (Kang & Rapkin, 2008; Patel et al., 2012; Vyavaharkar et al., 2011). Findings from previous studies suggest that PLHIV who choose not to disclose their HIV serostatus (nondisclosure) may experience negative and untoward

physical, emotional, and mental health conditions (Audet, McGowan, Wallston, & Kipp, 2013; Hult, Wrubel, Bränström, Acree, & Moskowitz, 2012; Kang & Rapkin, 2008).

From an extensive review of previous research, there is no known recent published study in which the racial and ethnic differences related to HIV-positive serostatus to casual sexual partners focusing on the API MSM population has been examined. In an outdated study, Stein et al. (1998) found that 40% of the 203 participants interviewed did not disclose their HIV serostatus to sexual partners. The participants in Stein et al.'s (1998) study did not include any API men but only Black (46%), Latino (23%), and White (27%) men. In a similar study, Serovich and Mosack (2003) investigated reasons for HIV disclosure or nondisclosure to casual sexual partners using a participants' pool of 78 HIV-positive gay men. Even though Serovich and Mosack (2003) expanded the study to specifically focus on "casual" sexual partners as opposed to "steady" or intimate sexual partners, the participants included an overwhelming 74% of White men and did not include any API gay men.

To date, there is one known systematic review of HIV behavioral prevention research that was conducted by Darbes, Kennedy, Peersman, Zohrabayan, and Rutherford (2002). The investigators evaluated the effects of behavioral, social, or policy interventions on at least one outcome measure related to HIV transmission in Asian Americans and Pacific Islanders and included studies with at least 50% or more API participants in their samples. Overall, 271 potential relevant studies of all ethnic minorities were identified, of which only 39 were potentially relevant for inclusion in the review as most studies were excluded because the sample comprised less than 80% API participants with no separate analyses (Darbes et al., 2002). The systematic review conducted by Darbes et al. (2002)

identified numerous gaps in research reflecting the need for well-designed intervention studies that specifically target the API populations (i.e., consisting of 100% API participants or have separate analyses for API participants). In addition, Darbes et al. (2002) only found one study focusing on either API MSM or gay men despite the rates of new infection for API, a population known to be most at risk for such an infection.

When developing HIV behavioral prevention programs and working with the API MSM population, it is important to consider cultural differences that may be unique this population. Notable anthropologists such as Hofstede and Triandis have developed models that help to explain cultural differences. Specifically, Hofstede (1980) classified and conceptualized cultures on a national level using the following dimensions: individualism-collectivism, power distance, uncertainty avoidance, and masculinity-femininity. Triandis and Gelfand (1998) expanded on Hofstede's (1980) cultural dimensions to examine different construals and interpretations of the self to help explain individual experiences, including behavior, cognition, and emotion. It is therefore plausible to make a connection between the cultural dimensions of the self or individual when examining factors that may influence HIV-positive disclosure behaviors, attitudes, and intentions. Despite the need, there have not been any studies published since 2002 that exclusively target 100% of API MSM in the United States to examine the influence of cultural values, level of acculturation, and other contributing factors on HIV-positive disclosure to casual sexual partners.

Problem Statement

Despite the documented successes in HIV prevention over the past three decades, there are additional prevention challenges. It is important to be inclusive of all racial and

ethnic minorities; historically, gay, White men in metropolitan areas have been the main population recruited in the majority of HIV-positive disclosure studies. Among all HIV infections in the API population, MSM are by far the largest at-risk group to contract the virus in the United States. They accounted for 80% of all HIV infections from 2001-2008 (Asian & Pacific Islander Wellness Center, 2012) which increased to 88% by 2013 (CDC, 2015a). APIs collectively share unique characteristics compared to other racial or ethnic groups in the United States and are a heterogeneous group with many different ethnicities, languages, and cultures (CDC, 2013; Ghosh, 2003; UNAIDS, 2013). In addition, the API population experienced the fastest rate of growth compared to other major race groups and is projected to increase from 5% to 9% of the total United States population by 2050 (U.S. Department of Commerce, 1996).

Coupled with these issues is the complex and emotionally charged process of HIV disclosure to others (Iwelunmor et al., 2014; O'Connell et al., 2014; Tshabalala, 2014). MSM are faced with the challenge and responsibility of disclosure of their HIV-positive serostatus to others including casual sexual partners (Knox et al., 2012; Tang, Bensman, & Hatfield, 2013). Tang, Bensman, and Hatfield (2013) argued that there is a relationship between culture and sexual self-disclosure and that people from different cultures behave differently in intimate self-disclosure. It is logical to propose that API MSM differ in their rate of HIV-positive disclosure compared to the non-API populations (i.e., Whites, Blacks, Hispanics, and Latinos) that are typically included in HIV-positive disclosure studies. Although the aforementioned research illuminates important findings regarding the need to focus on racial and ethnic minorities, a gap or lack of research exists in that there is no

known study that examines the influence of cultural factors as it relates to HIV-positive disclosure behaviors, attitudes, and intentions in API MSM. Thus, there is a need to examine the influence of cultural factors, level of acculturation, social determinants of health, and other confounding variables (e.g., age, education, level of income, and length of time since diagnosis) on HIV-positive disclosure to casual sexual partners for API MSM.

Purpose of the Study

The purpose of this two-phase, mixed methods, sequential explanatory study was to learn about HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners for API MSM. In the first phase, I used quantitative research questions to examine the influence of cultural factors, level of acculturation, length of time since diagnosis, age, level of education, and income. I further explored the information from this first phase in a second qualitative phase.

In the second phase, I used qualitative interviews to probe significant quantitative results by exploring aspects of the HIV-positive disclosure behaviors, attitudes, and intentions with a few participants. The reason for combining both quantitative and qualitative data was to first obtain statistical, quantitative results from a sample and then follow up with qualitative research in the second phase with a few individuals to better understand and explain those results in more depth.

Other contributing factors such as level of education, income, and age were also explored to understand if they contributed to the phenomenon of HIV disclosure. The findings from this study illustrated the relationship of cultural factors, level of acculturation, and other social determinants of health that would help to predict the intention of future

HIV disclosure to casual partners for API MSM. Counseling strategies, programs, and support can be implemented to remove barriers associated with HIV disclosure.

Policymakers and practitioners can incorporate the study's findings to develop culturally appropriate and sensitive HIV prevention programs for the API community.

Research Questions and Hypotheses

The following three research questions guided the quantitative portion of the study:

Research Question 1 (RQ1): What was the association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure behaviors in API MSM?

H_01 : There was no statistically significant association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure behaviors in API MSM.

H_a1 : There was a statistically significant association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure behaviors in API MSM.

Research Question 2 (RQ2): What was the association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure attitudes in API MSM?

H_02 : There was no statistically significant association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure attitudes in API MSM.

H_{a2} : There was a statistically significant association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure attitudes in API MSM.

Research Question 3 (RQ3): What was the association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure intentions in API MSM?

H_{03} : There was no statistically significant association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure intentions in API MSM.

H_{a3} : There was a statistically significant association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure intentions in API MSM.

For the followed up qualitative portion of the study, the central research question was: What factors influenced the HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners in API MSM? The subquestions included the following:

- a) How cultural values may have influenced HIV-positive disclosure?
- b) How level of acculturation may have influenced HIV-positive disclosure?
- c) What length of time since diagnosis may have influenced HIV-positive disclosure?
- d) How age may have influenced HIV-positive disclosure?
- e) How level of education may have influenced HIV-positive disclosure?
- f) How income may have influenced HIV-positive disclosure?

Theoretical Framework for the Study

The theoretical framework for this study was based on the combination of Hofstede's (2011) original typology of individualism-collectivism cultural values and Triandis's horizontal and vertical cultural dimensions, resulting in four types of cultural dimensions: horizontal collectivism, vertical collectivism, horizontal individualism, and vertical individualism (Sandhu & Ching, 2014; Singelis, Triandis, Bhawuk, & Gelfand, 1995; Triandis, 2001; Triandis, Bontempo, Villareal, Asai, & Lucca, 1988; Triandis & Gelfand, 1998). Horizontal collectivism (H-C) is a cultural pattern in which the individual emphasizes interdependence and equality, but does not submit easily to authority; vertical collectivism (V-C) is a cultural pattern in which the individual emphasizes interdependence and competition with out-groups (e.g., healthcare providers, service providers, law enforcement personnel, government bureaucrats, society) with the important aspects of serving and sacrificing the in-group (e.g., from immediate family members to extended family, cousins, close friends, and even those from the same hometown); horizontal individualism (H-I) is a cultural pattern in which the individual strives to be autonomous and distinct without desiring special status; and vertical individualism (V-I) is a cultural pattern in which the individual strives to be distinct, desires special status, and inequality is expected (Singelis et al., 1995; Triandis, 2001; Triandis et al., 1988; Triandis & Gelfand, 1998).

The additional vertical and horizontal cultural dimensions focusing on the individual that Triandis proposed expand on Hofstede's original typology of individualism-collectivism cultural values at the national level. Because the decision to self-disclose HIV

is at the individual level, the theoretical framework was applied at the individual level rather than at the national level (Bergiel, Bergiel, & Upson, 2012; Blodgett, Bakir, & Rose, 2008; Yoo, Donthu, & Lenartowicz, 2011). There have been numerous studies that have suggested that the influence of culture correlates with HIV-positive disclosure (Holt et al., 2011; Lee et al., 2013; Lin et al., 2015; Maiorana et al., 2012; Marks, Petrak et al., 2001; Simoni, Ruiz, and Richardson, 1995; Mason et al., 1995; Stein et al., 1998; Sullivan, 2005; Tshweneagae, Oss, and Mgutshini, 2015; Zea et al., 2004). Therefore, it was logical to incorporate Triandis's horizontal and vertical cultural dimensions to Hofstede's typology of individualism-collectivism to help explain the influence of cultural factors in predicting the behavior of self-disclosure of HIV-positive status to casual sexual partners in API MSM at the individual level.

As a group, the cultural values of Asian Americans are more closely aligned with the cultural dimension of collectivism over individualism. When Triandis (1995) introduced the two additional vertical and horizontal dimensions to complement Hofstede's individualism-collectivism cultural dimension, it allowed for more specificity and variety to examine culture at an individual level. In 2010, two-thirds (66.5%) of APIs in the United States were foreign-born and nearly three-fifths (57%) of foreign-born APIs were naturalized United States citizens (Immigration Policy Center, 2012). As mentioned previously, APIs are a heterogeneous group with many different ethnicities, languages, and cultures (CDC, 2013; Ghosh, 2003; UNAIDS, 2013). With this highly diverse API group, it was important to understand how an individual's level of acculturation might influence his cultural dimension (i.e., V-I, H-I, V-C, H-C) and decision to self-disclose HIV-positive serostatus.

Nature of the Study

This study was a two-phase, mixed methods, sequential explanatory study to show the relationship between individualistic-collectivistic cultural dimensions, level of acculturation, and HIV-positive serostatus self-disclosure to casual sexual partners for API MSM. Other contributing factors such as length of time or number of years since HIV diagnosis, age, level of education, and income were also explored to understand if these independent variables may have contributed to the phenomenon of HIV disclosure behaviors, attitudes, and intentions. The findings from this study provided empirical evidence of the characteristics that are associated with HIV-positive serostatus disclosure behaviors, attitudes, and intentions to casual sexual partners of API MSM.

For the first quantitative study, the sampling method used was purposeful, convenience sampling, which falls under the broad type of accidental nonprobability sampling category. Inclusion criteria for participants included those who have identified as API MSM and have been diagnosed with HIV/AIDS for more than six months, who are 18 years and older, who can read and write in English, and have engaged in casual sexual behaviors with other HIV-negative or unknown serostatus partners that resulted in a decision about whether to disclose their serostatus in the past three years. Volunteers were recruited from a pool of API MSM who reside in the United States and are members of Fridae, the largest Asia's LGBT online community that has presence in the United States and other countries. Specifically, members of Fridae who reside in the United States received an electronic or email direct marketing (EDM) campaign or email message soliciting their participation in the study. Fridae members were also encouraged to forward

the email message to other potential eligible API MSM participants (i.e., snowball sampling).

Participants completed an Internet-based survey measuring the constructs of the dependent and independent variables to address the six research questions. Specifically, the Individual Cultural Values Scale (CVSCALE) was used to assess Hofstede's cultural dimensions at the individual level (Yoo et al., 2011) together with the Culture Orientation Scale designed to measure the four dimensions of individualism and collectivism (Triandis & Gelfand, 1998). The Asian American Multidimensional Acculturation Scale (AAMAS) was used to measure the level of acculturation (Chung, Kim, & Abreu, 2004). Participants completed three scales developed by Serovich, Reed, Grafsky, and Andrist (2009) to assess the disclosure behaviors, attitudes, and intentions to casual sexual partners. Participants also completed additional demographic questions relating to age, level of education, income, and length of time since first diagnosed with HIV/AIDS.

For the second, follow-up explanatory qualitative study, data from a handful of participants were collected to help explain, build, or connect upon initial quantitative findings.

Definition of Terms

Acculturation: For the purposes of this study, the classical definition offered by Redfield, Linton, and Herskovits (1936) was used: "Acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups" (p. 149). Berry's (1997) framework on acculturation distinguishes

between group- or cultural-level acculturation (i.e., physical, biological, economic, social, and cultural) from individual- or psychological-level acculturation (i.e., life events, stressors, coping, stress, adaptation). It was the latter that was of interest as the individual- or psychological-level acculturation phenomenon has relevance to the individual decision to self-disclose one's HIV-positive serostatus.

Asian Pacific Islander (API): Asian referred to a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam (Office of Management and Budget, 1997; United States Census Bureau, 2011). Native Hawaiian or Pacific Islander referred to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or Pacific Islands (Office of Management and Budget, 1997; United States Census Bureau, 2011).

Casual Sexual Partner: For the purposes of this study, casual sexual partner was a broad term that described a partner who was not involved in an intimate, romantic, long-term, and committed relationship. Participants may assign one or more of the following labels to describe a casual sexual partner: “‘casual partner,’ ‘former casual partner,’ ‘fling,’ ‘trick’ (paying or not), ‘one-night stand,’ or ‘sex partner’” (Serovich & Mosack, 2003, p. 3); “‘booty call,’ ‘boy toy,’ ‘casual dating,’ ‘dick ‘em and dump ‘em,’ ‘fling,’ ‘fooling around,’ ‘friends with benefits,’ ‘fuck ‘n chuck,’ ‘fuck buddy (buddies)/fuck friends,’ ‘hit it and quit it,’ ‘hook-ups/hooks up,’ ‘last call,’ ‘no strings attached,’ ‘one night stand,’ ‘part-time boyfriend,’ and ‘use ‘em and lose ‘em’” (Wentland & Reissing, 2011, p.79).

Disclosure: Disclosure of HIV-positive serostatus can be active or passive. Active disclosure included verbal or written words that are relayed to a casual sexual partner. Passive disclosure included using codes or indirect hints such as HIV-related pamphlets or antiretroviral medications in plain view. Disclosure of HIV-positive serostatus was defined as one of the following situations: (a) the participant disclosed his HIV status and knew his casual sexual partner's or partners' HIV status to be HIV-negative; or (b) the participant disclosed his HIV status but did not know his casual sexual partner's HIV status (unknown serostatus). The definition of HIV-positive disclosure also included casual sexual partners who have not been tested, which would fall in the category of unknown serostatus. The above definition was generous in its inclusion of untested men and unknown serostatus of casual sexual partners which was believed to represent a more realistic picture of the ways in which HIV is raised in casual sex encounters between MSM.

HIV-positive: A person who is HIV-positive has antibodies against HIV detected on a blood test or gingival exudates (commonly known as a saliva test) (UNAIDS, 2011).

Lesbian, Gay, Bisexual, Transsexual, Transgender, Transvestite (LGBT): An abbreviation that covers lesbian, gay, bisexual, transsexual, transgender, and transvestite people and is a common abbreviation that emphasizes a diversity of sexuality and gender identities. Sometimes "LGBTI" is used as an abbreviation that covers lesbian, gay, bisexual, transsexual, transgender, transvestite, and intersex people (UNAIDS, 2011). To be consistent with most published research studies, the abbreviation LGBT was used over the less frequently used LGBTI abbreviation.

Men Who Have Sex With Men (MSM): An abbreviation used for “men who have sex with men” or “males who have sex with males”. The term was used regardless of whether or not these men had sex with women or had a personal or social gay or bisexual identity (UNAIDS, 2011). Therefore, the concept was useful because it also included men who self-identify as heterosexual but had sex with other men (UNAIDS, 2011).

People Living With HIV (PLHIV): The Joint United Nations Programme on HIV/AIDS (UNAIDS, 2011) recommends using this expression over PLWHA since this reflects the fact that an infected person may continue to live well and productively for many years. PLWHA is the abbreviation used to describe a group of people living with HIV/AIDS. Although PLWHA is commonly used in research studies, UNAIDS (2011) recommends replacing PLWHA with “people living with HIV” (PLHIV) because this phrase reflects the fact that an infected person may continue to live well and productively for many years. To align with the more recent UNAIDS (2011) recommendation, the abbreviation of PLHIV was used in this study.

Serostatus: “Serostatus” is a generic term that refers to the presence/absence of antibodies in the blood (UNAIDS, 2011). The term is often used to refer to HIV antibody status (UNAIDS, 2011).

Assumptions

In this study, proof of HIV diagnosis was not requested from participants and therefore the HIV-positive status of participants were assumed prior to consenting to participate in the study. All eligible participants were assumed to have access to the Internet to complete the web-based survey. It was also assumed that all participants responded to the

questions truthfully under the premise that the information gathered in the study was to be kept anonymous. It was assumed that participants were able to select the best response to a survey question. The selected instruments were intended to measure the individualism-collectivism and acculturation constructs and reasons for HIV-positive disclosure and non-disclosure. Another assumption was that the theoretical framework chosen had relevance and applicability to the participants, the research topic, and research questions. Lastly, the interpretation of the data accurately reflected the cultural values, level of acculturation, and other variables that would influenced participants' decision to self-disclose their HIV-positive status to casual sexual partners.

Scope and Delimitations

The scope and delimitations in the study were determined by a desire to better gain an understanding of the relationship between the cultural dimensions and values (e.g., individualism-collectivism), level of acculturation, and other social determinants of health (e.g., age, length of time since HIV diagnosis, level of education, income or socioeconomic status) and HIV-positive self-disclosure to casual sexual partners. The study consisted of participants who reside in the United States and had been identified as either Asian or Pacific Islander consistent with the definition outlined in the U.S. Office of Management and Budget's (OMB, 1997) *1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*. In this study, the focus was the influence of cultural factors, level of acculturation, and other social determinants of health such as age, length of time since diagnosis of HIV, and socioeconomic status such as income. The questions about

HIV-positive disclosure were directed toward self-disclosure to casual sexual partners as defined previously.

The study did not include participants who reside outside of the United States or have self-identified as having origins in any of the original peoples of Europe, the Middle East, or Africa (i.e., White); of the Black racial groups of Africa (i.e., Black or African American); of the original peoples of North and South America including Central America (i.e., American Indian or Alaska Native); or responses that are not included in the race categories mentioned above (i.e., Some Other Race) (OMB, 1997; U.S. Census Bureau, 2011). Other variables that may influenced whether a participant chooses to self-disclose his HIV-positive serostatus such as stigma, social support, self-efficacy, mental health diagnosis (i.e., depression), substance use, abuse, or dependence, communication styles, etc., were outside the scope of this study. As these factors have been shown to influence HIV-positive serostatus disclosure, they were considered confounder variables when interpreting the results. The survey instruments were composed of closed-ended Likert scales and questions without the option for participants to provide additional open-ended responses. A follow-up explanatory qualitative study was conducted to assess participants' reasons for HIV-positive serostatus disclosure and nondisclosure if statistically significant findings were found to one or more of the three research questions from the initial quantitative portion of the study.

Limitations

There are challenges to conducting surveys of socially stigmatized and hard-to-reach populations such as the API MSM on the topic of HIV-positive serostatus self-

disclosure to casual sexual partners. The difficult and multi-step process of sampling (i.e., from defining the theoretical population, to the study population, to the sampling frame, and to the sample) predisposes to a high possibility of introducing systematic error or bias (Trochim, 2006b). Even when the sample has been identified perfectly, it may not be possible to have access to all of the potential participants. Although it was preferable to use one of the probabilistic or random sampling methods over nonprobabilistic ones as the former allows for higher confidence intervals for the statistic that represent the population over the latter, it may not always be possible to do so. Therefore, it may be necessary to resort to one of the nonprobabilistic sampling methods when targeting the hidden and hard-to-reach populations of API MSM. The inability to use one of the probability sampling methods prevented generalization of the study results to the population.

There are fundamental limitations when using the correlational design and therefore any statistical difference or correlation must be interpreted with caution. Because there was no manipulation of the independent variables, causality cannot be implied but only correlation, if any. A phenomenon of reverse causality may also exist, which is a problem, when the direction of causality between two variables can be in either direction. There may also be the existence of one or more confounding variables that may not have been accounted for in the study, which can influence the rate of HIV-positive serostatus disclosure behaviors, attitudes, and intentions to casual sexual partners among API MSM. Another limitation of a correlational design was the presence of outliers – scores that fall substantially above or below most other scores in a data set and can alter the direction and

the strength of an observed correlation – that can obscure the correlation or relationship between any two variables.

There are other limitations in addition to those related to the methodological and the chosen cross-sectional, correlational design that warrant some attention. The use of a convenience sampling method was a limitation to the study. In other words, not all API MSM who reside in the United States are members of the Fridae online community website. Thus, the sample was limited to those who are members of the Fridae. As mentioned previously, the study was conducted over a certain interval of time (i.e., cross-sectional as opposed to a longitudinal study that includes follow-up intervals), which provided only a snapshot of the participants' HIV-positive disclosure behaviors, attitudes, and intentions. Another predictable limitation of the study was the nature of self-reported data from participants. Moreover, some researchers have noted the limitation of data collected about sexual behavior (e.g., HIV-positive disclosure behaviors, attitudes, and intentions) have the propensity to be flawed with errors in recall and tainted with biases such as social desirability and acquiescence bias (Jaccard et al., 2004; Przybyla et al., 2013; Reback, Kaplan, & Larkin, 2015; Semple, Patterson, & Grant, 2004).

Significance

The two-phase, mixed methods, sequential explanatory study was unique because it addressed an under-researched population of API MSM that is considered to be both a racial/ethnic minority and a sexual minority. Researchers will be able to incorporate the study's findings to address existing gaps and identify directions for future exploration to understand how culture might affect people's decision to self-disclose their HIV-positive

status. In addition, researchers can expand on the topic of HIV disclosure and add to the growing need for more research to other racial and ethnic groups. Paniagua (2014) discussed the need for practitioners (i.e., healthcare providers, counselors, therapists, and other healthcare professionals) to be multiculturally competent. The findings from this study will help raise awareness in multicultural counseling and cross-cultural communication. Specifically, practitioners will be able to incorporate culturally sensitive counseling, intervention strategies, and ongoing support to promote API MSM to self-disclose their HIV-positive serostatus to casual sexual partners when working with clients from this culturally diverse and marginalized population. Policymakers will be able to use the findings from the study to proactively develop or modify existing HIV prevention programs when working with different racial and ethnic groups in the LGBT community. Providing culturally sensitive and competent care to API MSM helps to reduce and eliminate the racial and ethnic healthcare inequities with the goal of decreasing the rate, prevalence, and incidence of HIV transmissions and other sexually transmitted infections.

HIV disclosure remains a key success factor in reducing the spread of the virus to others, especially between casual sexual partners. Therefore, the implications for positive change include knowledge useful for practitioners to incorporate culturally sensitive counseling strategies and ongoing support to facilitate appropriate, effective, and quality communication and policymakers to develop HIV prevention programs for HIV-positive API MSM to negotiate safer sex behaviors (e.g., condom usage, HIV-positive self-disclosure) that would promote competent quality care tailored to the needs of the high risk population of MSM who engage in casual sexual encounters. Sexual responsibility and

honest disclosure by seropositive individuals including API MSM remain at the center of HIV prevention especially in light of the growing number of API MSM who are infected with HIV. Those who disclose their HIV-positive serostatus tend to practice safer sex such as using a condom while those who not disclose their status tend to not use condoms (Grau et al., 2011; Hightow-Weidman et al., 2013; O’Connell et al., 2014). In addition to civil obligation and personal responsibility and accountability, many states in the United States continue to have stringent laws persecuting HIV-positive individuals who negligently, intentionally, or recklessly fail to disclose their positive serostatus to sexual partners. For example, the U.S. Public Health Service guidelines have recommended that individuals who have been diagnosed with HIV notify their sexual partners of their serostatus (Lehman et al., 2014). During the early years of the HIV epidemic and through the requirements of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act (Public Law 101-381; 104 Stat. 576), all states in the United States needed to certify that their criminal laws were adequate to prosecute any HIV-infected individual who knowingly, intentionally, or recklessly exposed another person to HIV (CDC, 2015d; Galletly, Lazzarini, Sanders, & Pinkerton., 2014; Lazzarini et al., 2013; Lehman et al., 2014; Mykhalovskiy, Betteridge, Sanders, & Jones, 2014). The CDC (2015d) reported that as of 2011, there were a total of 67 laws that had been enacted in 33 states focused explicitly on persons living with HIV. In 24 states, the laws require those who are aware of their HIV-positive serostatus to disclose to sexual partners (CDC, 2015d). In addition, 25 states criminalize those with HIV whose behaviors may pose a low or negligible risk for HIV transmission (CDC, 2015d). The

statistics on HIV criminalization laws in the United States help support the need to conduct more research on the topic of HIV-positive disclosure to casual sexual partners.

Summary and Transition

Even though HIV/AIDS is now considered a manageable and chronic condition, it remains a public health problem in the United States. There is an opportunity to address the health inequities and improve the quality of care including HIV prevention interventions for all individuals across the United States from various cultural backgrounds. The latest census report and epidemiological information on HIV/AIDS presented in Chapter 1 supported the need to devote more attention in addressing the needs of certain racial and ethnic groups, particularly the API MSM population. To prevent the spread of HIV transmission, individuals diagnosed with HIV/AIDS are emotionally burdened and morally and legally obligated with the complex decision to self-disclose their HIV-positive serostatus to others. Therefore, it is important to understand the shared unique cultural values, level of acculturation, and other social determinants of health that may influence whether API MSM will self-disclose their HIV-positive serostatus to others, particularly casual sexual partners.

Chapter 1 presented an introduction, background of the study, problem statement, purpose of the study, research questions and hypotheses, theoretical framework for the study, nature of the study, definition of terms, assumptions, scope and delimitations, limitations, and significance of the study. Chapter 2 will present an exhaustive review of the current and relevant literature, which includes the literature search strategy, theoretical foundation, key variables and concepts, and summary and conclusion.

Chapter 2: Literature Review

Introduction

The chronic disease HIV/AIDS continues to be a burden for public health, particularly for certain racial and ethnic groups. Coupled with the growth of the API ethnic group seen over the last decade, the number of HIV diagnoses among API MSM has increased in recent years. Until an effective vaccine or a cure is available, public health officials need to rely on HIV/AIDS behavioral control and prevention programs to decrease the spread of HIV. Disclosure of HIV-positive serostatus is one preventative strategy to decrease the spread of HIV and other sexually transmitted infections to casual sexual partners. In recent years, researchers have begun to focus on understanding, explaining, and predicting cultural similarities and differences that relate to HIV-positive self-disclosure. The purpose of this study was to examine the relationships between individualistic-collectivistic cultural dimensions, level of acculturation, age, length of time since HIV diagnosis, level of education, and income to the rate of HIV-positive serostatus disclosure behaviors, attitudes, and intentions to casual sexual partners for API MSM.

Chapter 2 begins with the literature search strategy, followed by a discussion of Hofstede's cultural values framework and Triandis's four cultural dimensions. The theoretical framework section includes a literature- and research-based analysis of how the theory has been applied previously in ways similar to the current study, the rationale for my choice of this theory, and a discussion of how the selected theory relates to the present study. An exhaustive review of the current and relevant literature that synthesizes findings from previous studies that examined the constructs of interest (i.e., cultural values, level of

acculturation, age, length of time since diagnosis, level of education, and income) and the dependent variables of HIV-positive disclosure behaviors, attitudes, and intentions follows. I also discuss an explanation of what is known about the variables, including mixed findings from previous studies and what remains to be studied. The chapter concludes with a summary of the major themes, what is known and what is not known in the discipline related to the topic of the study, and how the present study will address the gaps in the literature that would expand the knowledge in the discipline.

Literature Search Strategy

To locate the articles for the literature review, I used the following reputable databases and search engines: PubMed, MEDLINE, Cumulative Index to Nursing & Allied Health Literature (CINAHL), ScienceDirect, Sociological Abstracts (Cambridge Scientific Abstracts), PsycINFO, Social Sciences Citation Index (SSCI), ProQuest, Thoreau, EBSCOhost Online Research Databases, Health & Medical Complete, Cochrane Database of Systematic Reviews, Database of Abstracts of Reviews of Effects (DARE), Joanna Briggs Institute EBP Database, Google Scholar, ProQuest Dissertations and Theses, and ProQuest Dissertations and Theses at Walden University. I used Boolean operators coupled with the following key search terms and combination of search terms for the literature search: *HIV, AIDS, HIV/AIDS, HIV-positive, HIV-positive serostatus, HIV status, disclosure, HIV disclosure, serostatus disclosure, self-disclosure, nondisclosure, sex partners, sexual partners, casual sexual partners, Asian, Asian American, Asian Pacific Islander, men, men who have sex with men, culture, cultural, cultural dimensions, cultural values, Hofstede, Triandis, racial, ethnic, acculturation, age, length of diagnosis, time since*

diagnosis, income, education, and socioeconomic. Other strategies for locating articles for the literature review included using the keywords found in some articles and referring to the references section of other articles that were cited from them.

Most of the studies referenced in this review were published in peer-reviewed journals in addition to the handful of theoretical articles published in books. I only used English language articles. Where appropriate, I used government sources such as the CDC, U.S. Department of Health and Human Services (HHS), U.S. Census Bureau, U.S. Office of Management and Budget (OMB), and the Asian & Pacific Islander Wellness Center to supply demographic and statistical information. For this literature review, I applied the following inclusion criteria:

1. Articles that were published within the last 10 years (2005 – 2015) with preferences given to those that have been published in the last five years;
2. Articles related to HIV-positive disclosure and nondisclosure;
3. Articles related to HIV/AIDS with a focus on racial and ethnic minorities particularly Asian Pacific Islander;
4. Articles related to casual sexual partners; and
5. Articles and publications on Hofstede's and Triandis's cultural models and the concept of acculturation.

The exclusion criteria were as follows:

1. Articles that were not peer-reviewed (i.e., blogs, editorials, etc.);

2. Articles older than 10 years except those considered seminal literature and those related to Hofstede's and Triandis's cultural models and the concept of acculturation;
3. Articles on HIV/AIDS that did not reference disclosure and nondisclosure reasons; and
4. Articles on HIV/AIDS that were specific only to heterosexual transmission.

Theoretical Foundation

The theoretical foundation for this study was based on Hofstede's and Triandis's cultural models. The cultural dimensions that were of particular interest and served as the premise of this study were the influence of individualism-collectivism as it related to HIV-positive disclosure behaviors, attitudes, and intentions in API MSM.

Hofstede's Cultural Values Framework

One year ahead of the discovery of HIV/AIDS in 1981, Hofstede (1980) published his influential and seminal book on cultural classifications, *Culture's Consequences: International Differences in Work-Related Values*. Using empirical data extracted from over 116,000 paper-and-pencil morale survey results that were collected once in 1968 and then again in 1972 spanning 88,000 employees from 72 countries (reduced to 40 countries that had more than 50 responses each) in 20 languages within subsidiaries at IBM, a large multinational business organization, Hofstede derived the dimensions of national cultural values framework (Hofstede, 1980; Kirkman, Lowe, & Gibson, 2006). Based on a country level factor analysis and theoretical reasoning, Hofstede (1980) identified the following four main dimensions on which country cultures differed: individualism-collectivism, power

distance, uncertainty avoidance, and masculinity-femininity. In 1988, a fifth dimension of *Confucian dynamism* (or long-term versus short-term orientation) was later developed (Kirkman et al., 2006). Lastly, a sixth dimension of indulgence versus restraint was introduced in the 2000s as a result of research conducted by the Bulgarian scholar, linguist, and sociologist Michael Minkov using data from the World Values Survey (Hofstede, 2011).

Hofstede's conceptualization and operationalization of cultural values was intended only for the country level but many researchers have adapted his cultural values framework at the individual, group, and organization levels (Kirkman et al., 2006). Hofstede (2011) defined culture as "the collective programming of the mind that distinguishes the members of one group or category of people from others" (p. 3). Of the six dimensions of Hofstede's cultural values framework, the individualism-collectivism dimension is most pertinent to the research questions of this study. It is possible to examine only one dimension of Hofstede's cultural framework because there are independent scales or instruments to assess each of the six constructs. In fact, Triandis et al. (1998) were only interested in the individualism-collectivism dimension and expanded on it with the addition of the horizontal and vertical dimensions.

At the societal level, individualism and its opposite, collectivism, is the degree to which people in a society are integrated into primary groups (Hofstede, 2011). For individualistic cultures, the ties between individuals are loose and all people are expected to look after themselves and their immediate families (Hofstede, 2011). In contrast, people who live in collectivistic cultures are integrated into strong cohesive in-groups of immediate

family members, which often bleed into extended families comprising of cousins, aunts, uncles, and grandparents (Hofstede, 2011). Other characteristics of individualistic cultures include the right to privacy, the promotion of speaking one's mind (i.e., value of self-expression), and expectations of personal opinions. The differences from the characteristics of collectivistic cultures include the emphasis on belongingness, maintenance of harmony (i.e., demonstrating unquestioning loyalty to the in-group), and a predetermination of opinions by the in-group (Hofstede, 2011).

Economic development and climate are two predictors of the individualism-collectivism dimension. Hofstede (1980; 2011) found that individualistic cultures tend to be wealthy whereas collectivistic cultures tend to be poor. Individualistic cultures are also geographically located in the northern hemisphere and in colder climates and collectivistic cultures are found in the southern hemisphere and in warmer climates (Hofstede, 1980; Hofstede, 2011). Hofstede rated 53 countries on indices for each dimension and found that the majority of individualistic countries are located in the Western world (e.g., United States, Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Great Britain, Ireland, Italy, Netherlands, Norway, Sweden, and Switzerland) and the majority of collectivistic countries are located in the South (e.g., Arabic World, Argentina, Chile, Columbia, Costa Rica, Ecuador, El Salvador, Greece, Guatemala, Hong Kong, India, Indonesia, Iran, South Korea, Malaysia, Mexico, Pakistan, Panama, Peru, Philippines, Portugal, Singapore, Taiwan, Thailand, Turkey, Uruguay, Venezuela, and West Africa) (Fougère & Moulettes, 2007; Hofstede; 1980; Hofstede, 2011). Based on this finding, Asian countries are considered to be collectivist rather than individualist cultures.

Triandis

Triandis further explored Hofstede's dimension of individualism versus collectivism, which was the one dimension that was positively accepted among American psychologists mainly because the scores for this dimension happened to be the highest in the United States. The individualism in the United States culture prompted people to study cultural values at the individual level (i.e., comparing one person to another) instead of at the societal or national level (Hofstede, 2011). Hofstede (2011) argued that by examining cultural values at the individual level, it is no longer a dimension of culture but rather an aspect of personality with individualism and collectivism not as polar opposites but as separate features of personality.

The cultural focus at the individual level led Triandis to expand and split Hofstede's individualism-collectivism dimension into two additional horizontal and vertical dimensions. Triandis's emphasis at the individual and psychological levels rather than at the cultural level led to the dimension of allocentrism versus idiocentrism, which is synonymous with Hofstede's dimension of collectivism versus individualism (Triandis, Bontempo, Villareal, Asai, & Lucca, 1988). Allocentrism is a personality attribute whereby people center their attention and actions on other people rather than themselves and is positively correlated with social support and low levels of alienation (Triandis et al., 1998). In contrast, idiocentrism is a personality attribute whereby people center their attention upon themselves or their own ways rather than upon others or the ways of others and is positively correlated with an emphasis on achievement and perceived loneliness (Triandis et al., 1998). To eliminate confusion, it is appropriate to use the terms collectivist cultures and allocentric

individuals (Triandis et al., 1998). In general, there are more allocentric than idiocentric individuals in collectivist cultures and more idiocentric than allocentric individuals in individualist cultures (Triandis, 2001).

There is greater specificity when expanding Hofstede's collectivism-individualism dimension into the two additional horizontal and vertical dimensions. Singelis, Triandis, Bhawuk, and Gelfand (1995) discussed the constructs of individualism and collectivism prior to developing a new scale that theoretically distinguishes between horizontal and vertical individualism and collectivism. Individualism is largely predominant in the West while collectivism is largely predominant in Asia (Singelis et al., 1995). Modern, industrial, urban, and fast-changing cultures tend to be individualistic while traditional, agricultural, rural, and static cultures tend to be collectivist (Singelis et al., 1995). Many United States minorities such as Hispanics and APIs tend to be collectivist (Singelis et al., 1995). The upper classes in all cultures tend to be individualist, whereas the lower and middle classes tend to be collectivist (Singelis et al., 1995). Based on the review of the literature, Triandis (1995) concluded that it is important to make the distinction between horizontal and vertical individualism and collectivism. Specifically, Triandis (1995) argued that the four constructs of horizontal (H) and vertical (V), individualism (I) and collectivism (C) emphasize personal or collective aspects and can have priority over in-group or out-group goals. That is, individualism and collectivism dimensions should not be considered pure dichotomies but rather sharing a number of characteristics.

According to Triandis's theory, the horizontal dimension emphasizes equality while the vertical dimension emphasizes hierarchy (Singelis et al., 1995; Triandis, 2001; Triandis

& Gelfand, 1998; Triandis & Gelfand, 2012). As stated earlier in Chapter 1, horizontal collectivism (H-C) is a cultural pattern in which the individual or self is merged with the members of the in-group with an emphasis on interdependence and equality without submitting easily to authority; whereas vertical collectivism (V-C) is a cultural pattern in which the individual sees the self as an aspect of an in-group with an emphasis on interdependence and competition with out-groups (Singelis et al., 1995; Triandis, 2001; Triandis & Gelfand, 1998; Triandis & Gelfand, 2012). Inequality is accepted for the V-C dimension and individuals might serve and sacrifice for the preservation of the in-group (Singelis et al., 1995; Triandis, 2001; Triandis & Gelfand, 1998; Triandis & Gelfand, 2012).

Horizontal individualism (H-I) is a cultural pattern in which individuals are considered equal but also striving to be autonomous and distinct; without desiring special status; whereas vertical individualism (V-I) is a cultural pattern where inequality is expected and individuals strive to be different or distinct and desire special status (Singelis et al., 1995; Triandis, 2001; Triandis & Gelfand, 1998; Triandis & Gelfand, 2012). With the V-I pattern, the self is independent and different from others coupled with the characteristic of competition (Singelis et al., 1995; Triandis, 2001; Triandis & Gelfand, 1998; Triandis & Gelfand, 2012). Vertical individualism (V-I) is more common in the United States where people tend to be autonomous and independent, strive to do their best, and want to be noticed by others, especially in competitive situations (Triandis, 2004). Horizontal individualism (H-I) is common in Scandinavian countries where people also want to be independent but do not want to be noticed by others (Triandis, 2004). Compared with rural China or India, these cultures tend to be V-C while Israeli kibbutz culture tends to be H-C

(Triandis, 2004). Finally, API typically rate themselves higher on collectivist traits (i.e., “attentiveness, respectfulness, humility, deference, obedience, dutifulness, reciprocity, self-sacrifice, security, traditionalism, conformity, and cooperativeness”) and lower on individualist traits (i.e., “independence, pleasure seeking, assertiveness, creativity, curiosity, competitiveness, self-assurance, efficiency, initiative, and directness”) (Triandis, 2001, p. 915).

The four dimensions of H-C, V-C, H-I, and V-I afford more flexibility as cultures are neither pure nor dichotomous. For example, two cultures may be predominantly individualist at the national level but one culture may include individuals who are considered V-I 60% of the time, H-I 20% of the time, V-C 15% of the time, and H-C 5% of the time while the second culture may include individuals who are considered V-I 40%, H-I 40%, V-C 10%, and H-C 10% (Singelis et al., 1995). In a study by Yamada and Singelis (1999), the authors demonstrated that people who were raised in a collectivist culture and then lived in an individualist culture for several years through the process of acculturation were considered bicultural (i.e., high in both collectivism and individualism). Therefore the four dimensions of H-C, V-C, H-I, and V-I offer more flexibility, specificity, and variety over the individualism-collectivism dimension when measuring cultural dimensions at the individual level rather than at the cultural or national level. As of 2015, the majority (66%) of Asian Americans in the United States were foreign-born, the highest proportion of any racial group nationwide, compared to 37% of Latinos, and 8% of African Americans (Malik, 2015). Synthesizing the findings from Yamada and Singelis’s (1999) study, it is important to assess the level of acculturation of API MSM who were born in the United

States or were foreign in addition to Triandis's four cultural dimensions when examining cross-cultural differences of this population that may influence the decision to self-disclose their HIV-positive serostatus to others.

Review of the Literature

Disclosure of HIV-positive serostatus is an important and preventative public health behavior to diminish the spread of HIV particularly among MSM. Derlega and Berg (1987) published an entire book on the topic of disclosure or self-disclosure where they cited previous research studies and discussed numerous themes including the effects of disclosure on individuals who engage in the disclosing behavior and on the relationship they have with the person to whom they disclosed. Greene and Serovich (1996) investigated PLHIV's perceptions of appropriateness of others' access to information about HIV and explored to whom PLHIV disclose their HIV infection. The focus of this literature review is to present a convincing case for the need to further explore ethnic and cultural factors that may influence HIV-positive serostatus self-disclosure among API MSM to casual sexual partners.

Disclosure is the act of making something (such as information or HIV-positive status) known or revealed that was previously not known, concealed, or held secret (Merriam Webster Online Dictionary, 2015). Thus, self-disclosure is a process by which an individual shares or exposes information, thoughts, or emotions that have previously been withheld or concealed. Similarly, Sullivan (2005) defined self-disclosure as "a process that involves the self-initiated telling of previously concealed and potentially stigmatizing information to one or more persons with the intention of improving one's sense of

psychological well-being and/or maintaining relationship(s)” (p. 34). Self-disclosure has important characteristics that differ from other terms such as *telling* or *communicating* (Sullivan, 2005).

The concept of HIV-positive disclosure has its roots in self-disclosure, which is a concept that was originally developed by Sidney Jourard in 1958 (Eustace & Ilagan, 2010). Using the Walker and Avant concept analysis model (2005), Eustace and Ilagan (2010) revealed that HIV-positive serostatus disclosure is a complex and multifaceted process that involves individual factors (such as sex and age), relational factors (e.g., family, partner, or sexual dyad relationships), and cultural factors (e.g., Asian Pacific Islander, level of acculturation). Similarly, Sullivan (2005) described self-disclosure as a process that exemplifies a process-orientation or chronology leading to the action. Numerous factors influence the act of self-disclosure to sexual partners including background factors (i.e., age, education, and income), race/ethnicity, sexual orientation, disease chronology, contextual and psychosocial factors, intrapersonal factors (i.e., perceived disclosure responsibility), interpersonal factors (i.e., relationship status/context of relationships), sociocultural factors (i.e., acculturation and communication, knowledge about sexual orientation of sex partner), and situational factors (i.e., sex partner serostatus) (Sullivan, 2005). Other contributing attributes or characteristics may also influence individuals’ decision to disclose their HIV-positive serostatus; these include experiencing an event (i.e., when an individual is considering engaging in a sexual behavior), timing of HIV disclosure (i.e., number of years since HIV-positive diagnosis), relationship status or disclosure types (i.e., mother, father, sister, brother, family, friends, current sexual partner, or casual sexual partners) (Eustace &

Ilagan, 2010). Lastly, Serovich, Esbensen, and Mason (2007) suggested that it is plausible that HIV-positive disclosure rates may also vary over time mainly because of changes in medical treatment, overall public sentiment toward those living with HIV, and the increase in opportunities for individuals to disclose as they are living longer with the virus.

The CDC (1987) issued the U.S. Public Health Service guidelines that specifically recommend that persons infected with HIV notify their sexual partners and refer them for counseling and testing. The recommendations also state that partner notification assistance can be provided for those unable or unwilling to notify sexual partners themselves (CDC, 1987). Partner notification (or contract tracing) is the process of informing individuals of their potential exposure to HIV coupled by the offering of counseling and treatment (Fenton & Peterman, 1997). Partner notification or partner counseling and referral service (PCRS) has been recommended as a public health intervention strategy to prevent HIV transmission (Fenton & Peterman, 1997; Kissinger & Malebranche, 2007).

The success of PCRS rests on the assumption that the sexual partners of HIV-positive individuals will change their risky, sexual behaviors after undergoing HIV testing and counseling (Kissinger & Malebranche, 2007). Over the years, the use of partner notification has been debated as an effective strategy in HIV prevention mainly because of the relatively high cost to implement the PCRS program and the limited evidence for its effectiveness (Fenton & Peterman, 1997). In recent years, the balance of benefits outweighing the costs to support the partner notification program has shifted in favor of it as a promising approach to prevent the spread of HIV transmission especially with recent advances in HIV treatment options (e.g., HAART) and diagnostic technology (e.g., oral

fluid, urine, and home-based testing) (Fenton & Peterman, 1997). Partner notification or PCRS has been found to be a promising approach to addressing racial disparities related to HIV/AIDS among Black and Latino populations in the United States. (Kissinger & Malebranche, 2007). Specifically, Kissinger and Malebranche (2007) argued that:

The keys to success with PCRS among diverse racial/ethnic populations may ultimately lie in the attention paid to unique cultural approaches that ensure confidentiality, lack of coercion, and respect for the unique concerns, beliefs, and sensibilities of individuals who make up these communities. (p. S87)

Moreover, Golden et al. (2009) found that recipients of partner services were significantly more likely to report notifying at least one sexual partner following their HIV diagnosis than participants who did not receive partner services, thus supporting the hypothesis that HIV partner notification programs are an effective public health prevention strategy.

Finally, Kennedy, Fonner, Armstrong, O'Reilly, and Sweat (2015) conducted a systematic review of peer-reviewed articles published between January 1, 1990, and August 1, 2014, and found that partner notification had the strongest evidence of increasing the rates of voluntary disclosure of HIV serostatus in low and middle-income countries in sub-Saharan Africa. Laar, DeBruin, and Craddock (2015) presented an interest-analysis of partner notification in the context of HIV and discussed the dilemma that PLHIV faced with the desire to maintain the privacy of their health status from unnecessary disclosure because of the negative impacts. The authors discussed the need to balance the conflicted interests of bioethicists, public health, government, and the individual against the benefits and burdens of partner notification. The findings from the above studies not only support the continued

implementation of the partner notification program as it helps to increase the rates of voluntary disclosure of HIV serostatus, but also highlight the need to address the cultural needs of diverse racial and ethnic populations such as API.

Disclosure of HIV-positive serostatus can be measured as dichotomous (Przybyla et al., 2013) or on a broad continuum (Malebranche, Arriola, Jenkins, Dauria, & Patel, 2010; Reback, Kaplan, & Larkins, 2015). Dichotomous disclosure is when individuals either disclose their HIV-positive serostatus to all partners (i.e., 100% of the time) or when disclosure is less than 100% of the time (Przybyla et al., 2013). In Malebranche et al.'s (2010) qualitative study where the authors explored factors that affected disclosure of same-sex behaviors among Black bisexual men, the theory of a continuum of disclosure ranging from full disclosure to conscious omission of information to total secrecy emerged. The findings from the qualitative study by Reback et al. (2015) facilitated the understanding of the disclosure practices of bisexual men who identified as heterosexual supported Malebranche et al.'s theory of a continuum of disclosure. Thematic findings regarding disclosure included participants using all three strategies of disclosing to their female partners (i.e., full disclosure), engaging in conscious omission of telling half-truths, and operating in total secrecy about their HIV-positive serostatus (Reback et al., 2015). These more recent findings are consistent with an earlier study conducted by Parsons and colleagues (2005) where the authors concluded that "disclosure is not an all-or-nothing process, as evidenced by the 38% of the men in the sample who reported disclosing to some, but not all, of their casual sexual partners" (p. S87). The findings from the above studies support the need for using an instrument that can assess HIV-positive disclosure

behaviors, attitudes, and intentions on a broad continuum rather than in a dichotomous manner.

Psychological and Emotional Sequelae of HIV-Positive Disclosure

The reasons for HIV-positive serostatus disclosure and nondisclosure have been consistently cited in numerous studies spanning the last two decades of research. The most powerful force working against disclosure or in favor of nondisclosure is the psychological consequence of the risk of rejection (Klitzman, 1999; Lin et al., 2015; Okello et al., 2015; Serovich, 2000; Serovich et al., 2005; Stein et al., 1998; Tshweneagae, Oss, & Mgutshini, 2015). In a qualitative study with MSM, Serovich et al. (2005) found that the costs of disclosure included rejection, loss of sex, immediate ending of a relationship, violence, and emotional pain from direct rejection. The reasons for nondisclosure have remained consistent throughout the years dating back to an early longitudinal study of San Francisco gay men conducted by Hays et al. (1993), which included not wanting to worry others, fear of discrimination, fear of disrupting relationships, and emotional self-protection. Specific to Black MSM, barriers to serostatus disclosure, particularly to sexual partners, include real and perceived HIV stigma from family, churches, and the gay community (Bird & Voisin, 2013). For both API MSM and heterosexuals, Kang and Rapkin (2008) found that reasons for nondisclosure were related to internalized processes of maintaining secrecy, shame, and denial of illness. Additional reasons offered for disclosure included catharsis, seeking help, duty to inform, desire to educate, emotionally close and supportive relationships, and a desire to test someone's reaction; while reasons for nondisclosure included right to privacy, self-blame/self-concept difficulties, fear of rejection, protecting the other person, superficial

relationships, and communication difficulty (Derlega et al., 2002; Derlega et al., 2004).

Many of these disclosure and nondisclosure reasons were echoed in a recent study by Arrey et al. (2015) with sub-Saharan African migrant women living with HIV/AIDS in Belgium.

In this qualitative study, the reasons for disclosure included the desire to have children, informing people to avoid transmitting the disease, and the need to talk; while the main reasons for nondisclosure included fear of stigma and discrimination, shame, fear of disrupting relationships, abandonment and violence, and breach of confidentiality and distrust.

According to Serovich's (2001) consequence theory of HIV disclosure, individuals are more likely to disclose their serostatus to others once the rewards for disclosing outweigh the associated costs. Serovich and Mosack (2003) investigated the reasons for HIV disclosure and nondisclosure to casual sexual partners using a sample of 78 HIV-positive gay men. Using a 15-item questionnaire that was adapted from Derlega, Winstead, and Folk-Barron's work (1997; cited in Serovich & Mosack, 2003); the authors found that the main reason for disclosure was attributed to the responsibility factor solution relating to obligation and the right to know. That is, the HIV-positive gay men who disclosed believed that their casual sexual partners have the right to know their serostatus and held the conviction that disclosure was the responsible thing to do to protect others (Serovich & Mosack, 2003). The other three factor solutions that were examined included instruction, relationship consequences, and emotional release items (Serovich & Mosack, 2003). Instruction factor was related to the need to educate others about the disease, relationship consequences factor was related to the consequences of disclosing, and emotional release

factor was related to the cathartic experience as a result of disclosure. The reason for nondisclosure did not emerge and was therefore not clearly structured and remained inconclusive (Serovich & Mosack, 2003).

There are numerous costs and rewards of disclosing HIV-positive serostatus. Disclosure includes both negative and positive consequences. Stigma or discrimination was among the most frequently reported negative consequences (Arrey, Bilsen, Lacor, & Deschepper, 2015; Audet, McGowan, Wallston, & Kipp, 2013; Bharat, 2011; Derlega et al., 2002; Courtenay-Quirk, Wolitski, Parsons, & Gomez, 2006; Dowshen, Binns, & Garofalo, 2009; Feigin, Sapir, Patinkin, & Turner, 2013; Haile, Padilla, & Parker, 2011; Hatzenbuehler, O’Cleirigh, Mayer, Mimiaga, & Safren, 2011; Kang & Rapkin, 2008; Kipp et al., 2015; Lin et al., 2015; Maiorana et al., 2012; Preston, D’Augelli, Kassab, & Starks, 2007; Sayles, Ryan, Silver, Sarkisian, & Cunningham, 2007; Skinner & Mfecane, 2004; Steward et al., 2011; Stutterheim et al., 2011; Venable, Carey, Blair, & Littlewood, 2006; Wohl et al., 2010; Yi, Chhoun, Suong, Thin, & Tuot, 2015). Disclosure can also “provoke feelings of anxiety and threats to personal well-being stemming from violence, ostracism, isolation, stigma, parental worrying, ostracism, isolation, stigma, discrimination, and degradation” (Serovich, Graftsky, & Reed, 2010, p. 1052). Those who concealed their HIV-positive serostatus had higher internalized depression and were more likely to be clinically depressed compared with others who chose to disclose their seropositivity (Okello et al., 2015).

Conversely, some researchers found positive consequences of HIV disclosure including better physical health and psychological well-being, reduced stress, increased

participants' social support, and increased intimacy between partners (Derlega et al., 2002; Holt et al., 1998; Hult et al., 2012; Li et al., 2007; Lin et al., 2015; Parsons, VanOra, Missildine, Purcell, & Gomez, 2004; Serovich, 2001). Similarly, rewards to HIV-positive disclosure include acquisition of emotional, social, and instrumental support (Serovich et al., 2010). Serovich et al. (2010) investigated the prevalence of regret associated with disclosing HIV-positive serostatus and found that almost half of the HIV-positive MSM participants indicated no regret after disclosing their serostatus to family members. Specific to HIV-infected men and women in Jinja, Uganda in a developing country, positive outcomes of HIV serostatus disclosure to sexual partners included "risk reduction behavior, partner testing, increased care-seeking behavior, anxiety relief, increased sexual communication, and motivation to plan for the future" (King et al., 2008, p. 232). Despite the negative consequences of HIV-positive disclosure, Lin et al. (2015) concluded that voluntarily disclosing one's seropositivity to others resulted in more positive consequences than negative consequences. Thus, there is ample evidence to suggest that those who are diagnosed with HIV should disclose their serostatus to others.

HIV-Positive Disclosure Rates

There are numerous reasons why it is difficult to ascertain the average rate of HIV-positive serostatus disclosure. In the early years of the HIV/AIDS epidemic, most studies were focused on homosexual and bisexual men when fewer treatments (e.g., HAART) were available (Stein et al., 1998). Disclosure of HIV-positive serostatus can be to a primary, main, or steady sexual partner, to one or more casual sexual partners, or to both primary and casual sexual partners. Schnell and colleagues (1992) targeted MSM and found that both

seronegative and seropositive men disclosed their HIV test results at the rate of 89% of the time to their main sexual partner. When the authors followed up with the participants six months later, they found that those who disclose their HIV test results to their main sexual partner reported that the relationship with their main sexual partner was “as strong as ever” while those who did not disclose their HIV test results to their main sexual partner were much more likely to be “single” (Schnell et al., 1992). Thus, there was a positive correlation between HIV disclosure and the positive impact on the relationship for MSM and their primary sexual partners; whereas those who chose not to disclose their HIV test results experienced a disruption of their primary sexual relationship. The findings of Schnell et al.’s (1992) study are consistent with Marks, Richardson, and Maldonado’s (1991) study in which the rate of HIV-positive disclosure was lower among HIV-positive men to nonprimary sexual partners. The largest racial/ethnic groups represented in Schnell et al.’s (1992) study were White (86%) and Hispanic (10%) while the largest racial/ethnic group represented in Marks et al.’s (1991) study was mostly lower socioeconomic homosexual and bisexual Hispanic men. There were no API MSM participants in Schnell et al.’s (1991) study and only 2 out of 138 participants (1.4%) were API MSM in Marks et al.’s (1991) study.

Stein and colleagues (1998) examined the factors associated with HIV-positive serostatus disclosure among three different racial and ethnic groups of mostly men (69%): Blacks (46%), Latinos (23%), and Whites (27%). The authors found that 60% of the participants had disclosed their HIV status to all sexual partners that they had been with during the past six months and 40% had not (Stein et al., 1998). The rate of nondisclosure

increased from 21% for individuals who had one partner to 58% for individuals who had two or more partners (Stein et al., 1998). These findings were consistent with Marks et al.'s (1991) study where the rates of HIV-positive disclosure decreased from 69% to 36% to 18% for men who had only one sexual partner, two to four partners, and five or more partners, respectively. Thus, the likelihood of nondisclosure decreased in direct proportion to the number of partners. These findings suggest that MSM are more likely to disclose their HIV-positive serostatus to intimate, main, or steady partners than to casual or nonprimary partners.

It is difficult to know for sure the rate of HIV-positive disclosure for any particular racial or ethnic group as the findings from the above studies include varying disclosure rates of seropositivity depending on the sample of each study. In a review by Obermeyer, Baijal, and Pegurri (2011), the investigators scanned a total of 3,463 titles published between January 1997 and October 2008. They retained 231 sources that included only original studies or literature reviews that had appeared in peer-reviewed publications and found that few people actually keep their HIV-positive status completely secret. Obermeyer et al. (2011) also reported that partner disclosure varied greatly with HIV-positive serostatus disclosure to casual partners being generally lower than to steady partners.

Honing in on the average HIV-positive disclosure rate for a particular racial or ethnic group has been examined by other researchers. For example, Alemayehu, Aregay, Kalayu, and Yebyo (2014) assessed the factors related to HIV positive status disclosure to sexual partners among HIV positive women in a cross-sectional study conducted in Mekelle hospital in Northern Ethiopia and found that the rate of HIV disclosure to their partner was

low. Clark et al. (2010) found that the rate of HIV disclosure was 49% among males and 60% among females using a cross-sectional survey of 107 attendees to a HIV clinic at the University Hospital of the West Indies (Jamaica). Brown, Das, and Hsu (2014) compared the HIV epidemics in gay men in San Francisco and London and concluded that the higher testing rates in San Francisco appeared to lead to higher rates of HIV status disclosure between gay men. Wei and colleagues (2011) examined racial/ethnic differences and compared rates of eight different seroadaptive behaviors from a sample of 1,199 MSM of different racial/ethnic groups in San Francisco and found that there were no statistical differences in self-reported seroadaptive behaviors across racial/ethnic groups for both HIV-negative and HIV-positive cohorts. The investigators concluded that this finding does not provide support for the disparity of HIV prevalence across racial/ethnic groups. Of interest, API MSM were the least likely to discuss their HIV serostatus with their partners, to know their partners' serostatus before first having sex, to ask if their partner had high risk sex since their HIV test, and to have complete confidence in their partners' HIV-negative serostatus compared to White, Black, and Latino MSM (Wei et al., 2011). Despite the findings from the above studies, a research gap exists in that there has not been any study that specifically examined the HIV-positive disclosure rate, behaviors, attitudes, and intentions for the API MSM population in the United States.

HIV-Positive Disclosure Strategies

Not only is it important from a public health perspective to understand to whom MSM disclose their serostatus (i.e., disclosure to family, friends, employers, coworkers, and other disclosure targets) but also the means by which men disclose their HIV status,

particularly to casual sexual partners. In a qualitative study conducted with 57 HIV-positive adult MSM, Serovich et al. (2005) revealed five primary disclosure strategies that MSM typically use when disclosing their HIV-positive serostatus to casual sexual partners: point-blank, stage-setting, indirect disclosure, buffering, and seeking similar. Point-blank disclosure is the most common disclosure strategy whereby HIV-positive MSM overtly disclosed their serostatus either in written or verbal form, especially when carried out in-person either bluntly (i.e., face-to-face) to eliminate confusion or in public places such as bars, clubs, restaurants, or among trusted friends (Serovich et al., 2005). Stage-setting is an alternative, but also effective, method of disclosure using a “variety of hints and symbols that work to prime a disclosive event” (Serovich et al., 2005, p. 827) including verbal hinting, symbolic hinting, online, asking a partner first, and insisting on condom usage. The third disclosure strategy, indirect, is different from stage-setting method because there is no attempt to link these hints to an overt disclosure in which the sexual partner assumed or acknowledged that the discloser has an HIV-positive diagnosis from the clues left for the partner to figure it out on his own (Serovich et al., 2005). When the anticipated costs outweighed the benefits of disclosure, a buffering method of utilizing a third party (person, thing, or event) may be used to cushion between the discloser and his sexual partner, of which supportive friends are the most common buffers (Serovich et al., 2005). The fifth disclosure strategy, labeled as seeking similar, is when HIV-positive MSM “[positioned] themselves where they could easily meet other HIV-positive persons or where other positive persons or those sympathetic or compassionate towards those with HIV could be found” (Serovich et al., 2005, p. 829) such as AIDS walks or HIV support groups. It is important to

note that this fifth disclosure strategy, seeking similar, is different than serosorting because the former is a strategy used by PLHIV to surround themselves with people who are likely to be accepting of having sex with someone who is also HIV-positive to reduce disclosure anxiety while the latter strategy is intended to seek sexual partners for unsafe encounters (Serovich et al., 2005). In a mixed methods study comprised of HIV-infected men and women in Eastern Uganda, King and colleagues (2008) discussed three disclosure techniques, which included direct face-to-face discussion (55%), indirect disclosure (27%), and assisted disclosure (18%).

In addition to the HIV-positive strategies, Chaudoir and Fisher (2010) presented the disclosure processes model (DPM) to examine when and why disclosure may be beneficial. Chaudoir and Fisher (2010) argued that disclosure must be conceptualized as a single but ongoing process by highlighting the impact of the following five components of the DPM: antecedent goals, disclosure event, mediating processes, outcomes, and a feedback loop. According to the DPM, disclosure begins with a decision-making process where an individual is motivated to make a decision on when to disclose by adopting an approach versus avoidance goal framework (Chaudoir & Fisher, 2010). Once an individual has made the decision to disclose, then the disclosure event follows. For some individuals, the disclosure event will be a one-time situation; while for others, the disclosure event may unfold over a longer period of time (Chaudoir & Fisher, 2010). Next, the disclosure event can yield a number of different types of consequences impacting various outcomes that may occur at an individual, dyadic, and social contextual level (Chaudoir & Fisher, 2010). Finally, the DPM specifies that the outcomes of a single disclosure event can affect multiple

disclosure processes through a feedback loop, suggesting that disclosure is a dynamic process (Chaudoir & Fisher, 2010).

Expanding on Chaudoir and Fisher's dynamic DPM, Greene (2009) presented an integrated model of health disclosure decision-making. The disclosure decision-making model (DD-MM) provides a framework to predict decisions when individuals need to disclose a health diagnosis to others. The DD-MM has several components including: assess information (5 aspects), assess receiver, disclosure efficacy, enact message strategies, third party alternatives, outcomes, and feedback/reassess (Greene, 2009). The first component of assessing information includes weighing the following five interrelated aspects: stigma, preparation, prognosis, symptoms, and relevance to others (Greene, 2009). The second component of the DD-MM is consideration of the potential receiver and includes the two factors of relational quality and anticipated response (Greene, 2009). The last component of the model is disclosure efficacy, which is an individual's perception of his or her ability to disclose a health diagnosis (Greene, 2009). Alternatively, if individuals do not perceive that they have the ability to disclose, then they may enlist another to disclose or choose other options (Greene, 2009).

Although there may be numerous disclosure methods, the five strategies discussed by Serovich et al. (2005) above are specific to HIV-positive disclosure among MSM to casual sexual partners. They suggested that the selection of which disclosure strategy to deploy may be impacted by the individual's personality, the environment, and the nature of the sexual relationship. For example, "men who tend to be introverted in social settings, fearful of rejection, or prefer a passive role in sexual encounters may chose strategies that

are not as confrontational as point-blank disclosure” (Serovich et al., 2005, p. 830).

Concerns about legal and moral obligations from mandatory disclosure statutes may persuade an individual to use a point-blank disclosure strategy (Serovich et al., 2005). The environment such as bathhouses or parks may have “unspoken codes” that facilitate the individuals to use a stage-setting disclosure strategy while fears of violence or abuse may promote the use of more distant disclosure strategies (Serovich et al., 2005). Of particular interest to this study is the nature of the relationship with the sexual encounter. Serovich et al. (2005) suggested that fleeting sexual encounters may encourage MSM to use a point-blank disclosure strategy while men who desired intimacy in their sexual encounters or were willing to delay sex may prefer one of the stage-setting disclosure strategies (Serovich et al., 2005). Therefore, “the successful utility of a particular strategy was the result of the complex interplay between strategy-personality fit, environmental circumstances, and the nature of the sexual relationship” (Serovich et al., 2005, p. 831). What is not clear from this review of the five HIV-positive disclosure strategies is whether the point-blank disclosure strategy is the strategy that API MSM would use when disclosing their serostatus to casual sexual partners. The first step to making this connection is to examine the HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners for this population.

Factors Influencing HIV-Positive Disclosure

There are numerous factors that may influence HIV-positive serostatus disclosure. The following factors will now be explored to reiterate the point that disclosure is a complex and multifaceted process that needs further exploration: relationship types such as sexual partners, casual sexual partners, and anonymous partners; sociocultural, cultural,

racial/ethnic, and level of acculturation factors; length of time or number of years since HIV diagnosis; age, level of education, and income.

Relationship types. Men who have sex with men are disproportionately represented in national HIV/AIDS statistics. Compared to heterosexual men or women, MSM tend to engage in sex with multiple partners and in less-than-committed relationships (Sullivan, 2009). Tshweneagae, Oss, and Mgutshini (2015) explored and identified factors that influenced disclosure of HIV-positive status to sexual partners in a qualitative study using in-depth interviews. They found that male participants were more reluctant to disclose their sexual partners compared to female participants. Serovich, Oliver, Smith, and Mason (2005) reviewed numerous articles and found that rates of reported HIV-positive disclosure of MSM to sexual partners varied considerably ranging as high as 98% (Hays et al., 1993) to as low as 48% (Marks, Richardson, & Maldonado; 1991) with other researchers reporting disclosure rates of 89% (Schnell et al., 1992), 76.3% (Marks et al., 1992), 66% (Perry, Ryan, Fogel, Fishman, & Jacobsberg, 1990), and 65% (Marks, Richardson, Ruiz, & Maldonado, 1992). Niccolai, Dorst, Myers, and Kissinger (1999) reported disclosure rates of 75.7% to last sexual partners compared to Stein et al.'s (1998) study, which reported 60% to all sexual partners. In another study, Kalichman and Nachimson (1999) reported that 41% of participants had not disclosed their HIV serostatus to sex partners from a small sample of 203 HIV-seropositive men and 129 seropositive women of ethnically diverse backgrounds but did not include Asian Pacific Islanders.

Similarly, Niccolai et al. (1999) reported rates of disclosure to sex partners among populations of predominantly gay or bisexual men ranging from 50% to 95%. Using a large

sample of 1,421 drawn from the HIV Cost and Services Utilization Study (HCSUS), Ciccarone et al. (2003) reported that “overall, 42% of gay or bisexual men, 19% of the heterosexual men, and 17% of all the women reported any sex without disclosure, predominately within non-exclusive partnerships” (p. 949). The authors concluded that sex without disclosure of HIV status is relatively common among PLHIV. The rate of disclosure continues to be problematic in more recent studies. Duru et al. (2006) conducted a follow-up study using a sample of 875 participants from the HCSUS and confirmed these findings; that sex without disclosure was more prevalent among occasional partnerships and one-time encounters compared to marriage and/or primary same-sex relationships. Of importance, MSM were less likely to disclose their HIV status to their sexual partners compared to HIV-positive heterosexual men (Lin et al., 2015; Sullivan, 2005). For example, Okello et al. (2015) reported that 39% chose to not disclose their HIV status to most people while only 34% had disclosed their HIV status to all casual sexual partners among 425 participants recruited from Kampala, Uganda. Okello et al. (2015) also reported that varying rates of HIV nondisclosure ranged from 5.5% to 83% in different subpopulations across Africa. International research shows varied rates of HIV disclosure during casual sex encounters between MSM. Holt et al. (2011) reported that in U.S. studies, over a third of HIV-positive men say they disclose to all their casual male partners, and around three-quarters say they disclose to some of their casual partners. Overall, the rates of HIV-positive serostatus disclosure to sexual partners are varied and can be quite low. The findings from these studies also highlight the need to examine the average HIV-positive disclosure rate of MSM to casual sexual partners among the API population.

Sullivan (2005) conducted an extensive review of the literature using 71 valid and reliable studies published between 1996 and 2004 spanning multiple disciplines including nursing, medicine, psychology, counseling, social work, law, and ethics to identify factors influencing male self-disclosure of HIV-positive serostatus to sex partners. The premise of the review was related to the fact that numerous studies have reported that significant numbers of HIV-positive men have difficulty disclosing their HIV-positive serostatus to sexual partners. The analysis suggests that disclosure rates vary based on sex partners influencing serostatus, relationship status, and number of sex partners (Sullivan, 2005). Specifically, disclosure rates to primary sex partners ranged from 67% to 88%; while disclosure rates to casual sexual partners were lower ranging from one quarter (25%) to slightly over half (58%) (Sullivan, 2005).

Semple, Patterson, and Grant (2004) compared the disclosure rates for men with or without anonymous sex partners and found that rates of serostatus disclosure were significantly lower for men with anonymous sex partners. Men with anonymous sex partners also had five times as many HIV-negative or unknown serostatus partners as compared to men with no anonymous partners (Semple et al., 2004). Anonymous partners were defined as persons whom the participant did not know (e.g., prostitute or hustler, someone encountered at a park, bathhouse, public bathroom, beach, porn shop, adult theatre, or “on the street”) while casual partners were defined as persons with whom the participant was acquainted and had a one-night stand or had sex only once or twice (Semple et al., 2004). It is important to note that the sample of this study consisted of predominantly

White, well-educated men who live in affluent regions of the United States and therefore may not be generalizable to HIV-positive ethnic minorities such as API MSM.

In a more recent study, Przybyla et al. (2013) examined differences in HIV-positive serostatus disclosure patterns among subgroups of PLHIV of MSM, heterosexual men, and heterosexual women using a randomized, controlled trial of a safer sex intervention. They found that, overall, 79% of participants had disclosed their HIV status to all sexual partners in the past three months. Important differences were found between the three subgroups. The MSM subgroup was less likely to disclose their HIV status to sexual partners (69%) compared to both the heterosexual men (86%) and women (85%). “Additionally, disclosure was more likely among participants with only primary partners than those with only casual or both casual and primary partners (95%, 54%, and 62%, respectively)” (Przybyla et al., 2013, p. 566). Finally, “participants with only HIV-positive partners were also more likely to disclose than those with only HIV-negative partners, unknown serostatus partners, or partners of mixed serostatus (96%, 85%, 40%, and 60%, respectively)” (Przybyla et al., 2013, p. 566). The above findings suggest differences in disclosure based on partnership characteristics including relationship types (i.e., primary partners only, casual partners only, or mixed relationship type partners) and partner serostatus (i.e., HIV-positive partners only, HIV-negative partners only, unknown serostatus partners only, or mixed serostatus partners). In this study, MSM disclosed less to unknown serostatus partners (22.6%) than did women (69%) (Przybyla et al., 2003). In a pilot study, Serovich et al. (2009) also found that MSM disclose more frequently to partners of known serostatus than unknown status. In addition, HIV serostatus disclosure occurs least frequently with casual sexual partners and

partners of unknown serostatus (Serovich et al., 2009). These findings were consistent for Hawaiian men and women comprised of mostly Asian Pacific Islander participants where the disclosure rate occurred significantly less often when a sexual partner was HIV-negative or the HIV-status was unknown compared to sexual partners who were HIV-positive (Sullivan, 2009). The relationship status of the vast majority of sexual partners (70.3%) among homosexual and bisexual male participants included “less-than-committed (‘casual’)” or “anonymous” compared to women’s sexual partners (65.8%), which included “more-than-casual (‘committed’ or ‘regular’)” (Sullivan, 2009, p. 693). Disclosure of serostatus also occurred more frequently in committed rather than less committed level relationships for both Hawaiian men and women (Sullivan, 2009). Therefore, as relationship commitment decreases, the rates of disclosure also decrease, with less than one in five anonymous partners having received a disclosure (Sullivan, 2009).

Findings from other studies illuminate the complex and inconsistent disclosure rate of HIV serostatus involving occasional or casual sexual partners. For example, MSMW who identify as heterosexual do not disclose their HIV serostatus to their female sexual partner consistently (Reback et al., 2015). Specifically, 58% of the MSMW participants in this study disclosed their positive HIV serostatus to their wife, girlfriend, or female sexual partners but rarely disclosed their HIV serostatus to their occasional male sexual encounters or casual sexual partners (Reback et al., 2015). Therefore, disclosure of HIV serostatus to male casual sexual partners was minimal or inconsistent. Serovich et al. (2007) suggested that there may be a negative correlation between the closeness and intimacy of a relationship to the rate of HIV-positive serostatus disclosure because of fears of losing the

relationship or needing to protect the recipient. That is, the disclosure rate to long-term, valued friends resembles that of family when compared to typical friends (Serovich et al., 2007). It is unclear whether this finding can be generalized to casual or anonymous sexual partners with the expectation of a higher disclosure rate without the premise of an emotionally laden relationship. The findings from these studies highlighted the complexities in decision-making about HIV-positive serostatus disclosure.

Sociocultural, cultural, racial/ethnic, and level of acculturation factors. Cultural, racial, and ethnic differences in disclosure were noted from previous research studies as early as the 1990s. Mason, Marks, Simoni, Ruiz, and Richardson (1995) found that HIV-positive Latino men were less likely than seropositive White men to disclose their HIV infection to the following persons: mother, father, sister, brother, closest friend (either man or woman), and intimate lover. Upon further examination, only less acculturated Latinos (i.e., Spanish-speaking or foreign born) differed (15%) from Whites (4%) for all disclosure targets; that is, disclosure among English-speaking Latinos was similar to that of Whites (Mason et al., 1995). The authors offered an explanation of the traditional Latino cultural values of familism and *simpatía* to help explain the differences in the HIV-positive disclosure rate between Latino and White men (Mason et al., 1995). “Familism promotes identification with and attachment to one’s family, strong feelings of familial loyalty, and the obligation to support the family emotionally and materially” while “*simpatía* is a cultural script that mandates politeness, respect, and harmonious interpersonal relations and has been shown to be stronger among Latinos than Anglos” (Mason et al., 1995, p. 7). In another study, Stein et al. (1998) posited that the lower rates of HIV-positive serostatus

disclosure among Blacks compared to their White or Latino counterparts are in part due to the differences in cultural attitudes. The findings from these two early studies suggest that cultural values do indeed influence the rate of HIV-positive serostatus disclosure behaviors, attitudes, and intentions.

In addition to the above early studies, findings from subsequent studies also highlight the importance of cultural differences. For example, Yoshioka and Schustack (2001) conducted in-depth interviews with 16 HIV-positive Asian men recruited from an AIDS organization in northeastern United States to describe how Asian cultural values of harmony and avoidance of conflict (i.e., collectivism cultural dimension) might affect HIV-positive disclosure experiences. Three themes related to the collectivist cultural dimension were identified as barriers to disclosure that provided evidence for the need of culturally sensitive counseling strategies to facilitate disclosure in the API population. The themes that emerged from this qualitative study were “protection of family from shame, protection of family from obligation to help, and avoidance of communication regarding highly personal information” (Yoshioka & Schustack, 2001, p. 77). Specific to API MSM, Nemoto et al. (2003) facilitated five focus groups with 38 API MSM recruited from the San Francisco Bay Area using convenience sampling methods and identified six themes reflecting multiple levels of influence upon HIV risk including intrapsychic, interpersonal, behavioral, and community influences. The theme of HIV disclosure relates to the research’s problem in which participants reported anxiety around sharing their sexual identity and health status with others and reflected on ways to improve HIV prevention and other social services for API gay men (Nemoto et al., 2003). In another qualitative study, Körner (2007) conducted

semi-structured, in-depth interviews with HIV-positive people from minority cultures in Sydney, Australia and concluded that disclosure decisions are influenced by gender, sexual orientation, and cultural background. Körner (2007) argued that the existing but outdated rational models of health should be replaced with a new ecological perspective to encompass a broader context of family and community. The findings from these qualitative studies suggest that it is important to examine the relationship of cultural values and HIV-positive disclosure behaviors, attitudes, and intentions.

Cultural factors that influence HIV-positive serostatus disclosure have been documented for different samples. In a qualitative study, Tshweneagae, Oss, and Mgutshini (2015) found that participants recruited from the Galeshewe Day Hospital Wellness Clinic in Kimberly in the Northern Cape Province (South Africa) used cultural explanations to disclose their HIV status to their partners. Lin et al. (2015) cited numerous articles and concluded that API MSM had particularly low levels of disclosure in comparison with other racial groups, which is especially true for PLHIV in China. To address the research gap of limited data or studies conducted for PLHIV, Lin et al. (2015) conducted a qualitative study by employing in-depth interviews to explore the disclosure rates, targets, and consequences of HIV-positive disclosure using a sample of 37 HIV-positive MSM recruited from a hospital in China. The authors discussed the family orientation that is unique to the Chinese culture emphasizing “filial piety” by citing Mencius, the famous Chinese philosopher: “There are three forms of unfilial conducts, of which the worst is to have no descendants” (Lin et al., 2015, p. 7). This explanation was given to the interesting finding that many of the participants disclosed their seropositivity because by doing so it reduced the pressure to

marry and have children (Lin et al., 2015). In this study, 20.6% of HIV-positive MSM disclosed their seropositivity but not their sexual orientation because homosexuality remains unacceptable in Chinese society (Lin et al., 2015). In fact, the term “gay” is associated with the terms “abnormal,” “promiscuous,” and “immoral” (Lin et al., 2015, p. 7). The findings from this study suggest the need to conduct further research to understand the effects of cultural differences on HIV-positive disclosure. There is an opportunity to explore cultural factors including the effects of acculturation and disclosure to casual sexual partners using a quantitative method of inquiry.

Other researchers have explored the relationships between cultural beliefs, partner characteristics, communication, and sexual risks. For example, Lo, Reisen, Poppen, Bianchi, and Zea (2011), found that cultural beliefs were not predictive of communication about condom use or unprotected anal intercourse (UAI) among 356 Latino men living in the New York City metropolitan area. Choi, Paul, Ayala, Boylan, and Gregorich (2013) examined the associations between specific types and sources of discrimination and mental health outcomes among African American, Latino, and API MSM in Los Angeles County, California and found that perceived racism within the gay community with anxiety only differed for API MSM but not for the other two racial/ethnic groups. The perceived discrimination experienced by API MSM was differentially linked to negative mental health outcomes of anxiety.

Culture also influences how one communicates to one another. The act of self-disclosing one’s HIV-positive seropositivity requires a certain level of communication self-efficacy. For example, Knox et al. (2012) used a quota sampling method stratified by age,

race, and township and recruited 300 MSM in Pretoria, South Africa, where participants self-reported to a series of questions about their last sexual encounter (LSE). The researchers found that men who reported higher HIV communication self-efficacy were likely to communicate their HIV status with their partner prior to their LSE but being with a steady partner decreased the likelihood of HIV disclosure (Knox et al., 2012). Black MSM were less likely to communicate their HIV status compared to White MSM, which suggests that there may be additional characteristics beyond social cognitive behavior constructions and situational contexts (Knox et al., 2012). Since the participants sampled in Knox et al.'s (2012) study are from South Africa and did not include API MSM, it is not known whether the study's findings are generalizable to the API MSM population in the United States and in the context of casual sexual partners. Although the scope of this study does not include the measurement of communication self-efficacy, it is important to acknowledge that there is a relationship between communication and cultural values.

Sullivan (2005) argued that communication about sensitive topics such as HIV seropositivity is influenced by cultural background. For example, Zea, Reisen, Poppen, and Díaz (2003) found that communication about one's HIV status either asking or soliciting information about a sex partner's HIV status and telling or disclosing one's own HIV-positive status was influenced by cultural factors in a sample of 129 Latino HIV-positive, gay men. Specifically, the authors found that "region of birth was associated with both asking and telling" and "participants with bilingual friendship networks reported more communication with partners" (Zea et al., 2003, p.143). In another study conducted by Zea, Reisen, Poppen, Echeverry, and Biachi (2004) using a sample of 155 HIV-positive Latino

gay men from New York City and Washington, DC, the authors found that greater U.S. acculturation was related to disclosure to fathers and marginally related to disclosure to mothers, but not related to disclosure to closest friends. The authors suggested that the Latino cultural expectations that have been labeled as *simpatía* and the tendency to be “silent about homosexuality” may be an explanation of why men who are less acculturated into the United States may adhere to norms limiting conversation about topics associated with homosexuality, such as HIV status (Zea et al., 2004).

Except for a few studies that have been conducted abroad, there is limited research in which HIV-positive disclosure rates and behaviors in casual sex settings have been examined. Using a sample of 804 MSM in Australia, Holt et al. (2011) reported that 413 (51.4%) reported HIV disclosure and 391 (48.6%) reported no disclosure. That is, just over half of Australian MSM who had anal intercourse with their casual sexual partners in the past six months disclosed their HIV status. Holt et al. (2011) concluded that these findings were consistent with other studies in that HIV-positive disclosure is less likely in casual or anonymous settings where there is less of a burden for HIV-positive MSM to initiate disclosure. Using a qualitative design, Lee et al. (2013) examined HIV disclosure barriers and motivators among a sample of 50 PLHIV in Northeastern Thailand. The authors concluded that the motivators to HIV disclosure included coping with illness, seeking help, and common experiences; the motivators included seeking supportive relationships, duty to inform, and catharsis. The importance of cultural norms was highlighted in the study as Thailand is a family-oriented society that has roots consistent with Hofstede’s collectivist cultural dimension. In another qualitative study, Maiorana et al. (2012) also highlighted

cultural differences and reported that HIV serostatus disclosure to sexual partners may vary by race or ethnicity. That is, in order to understand the complex process of disclosure to sexual partners, it is necessary to understand the relationship to other individual and contextual factors such as partner serostatus, the nature of the sexual encounter, as well as community norms (Maiorana et al., 2012).

Asian Pacific Islander men who have sex with men. The decision to disclose serostatus is heightened and presented with unique challenges for API MSM. One difference for API MSM is the cultural restraint or restriction against homosexuality and HIV. Kang and Rapkin's (2008) study is one of the few studies that examined HIV-positive serostatus disclosure in API using a sample of 56 participants of different racial/ethnic cultures (i.e., Chinese, Filipino, Cambodian, Laotian, Malaysian, and Thai) in New York City. The API participants in the study reported that HIV-related stigma prevented them from disclosing their serostatus (Kang & Rapkin, 2008). Interestingly, API MSM reported less stigma-related social rejection and therefore were more likely to disclose their serostatus compared to API who self-identified as heterosexual (Kang & Rapkin, 2008). Moreover, particular API groups comprising of mostly (i.e., 66% of the participants) ethnic Chinese tend to place value on their ability to cope and receive social support from "in-group" (e.g., family and intimate friends) and "out-group" members (e.g., service providers) (Kang & Rapkin, 2008). The issue of cultural, racial, and ethnic differences in HIV-positive serostatus disclosure merits attention in light of the disproportionately represented and growing rate of minorities, especially among APIs, in the United States.

Disclosure of HIV-positive serostatus to sexual partners was also studied using participants in high-risk areas in southern China. Wang et al. (2010) found that there was a large differential between the proportions of disclosure to regular partners defined as a spouse, boyfriend/girlfriend or co-habiting partners compared to casual partners defined as commercial sex workers, drug partner or an anonymous sex partner (94.8% versus 13.0%, respectively), which differs from previous studies. For example, Kalichman, Rompa, Luke, and Austin (2002) reported 78% disclosure rate to regular serodiscordant partnerships versus 54% to casual sexual partners in 2006 in the United States. Landau and York (2004) reported 52% disclosure rate to regular partners versus 29% to casual partners in 2004 in Israel. Wang et al. (2010) hypothesized that these differences in disclosure rates in their study compared to Kalichman et al.'s (2002) and Landau and York's (2004) studies were primarily attributed to the different cultural relationship norms. That is, both Israel and the United States are considered individualistic countries whereas China is considered a collectivistic country (Wang et al., 2010). In collectivist cultures, there is a tendency to gravitate toward interactions between in-groups, such as family unit, rather than between out-groups, such as strangers or outsiders (Wang et al., 2010). The individuals in collectivistic societies may view their place as within an in-group of a family unit and therefore have less of a feeling of responsibility to those outside those groups to disclose their serostatus, which in this case, would include casual sexual partners (Wang et al., 2010). The findings from these three particular studies warrant the need to further explore the potential influence of cultural dimensions or values (i.e., collectivism versus individualism) on HIV-positive serostatus disclosure rates with API MSM.

Although racial and ethnic factors were noted above to influence the rate of HIV-positive disclosure, this finding is not definitive for studies that have been conducted in the United States. For example, Serovich, Esbensen, and Mason (2007) found that race did not influence the disclosure rates over time in their retrospective study where they examined the rates of HIV disclosure to family and friends over a 15-year time span. Sullivan (2009) reported that the frequency of disclosure for men and women (i.e., within and between gender groups) was similar based on ethnicity. In addition, there was little difference in disclosure rates among men who self-identified as homosexual, bisexual, or heterosexual (Sullivan, 2009). Interestingly, men who were born in Hawaii had a higher frequency of disclosure compared to their non-native counterparts while the frequency of disclosure to sexual partners by women who were born in Hawaii was lower than among women who had migrated to the islands (Sullivan, 2009). This finding suggests that more research is needed to further understand the influences of sex, transient residency, or acculturation in Hawaii and other U.S. states.

Length of time since HIV diagnosis. Length of time since the individual was diagnosed with HIV also influences the rate of HIV-positive serostatus disclosure. Two earlier studies from the 1990s suggest that disclosure to family and friends was positively correlated with length of time since HIV-seropositive diagnosis (Hays et al., 1993; Mason et al., 1995). Petrak et al. (2001) also reported that length of time since testing HIV diagnosis did predict disclosure to partners, friends, and family members. However, the association between length of time since HIV diagnosis did not exist for disclosure to intimate partners in two subsequent earlier studies (Mansergh, Marks, & Simoni, 1995; Stein et al., 1998).

Contrary to the authors' expectation, Zea and colleagues (2004) found that time since diagnosis was positively correlated only to disclosure to friends but negatively correlated with disclosure to mothers and fathers in a sample of 155 HIV-positive Latino gay men. Among API MSM, heterosexual API males, and heterosexual API females, there was no correlation between the length of time since HIV diagnosis and acceptance of illness and the negative consequences of stigma (Kang & Rapkin, 2008). In a sample of Hawaiian men and women, the variable of time since testing positive was associated with disclosure only for men but not for women; that is, those who were diagnosed for a longer time were more likely to disclose to sexual partners prior to sex (Sullivan, 2009).

The relationship between disease chronology and HIV-positive disclosure rates to sexual partners among MSM remains unclear. In Sullivan's (2005) review of the literature, the findings from the 13 studies (representing 76.5% of the articles reviewed) showed a typical pattern of lower levels of self-disclosure after individuals test positive followed by more disclosure over time as individuals come to terms with their illness. In one earlier qualitative study of self-disclosure of HIV status to sexual partners, Klitzman (1999) found that gay men took time to accept their HIV-positive diagnosis and waited several months to even years before disclosing their serostatus to sex partners. Marks and Crepaz (2001) found that nondisclosure was associated with having an HIV diagnosis for less than three years among a sample of multiethnic men. However, Stein et al. (1998) reported no association between length of time since diagnosis and self-disclosure to intimate partners. In addition, Serovich (2000; 2001) reported that the disease progression model of self-disclosure was not predictive of self-disclosure to sexual partners even when individuals

became ill and symptoms could no longer be hidden. The mixed findings of disease chronology warrant more research to examine the relationship, if any, between length of time since HIV-positive diagnosis and disclosure to casual sexual partners, specifically for the API MSM population.

Age, level of education, and income. In previous studies, factors such as a participant's age, level of education, and income have shown to influence the rate of HIV-positive serostatus disclosure. Serovich and Mosack (2003) reported that men who were likely to disclose their serostatus to casual sexual partners were, on average, younger in age. However, Serovich et al. (2007) found that age of the participant at the time of disclosure did not significantly influence HIV-positive disclosure rates of HIV-positive men to family members and friends over a 15-year time span. In a recent study, Cook, Valera, and Wilson (2015) reported that approximately one-half (52.4%) of the young men who have sex with men (YMSM) reported disclosing to their current sexual or romantic partner. On the other spectrum, Brown, Serovich, Kimberly, and Umasabor-Bubu (2015) assessed the associations between age and HIV-positive disclosure behaviors, attitudes, and intentions among MSM (age 50 and older) and found that these men scored lower in disclosure behavior ($\beta = -7.49$; 95% CI: -14.8 , and -0.18) compared to MSM 18-34 years (Brown et al., 2015). The findings from these studies warrant more exploration to examine whether there is an association between age and HIV-positive disclosure behaviors, attitudes, and intentions for the targeted API MSM population.

Level of education is another factor that influence HIV-positive disclosure rate. Serovich and Mosack (2003) reported that men with higher education were more likely to

disclose their serostatus to casual sexual partners. Similarly, Kang and Rapkin (2008) found that API who self-identified as MSM completed more years of education and were more inclined to disclose their serostatus for purposes of receiving support from others than API who self-identified as heterosexual. However, Sullivan (2009) reported that those with higher education were less likely to disclose to sexual partners. Sullivan (2009) speculated that those with more education may feel greater stigma about having contracted HIV and therefore may be less likely to disclose their seropositivity as they have a reputation to uphold. In a recent study, Lee, Yamazaki, Harris, Harper, and Ellen (2015) reported that education level was not associated with HIV-positive disclosure to friends and family among 402 youths (aged 12-24 years) living with HIV. The mixed findings reported from the above studies warrant more exploration on whether level of education has an influence on HIV-positive disclosure behaviors, attitudes, and intentions among API MSM to casual sexual partners.

The findings from previous studies have also suggested that level of income and socioeconomic status may influence the rate of HIV-positive serostatus disclosure. In Sullivan's (2005) review of the literature, she noted that only one researcher (Klitzman, 1999) gathered background data of participants; however, no conclusions were made based on income and HIV-positive disclosure rate. Even though Crepaz and Marks (2003) did report that increased income was correlated with safer sex practices, it is not known whether safer sex practices translate to HIV-positive disclosure behaviors, attitudes, and intentions. Sullivan (2005) also pointed out that several studies (Crepaz & Marks, 2003; Marks & Crepaz, 2001; Zea et al., 2003; Zea et al., 2004) that included participants of mixed

ethnicity also included large percentages (49%-75%) reporting earning less than \$10,000/year. Because these studies do not specifically target the API MSM, it is uncertain whether level of income influences the rate of HIV-positive disclosure behaviors, attitudes, and intentions for this population. In addition, Sullivan (2009) also reported that income influenced men's disclosure with those having lower income disclosing more frequently than men with higher income among a sample of 122 Hawaiian men and women. Relatedly, Obermeyer et al. (2011) reported that HIV-positive serostatus disclosure tends to be higher in high-income countries such as the United States, United Kingdom, Western Europe, Australia, and Canada. When synthesizing the findings from the above studies, clarity is needed to understand whether there is any association between income and HIV-positive disclosure behaviors, attitudes, and intentions for the targeted API MSM population.

The above section illustrates that HIV-positive serostatus disclosure is a complex and multifaceted process. Based on the review of the literature, there are numerous factors that influence disclosure including relationship types (i.e., sexual partners, casual sexual partners, and anonymous partners); sociocultural, cultural, racial/ethnic, and level of acculturation; length of time or number of years since HIV diagnosis; age, level of education, and income. Of importance, the findings from previous studies highlight the need to explore the aforementioned factors that influence HIV-positive serostatus disclosure. Specifically, the findings from previous studies have been mixed or inconclusive. Moreover, it is not known whether the factors that influence serostatus disclosure are relevant to the targeted population of API MSM. It is now appropriate to discuss the methodological considerations that will help to inform the proposed study.

Methodological Considerations

There are numerous limitations from previous studies on HIV-positive disclosure rates that need to be considered. Self-disclosure research has evolved over the last few decades highlighting the importance of clearly specifying inclusion and exclusion criteria based on research questions, target groups, and disclosure types. Studies' participants may include both homosexual and heterosexual males and females, or homosexual and heterosexual males only, or homosexual and heterosexual females only, or exclusively homosexual males. Because the most at-risk population is homosexual males, men who have sex with men represented the majority of the samples. In the United States, MSM continue to represent the majority of the HIV/AIDS cases (Brown et al., 2015). Within the API community, MSM also represent the majority of the HIV/AIDS cases (CDC, 2015a). Therefore, it was appropriate to target API MSM in this study.

The operational definitions for intimate, steady, casual, and anonymous sexual partners are also different from study to study making it difficult to interpret the wide range of disclosure rates that have been reported. Disclosure targets may include family, fathers, mothers, siblings, children, friends, co-workers, intimate partners, or sexual partners. Because the rate of HIV-positive serostatus disclosure tend to be lower in casual or anonymous sexual encounters (Groves, Hirschfield, Remien, Humberstone, & Chiasson, 2013), it was appropriate to focus on the disclosure target of casual sexual partners as it presented the greatest opportunity to prevent HIV transmission and reduce risky sexual behaviors. The inclusion or exclusion criteria of whether participants have a comorbid or co-existing substance use/abuse and/or mental or psychiatric condition made it difficult to

interpret the reported serostatus disclosure rates between studies. To this end, it was necessary to exclude participants who currently had any co-existing substance use/abuse and/or mental or psychiatric condition.

The serostatus of sex partners may be known or not known depending on the study. Even if known, researchers may elect to rely on self-reported data versus actually obtaining test results from sexual partners. For this study, participants were asked to self-report the serostatus of their casual sexual partners as it was not feasible to obtain test results from all sexual partners. Finally, it was important to ascertain whether participants verbally disclosed or used nonverbal modes of communication such as leaving clues (e.g., medication bottle, HIV-related magazines) in plain sight. In this study, participants were asked whether they had employed a point-blank disclosure strategy as it was the most common disclosure strategy – compared to the other four strategies of stage-setting, indirect disclosure, buffering, and seeking similar – whereby HIV-positive MSM overtly disclosed their serostatus either in written or verbal form (Serovich et al., 2005). Equally important was to be clear on whether disclosure occurred before or after sexual encounters. To reap the preventative effects of HIV-positive disclosure, it was important to examine disclosure prior to (and not after) engaging in casual sexual encounters in this study.

Measurement of cultural values, cultural dimensions, and level of acculturation. Based on the latest U.S. Census Bureau (2011) data, Asian Americans are the fastest growing ethnic group in the United States. Within this collective group, there exists a tremendous variation. The heterogeneity of this group is represented by the numerous countries (e.g., China, Japan, Korea, Philippines, Vietnam, etc.) that comprise the

Asian Americans group but also in the length of time they have spent in the United States, their generational status (e.g., first generation, second generation, etc.), their reasons for migrating to the United States (e.g., in search of occupation opportunities, to seek freedom, or to flee persecution in their homelands), and in their view of the United States (e.g., temporary workplace or as a new home) (Zhang & Tsai, 2014).

There are numerous scales and instruments available to assess and measure levels of acculturation and enculturation. Unidimensional (sometimes termed “unilinear” or “bipolar”) and bidimensional (sometimes termed “bilinear” or “multidimensional”) are two models or approaches to measure levels of acculturation and enculturation (Zhang & Tsai, 2014). The unidimensional approach is now considered inferior to the bidimensional or multidimensional approach as the former model is unable to account for the “bicultural” identification (i.e., one may feel strongly American and strongly Vietnamese at the same time) while the latter model assumes that individuals (immigrant or nonimmigrant) may fall into one of the following categories: (1) can strongly identify with both their host and heritage cultures, (2) weakly identify with both cultures, or (3) strongly identify with one culture and only weakly with the other culture (Zhang & Tsai, 2014). Some acculturation scales were also developed, tested, and used for specific target populations such as Chinese American or Vietnamese American. Finally, Zhang and Tsai (2014) also argued that it is important to consider how measuring cultural orientation with acculturation and enculturation and not singularly or independently as these concepts may interact or intersect with environmental factors, including socioeconomic status. Therefore, a cultural orientation scale and an acculturation scale that is multidimensional in its approach that can

be applied to all Asian Americans will be used in this study. Stated differently, to fully understand the multifaceted influence of culture, it is necessary to use more than one instrument to measure cultural values or cultural dimensions (individualism-collectivism) and the level of acculturation for the Asian American population.

For this study, it was important to use an instrument that measure cultural values at the individual level rather than at the national level. Yoo et al. (2011) argued that a new instrument needs to be developed to address the criticisms of the well-known Hofstede's five dimensions of cultural values: power distance, uncertainty avoidance, individualism, masculinity, and long-term orientation. One of these criticisms is that the Hofstede's metric was developed to measure national cultural dimensions and not individual cultural dimensions (Robinson, 1983; Søndergaard, 1994; Triandis, 1982). Therefore, Hofstede's metric was flawed with methodological difficulties coupled with disappointing psychometric results. In fact, Hofstede (1980) found a weak correlation matrix among cultural dimensions when he analyzed his own data at the individual level. Yoo et al. (2011) made a convincing argument that "by measuring individual cultural orientations and not equating them to the national culture, researchers can avoid the ecological fallacy that occurs when ecological or country-level relationships are interpreted as if they applied to individuals" (p. 195). Consequently, Yoo et al. (2011) developed their own measurement tool, the Individual Cultural Values Scale (CVSCALE), to assess Hofstede's five dimensions of culture at the individual level.

Measurement of self-disclosure. Different researchers have used various scales and instruments to measure HIV-positive serostatus disclosure to sex partners. For example,

Kalichman and Nachimson (1999) developed a self-efficacy scale for HIV-serostatus disclosure to sex partners consistent with Bandura's (1997) social cognitive theory and research conducted by Forsyth and Carey (1998) and Maibach and Murphy (1995) on the assessment of self-efficacy for practicing safer sex. Derlega et al. (2002; 2004) used three questionnaires in their study including The Reasons for Disclosure Questionnaire (24 statements measuring five reasons for disclosing), The Reasons for Nondisclosure Questionnaire (23 items measuring six reasons for not disclosing), and an HIV-related stigma scale constructed by Bauman, Camacho, Forbes-Jones, and Westbrook (1997) measuring how much they believed that the public stigmatized someone with HIV or AIDS. For the disclosure and nondisclosure questionnaires, research participants completed three versions of the questionnaires: with friend, intimate partner, and a parent as target persons (Kalichman & Nachimson, 2002). Serovich and Mosack (2003) used a 15-item scale adapted from Derlega, Winstead, and Folk-Barron's (1997) work to assess reasons for disclosure and another 15-item scale adapted from Derlega et al. (1997) to assess reasons for nondisclosure to casual sexual partners in their study. Instead of using a standardized instrument, Okello et al. (2015) used three questions to measure general disclosure, disclosure to sex partners, and the extent of disclosure to casual sexual partners (i.e., "did not disclose to any," "disclosed to some," or "disclosed to all"). Similarly, Serovich et al. (2009) specifically developed their own questionnaire to measure serostatus disclosure behaviors, attitudes, and intentions to casual sexual partners. Similarly other researchers developed their own questions to assess HIV-positive serostatus disclosure to target groups (Cook et al., 2015; Shushtari et al., 2014; Zea et al., 2005). For this study, Serovich et al.'s

(2009) HIV-Positive Disclosure Scale was used as this scale was specifically developed to assess the disclosure behaviors, attitudes, and intentions to casual sexual partners.

Sampling. Researchers used different sampling strategies or methods to recruit participants for their studies. Sullivan (2005) reported that the sampling method that was most frequently used from the review of 17 studies on male self-disclosure of HIV-positive serostatus to sex partners was convenience and purposive sampling from large metropolitan cities, with subjects recruited from public health clinics, clinical trials, mental health care services, and longitudinal prevention intervention programs. To recruit participants from hidden and hard-to-reach populations, many researchers have resorted to using one or more of the following sampling methods: targeted sampling, snowball sampling, time-location sampling (TLS), network-based sampling, respondent-driven sampling (RDS), venue-based sampling, and venue-day-time periods (VDT) sampling (Catania, Canchola, Pollack, & Chang, 2001; Charurat et al., 2015; Gustafson et al., 2013; Heckathorn, 1997; Karon, 2005; Nehl et al., 2015; Salganik, & Heckathorn, 2004; Semaan, 2010). These nonprobability sampling methods have been shown to be effective in reaching hidden and hard-to-reach populations such as Asian MSM in Vancouver, British Columbia (Canada) (Maung et al., 2013), young Latino MSM in New York City (Stueve et al., 2001), female sex workers in Liuzhou, China (Weir et al., 2012), and MSM, male and female sex workers, or mobile populations such as long-distance truck drivers (truckers) in Mexico (Gayet & Fernández-Cerdeño, 2007). Zea et al. (2004) used a combination of sampling methods to recruit hard-to-reach or hidden communities including targeted sampling, snowball sampling, and respondent-driven sampling to recruit HIV-positive Latino gay men from New York City

and Washington, DC. In yet another study, Wei et al. (2011) used TLS and VDT sampling methods to recruit hidden or hard-to-reach populations of API, Black, Latino, and “other” race/ethnicity in San Francisco.

In addition to the studies discussed above, many researchers have conducted studies related to disclosure of HIV seropositive status to sexual partners in the United States and abroad. In the United States, studies have been conducted using samples from the following states and cities: Birmingham, Alabama (Elopre et al., 2015); young MSM in Chicago (Downshen, Binns, & Garofalo, 2009); gay and bisexual men in New York City and San Francisco (Parsons et al., 2005); participants recruited from clinics, hospitals, and community agencies in New York City, Washington, DC, and Boston (Zea, Reisen, Poppen, Bianche, & Echeverry, 2005); gay or bisexual males in New York City (Haile, Padilla, & Parker, 2011); MSM recruited from Columbus, Ohio and Tampa, Florida (Serovich, Reed, Kimberly, & Putney, 2014); diverse, low-income women and men living with HIV in Los Angeles (Sayles et al., 2007); ethnically-diverse young MSM in Chicago (Downshen et al., 2009); MSM who were recruited from four gay-oriented sexual networking websites across the United States. (Hirshfield et al.2012); men and women recruited from HIV and AIDS research sites and service organizations in Virginia, North Carolina, Ohio, and Texas (Derlega et al., 2002; Derlega et al., 2004); and Nashville, Tennessee (Audet, McGowan, Wallston, & Kipp, 2013). Despite the numerous studies related to HIV-positive disclosure to sexual partners that have been conducted in the United States, there has been no study that has specifically included a sample of the diverse API MSM population throughout the United States.

Studies that have been conducted outside of the United States included a variety of countries across numerous continents including: Mekelle, Ethiopia (Genet, Sebsibie, & Gultie, 2015); in Assela town health facilities, Arsi Zone, Oromiya Region, Ethiopia (Fekadu, Addisie, & Mellie, 2014); Accra, Ghana (Kenu et al., 2014); Kampala, Uganda (Muhimbuura et al., 2014; Okello et al., 2015); Jinja, Uganda (King et al., 2008); Kinshasa, Democratic Republic of the Congo (Vaz et al. 2008); KwaZulu-Natal Province, South Africa (Tshabalala, 2014); Gugulethu, South Africa (Iwelunmor et al., 2014); Pretoria, South Africa (Knox, Reddy, Kaighobadi, Nel, & Sandfort, 2012); Soweto, South Africa and Vulindlela, South Africa (Maman, van Rooyen, & Groves, 2013); adolescents recruited from four locales in Nigeria (Elegbeleye, Taiwo, Omole, Adebusuyi, & Atiri, 2012); Malawi, Namibia, and Botswana (Fay et al., 2011); sub-Saharan African (SSA) migrant women living with HIV/AIDS in Belgium (Arrey et al., 2015); African and Afro-Caribbean people living in the Netherlands (Stutterheim et al., 2011); other South African communities (Skinner & Mfecane, 2012); women in Cayenne, French Guiana (Narcisse, Matthieu, & Matthieu, 2012); women living with HIV who are French-speaking, Quebec-born (Rouleau, Côté, & Cara, 2012); women from Mexico and Central America (Simoni et al. 1995); MSM in Lisbon, Portugal (Meireles et al., 2015); East London (Pettrak, Doyle, Smith, Skinner, & Hedge, 2001); Tehran, Iran (Shushtari, Sajjadi, Forouzan, Salimi, & Dejman, 2014); and in India (Bharat, 2011; Chandra, Deepthivarma & Manjula, 2003; George & Lambert, 2015; Steward et al., 2011). Although the studies above have examined how cultural factors may have influenced HIV-positive disclosure, none of them have addressed how cultural values

and level of acculturation may influence HIV-positive disclosure behaviors, attitudes, and intentions for API MSM living in the United States.

The preceding section highlights the methodological considerations that should be taken into account when designing a study to examine the relationships between individualistic-collectivistic cultural dimensions, level of acculturation, age, length of time since HIV diagnosis, level of education, and income to the rate of HIV-positive serostatus disclosure behaviors, attitudes, and intentions to casual sexual partners for API MSM. Specifically, the rationale to use the disclosure target of casual sexual partner among API MSM was discussed followed by the serostatus of sex partners. Next, the direct disclosure strategy that occurs prior to (and not after) engaging in casual sexual encounters was the focus of the study. Then, an argument was made to use instruments that are multidimensional in their design when measuring cultural values, cultural dimensions, and the level of acculturation for the API population. Finally, Serovich et al.'s (2009) HIV-Positive Disclosure Scale was used to measure serostatus disclosure behaviors, attitudes, and intentions to casual sexual partners for the targeted population of API MSM.

Summary and Transition

Thanks to the advances in technology and pharmaceutical antiretroviral therapy, men and women with HIV are living longer, healthier lives with less outward manifestation of the disease. That is, HIV/AIDS is now considered a chronic, manageable disease that is multifaceted, highly complex, and intertwined with prolonged physical deterioration, social stigma, and moral implications. With longevity, PLHIV have the opportunity to nurture their interpersonal relationships and further embrace their sexuality. Naturally, PLHIV

continue to engage in sex after diagnosis. The number of HIV-positive MSM continues to account for the largest proportion of newly reported HIV infections worldwide (Lin et al., 2015). Interventions focused on at-risk groups such as MSM who engage in casual sex with partners who are of HIV-negative and unknown serostatus need to be tailored to address the unique personal, environmental, cultural, and behavioral challenges they face. Disclosure of HIV infection in the context of sexual relationships, particularly for the most at-risk group of casual sexual partners, enables partners to make informed decisions and communicate about behavioral risks that influence transmissions of HIV. Factors associated with disclosure of HIV status to sexual partners offer considerable benefits from both an individual and a public health perspective.

This literature review has focused on the topic of HIV-positive serostatus disclosure to sexual partners. While much research has been conducted on the topic since HIV/AIDS was introduced to the public health arena, there is a lack of research that focuses on the population of API MSM in previous studies. Findings from selected studies suggest that there may be a relationship between disclosure and cultural, sociocultural, racial, and ethnic factors. The evidence suggests cultural values and level of acculturation play a role in whether or not HIV-positive MSM self-disclose their serostatus to others including sex partners. There is also mixed findings relating to whether or not length of time since HIV diagnosis, age, level of education, and income may negatively or positively influence disclosure to others. Accordingly, this study was unique and important because it was designed to explore how the cultural values that are unique to the API MSM population coupled with other factors such as level of acculturation, length of time since diagnosis, age,

education, and income may influence seropositivity disclosure to casual sexual partners.

The following chapter 3 will explain the research design and rationale, methodology, threats to validity, and ethical procedures.

Chapter 3: Research Method

Introduction

The purpose of this study was to examine the relationship between individualistic-collectivistic cultural dimensions and HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners for API MSM. Other contributing factors that have resulted in mixed or inconclusive findings as discussed in the review of the literature, such as level of acculturation, length of time since HIV diagnosis, age, level of education, and income were also explored to understand if they contributed to the phenomenon of serostatus disclosure.

In this chapter, I will describe the research designs employed and the rationale for their selection as well as provide a concise explanation of the independent variables (i.e., cultural values, level of acculturation, length of time since HIV diagnosis, age, level of education, and income) and the dependent variables of disclosure behaviors, attitudes, and intentions. I will also describe the rationale for choosing a phenomenological approach for the qualitative phase of the mixed methods sequential explanatory study. A comprehensive discussion of the research design and rationale will follow including a description of the target population of API MSM in the United States, sampling and sampling procedures, sample size calculation using G* Power, procedures for recruitment and participation, plans for data collection methods and data analysis, and identification of the instrumentation and operationalization of constructs. Next, a discussion of the potential and expected threats to validity and reliability of the measurement instruments as well as data collection procedures will follow. Finally, aspects of ethical procedures, informed consent, participant

confidentiality, safety, and data protection are described including plans to address anonymity of the participant for this two-phase, mixed methods study.

Research Design and Rationale

The research questions merit the two-phase, mixed methods approach as choosing either a quantitative or qualitative approach singularly would result in insufficient data sources without the opportunity for explanation or exploration of the results. In addition, a mixed methods approach helps to augment, connect, and integrate the data between the two phases of quantitative and qualitative approaches.

When considering the specific research design, it is important to be acquainted with the major types of mixed methods designs, and the intent, key procedures, common variants, and inherent strengths and challenges of these designs. Creswell and Plano Clark (2011) identified and discussed four major types of mixed methods designs including triangulation, embedded, explanatory, and exploratory. Of these, the explanatory design was most appropriate to use for this study because the overall purpose of this design was to use qualitative data to aid in explaining and building upon initial quantitative results that are significant (or nonsignificant), outliers, or surprising (Creswell & Plano Clark, 2011). This design is a two-phase mixed methods design with the first phase starting with the collection and analysis of quantitative data followed by the second qualitative phase designed to connect to the results of the first quantitative phase.

To adequately address the research problem, other factors such as timing, weighting, and mixing need to be considered when selecting the most appropriate research design. For this study, the quantitative phase was implemented first followed by the qualitative phase

(i.e., sequential timing). In addition to choosing the timing, the relative weighting or relative importance or priority of the quantitative and qualitative approaches needed to be considered. For this study, the primary emphasis was on the first quantitative phase followed by the explanatory design (i.e., unequal weighting). Finally, the third procedural consideration was the mixing decision for choosing how the quantitative and qualitative methods were mixed. Conceptually, there are three overall strategies that are available for mixing data including merging, embedding, and connecting (Creswell & Plano Clark, 2011). For this study, the quantitative results from the first phase were connected to the qualitative findings of the second phase.

In summary, the two-phase, mixed methods, sequential explanatory design was used to interpret and integrate the quantitative and qualitative results, allowing for a deeper, richer, and better understanding and explanation of those results than either approach alone. The research design deployed with its corresponding characteristics of timing, weighting, and mixing considerations is depicted in Figure 1 below.

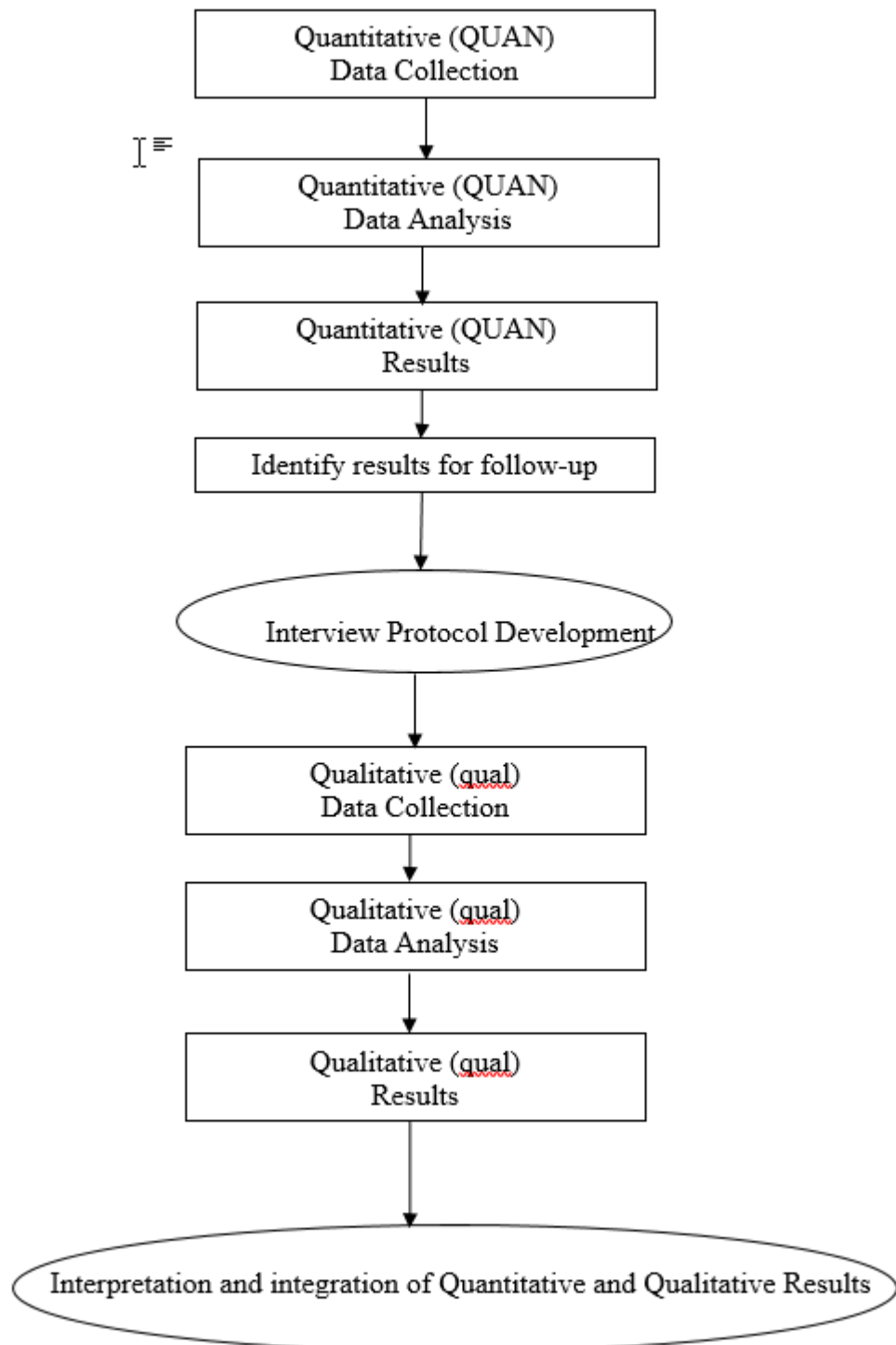


Figure 1. Explanatory design: Follow-up explanations model.

Quantitative

In evaluating the most appropriate quantitative research design to use, ethical and legal concerns must be taken into consideration including other aspects of self-disclosure of participants' HIV-positive serostatus. For example, the issues of confidentiality, deception, sensitivity, and nonmaleficence must outweigh the benefits and strengths of any design. Thus, the selected research design needs to take into consideration the heightened sensitive topic of HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners while at the same time preserving the participants' confidentiality and psychosocial well-being.

I used a cross-sectional survey design to explore patterns and the factors that may influence HIV-positive serostatus disclosure among API MSM. The cross-sectional design was a good fit for investigating the relationship between one or more factors influencing HIV-positive serostatus disclosure. This design also facilitated the testing of the aforementioned hypotheses to determine possible factors that may influence API MSM participants to self-disclose their HIV-positive serostatus to casual sexual partners. Specifically, I used this design to determine or estimate the influence of cultural values, level of acculturation, length of time since HIV diagnosis, age, level of education, and income on HIV-positive serostatus disclosure behaviors, attitudes, and intentions to casual sexual partners among API MSM.

It is appropriate to consider both survey and Internet research methods in gathering data for this study. Questionnaires and interviews are two types of surveys. I used the questionnaire approach of survey research because it was more cost effective to deploy

compared to conducting personal and telephone interviews. The questionnaire approach is also a superior approach because it eliminates the presence of interviewer bias, preserves anonymity of the participants' responses to questions, and facilitates much information gathering compared to using personal and telephone interviews (Frankfort-Nachmias & Nachmias, 2008).

The utility and ubiquitousness of the Internet have also offered another way of conducting survey research. There are numerous advantages of using the Internet to conduct survey research using techniques such as Internet surveys or "e-survey" methodology. The advantages for researchers include: (a) decreased cost, (b) increased pool of participants that would also improve external reliability and generalizability, (c) increased access for sensitive issues or ease of reaching large number of potential cultural groups and "hidden" populations such as API MSM, (d) decreased time; methodological rigor and/or control by researcher, (e) faster response times, and (f) increased accuracy and efficiency of data entry and analysis (Ahern, 2005; Jansen, Corley & Jansen, 2007). There are also advantages for study participants including: (a) anonymity, (b) autonomy over the pace of answering the questions within a survey, (c) perception of control, (d) increased response rates, and (e) ease of use (Ahern, 2005; Jansen et al., 2007). With these advantages, the questionnaires were disseminated to study participants using the Internet.

It is also important to note that there are challenges and limitations to conducting survey research using the Internet. Some of these limitations include: (a) lack of control over sample (i.e., subject recruitment bias) as participants will be self-selected from a non-random pool of computer/Internet users, (b) possible equipment problems and/or network

incompatibility, (c) increased time for creation and maintenance of user-friendly, web-based instrument(s), (d) questionable authenticity of respondents' data including multiple submissions from the same participant, (d) possible data entry errors, (f) security, privacy, and confidentiality issues relating to hosting of the website and the location of data storage, and (g) literacy and disability issues of participants (Ahern, 2005; Jansen et al., 2007).

Despite these limitations and challenges, the Internet does offer a low-cost, quick way to gather data from difficult-to-reach populations of API MSM on the sensitive topic of HIV-positive serostatus disclosure to casual sexual partners. Thus, a cross-sectional, correlational design using a web-based survey was inexpensive, less time consuming, and less cumbersome compared to other research designs to arrive at the study results and conclusions.

Qualitative

For the qualitative phase of the study, I implemented a phenomenological approach. As the name implies, a phenomenological approach is used to describe the common meaning for several individuals of their lived experiences (as opposed to second-hand experience) of a phenomenon. Edmund Husserl is generally considered to be the founder of phenomenology (Hein & Austin; 2001).

For this study, the phenomenon of interest was HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners among API MSM. Over the years, phenomenology has become so popular that its definition has blurred. Patton (2002) argued that phenomenology could be referred to as a philosophy, an inquiry paradigm, an interpretative theory, a social science analytical perspective or orientation, a major

qualitative tradition, or a research methods framework. To complicate matters, there are also various forms of phenomenology including transcendental, existential, and hermeneutic phenomenology (Patton, 2002). Similarly, Creswell (2013) highlighted two approaches to phenomenology: hermeneutic phenomenology and empirical, transcendental, or psychological phenomenology. For the former, researchers make interpretations of the meaning of the lived experiences (Creswell, 2013). For the latter, researchers set aside their experiences as much as possible to ensure a fresh perspective toward the phenomenon under examination (Creswell, 2013; Hein & Austin, 2001). According to Hein and Austin (2001), the works of van Kaam, Giorgi, and Colaizzi have been influential in the development of empirical phenomenology. Of the two broad approaches to phenomenology, empirical phenomenology is also the more common form of phenomenological research (Hein & Austin, 2001).

Specifically, I employed the empirical phenomenological approach. The technique of bracketing is aligned with one of Husserl's concepts: *epoché* (Creswell, 2013; Hein & Austin, 2001). *Epoché* is an ancient Greek term that is used to describe the act of suspending judgment about the natural world and focusing on analysis of experience (Creswell, 2013). Phenomenology has its root in the traditions of psychology and sociology. Despite the numerous definitions and forms of phenomenology, there is arguably one shared common focus to this qualitative approach: exploring, capturing, and describing how people experience a phenomenon.

Research Questions, Hypotheses, and Variables

Quantitative

The following three research questions guided the quantitative portion of the study:

Research Question 1 (RQ1): What was the association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure behaviors in API MSM?

H_01 : There was no statistically significant association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure behaviors in API MSM.

H_a1 : There was a statistically significant association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure behaviors in API MSM.

The null hypothesis (H_01) was rejected if the p -value was less than the significance or alpha (α) level set at 0.05.

Research Question 2 (RQ2): What was the association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure attitudes in API MSM?

H_02 : There was no statistically significant association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure attitudes in API MSM.

H_{a2} : There was a statistically significant association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure attitudes in API MSM.

The null hypothesis (H_{02}) was rejected if the p -value was less than the significance or alpha (α) level set at 0.05.

Research Question 3 (RQ3): What was the association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure intentions in API MSM?

H_{03} : There was no statistically significant association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure intentions in API MSM.

H_{a3} : There was a statistically significant association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure intentions in API MSM.

The null hypothesis (H_{03}) was rejected if the p -value was less than the significance or alpha (α) level set at 0.05.

The dependent variable for the three research questions were HIV-positive disclosure behaviors, attitudes, and intentions, respectively. The independent variables for the three research questions were cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income.

Qualitative

For the follow-up qualitative portion of the study, the central research question was: What factors influenced the HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners in API MSM? The subquestions included the following:

- a) How may cultural values have influenced HIV-positive disclosure?
- b) How may level of acculturation have influenced HIV-positive disclosure?
- c) How did length of time since diagnosis influence HIV-positive disclosure?
- d) How may age have influenced HIV-positive disclosure?
- e) How may level of education have influenced HIV-positive disclosure?
- f) How may income have influenced HIV-positive disclosure?

Methodology

Population

The target population for the study included all API MSM in the United States who are also members of Fridae, the largest LGBT online community for Asians with a presence in the United States. According to the company's website, "Fridae is a diversified media and services company" (Fridae, 2015, para. 1) that provides a platform to bridge and unite cultures to the diverse and hard-to-reach gay and lesbian communities. The company's mission is to "transcend geographical borders" and to "[empower] gay Asia to: come together, stay connected, be informed, overcome discrimination, nurture personal growth, and foster healthy relationships" (Fridae, 2015, para. 4). The company's vision statement is: "Fridae seeks to be gay Asia's leading media & social networking website; the business

community's primary conduit to the Asian gay community; and a respected voice in our advocacy for equality and freedom of choice" (Fridae, 2015, para. 5).

In order to cast a wider net of participants across the United States, I recruited participants from other API organizations including the following:

- a) AIDS Housing Information Project (AHIP) – Hayward, CA
- b) AIDS Project Angeles – The David Geffen Center – Los Angeles, CA
- c) Asian & Pacific Islander Wellness Center – San Francisco, CA
- d) Asian & Pacific Islander American Health Form (APIAHF) – Oakland, CA
- e) Asian Pacific AIDS Intervention Team (APAIT) Health Center – Los Angeles, CA;
Orange County, CA
- f) Asian American Recovery Services, a program of HealthRIGHT 360 – San
Francisco, CA
- g) Asian Americans for Community Involvement – San Jose, CA
- h) Asian Health Services – Oakland, CA
- i) Center for Pan Asian Community Services, Inc. (CPACS) – Atlanta, GA
- j) Center on Halsted – Chicago, IL
- k) Fenway Health – Boston, MA
- l) Massachusetts Asian + Pacific Islanders (MAP) for Health – Boston, MA
- m) The Thrive Tribe Foundation – Los Angeles, CA

The United States was selected as the population of the study because the country has a large population of MSM especially in major cities such as San Francisco, Oakland, San Jose, Los Angeles, New York City, Houston, Chicago, Boston, Miami, and

Philadelphia, among others. Coincidentally, there are many API MSM who also reside in these metropolitan areas. As mentioned previously in chapter 1, the Asian population experienced the fastest rate of growth compared to other major race groups with an increase by 43% or more than four times as fast as the total population (U.S. Census Bureau, 2011). Between the 1990 and 2000 censuses, the Asian American population grew by 72% and the Native Hawaiian and Pacific Islander population by 140% (U.S. Census Bureau, 2011). The estimated number of U.S. residents in 2013 who were API, either one race or in combination with one or more additional races was 19.4 million (U.S. Census Bureau, 2015). Within the United States, the Chinese (except Taiwanese) population was the largest API group (4.3 million), followed by Filipinos (3.6 million), Asian Indians (3.5 million), Vietnamese (1.9 million), Koreans (1.8 million), and Japanese (1.4 million) (U.S. Census Bureau, 2015).

Quantitative Sampling and Sampling Procedures

The sample is the group of people that will be recruited based on meeting the eligibility or inclusion criteria in the study. Probability and nonprobability are two broad types of sampling methods. The former utilizes some form of random selection while the latter does not (Trochim, 2006a). Nonprobability sampling methods can be divided into two broad types, accidental and purposive (Trochim, 2006a). Subcategories of nonprobability, purposive sampling methods include modal instance sampling, expert sampling, quota sampling (proportional and nonproportional), heterogeneity sampling, and snowball sampling (Trochim, 2006a).

For the quantitative portion of the study, a purposeful convenience sampling method was used, which falls under the broad category of accidental nonprobability sampling. In addition to purposeful convenience sampling, snowball sampling was also used to recruit the hidden and hard-to-reach API MSM population. Thus, a cross-sectional, correlational design using a purposeful convenience sampling coupled with snowball sampling was selected for the study because the target population of API MSM is difficult to reach and the sampling method was comparatively inexpensive, less time consuming, and less cumbersome compared to other sampling methods to arrive at the study results and conclusions.

Quantitative Sample Size Calculation

For each of the three research questions, there were six independent variables (i.e., cultural values, level of acculturation, length of time since HIV diagnosis, age, level of education, and income) and one dependent variable (i.e., disclosure behaviors, attitudes, and intentions, respectively) thus it was appropriate to conduct a linear multiple regression statistical analysis. To calculate the sample size, three interrelated components of effect size, alpha level, and power must be available. Because statistical software such as IBM Statistical Package for the Social Sciences (SPSS) or Predictive Analytics SoftWare (PASW) does not compute power, it is necessary to use G*Power, which is a stand-alone power analysis program that can be downloaded free of charge via the Internet (Faul et al., 2007; Faul et al., 2009; Mayr et al., 2007). G*Power, will be used to determine the estimated total sample sizes necessary for a .80 power with a medium effect size.

Cohen's F -squared (f^2) was the appropriate size measure to use in the context of linear multiple regression analysis (Durlak, 2009). The effect size (Cohen's f^2) conventions were as follows when using a linear multiple regression model: 0.02 (small), 0.15 (medium), and 0.35 (large). According to Durlak (2009), the rule of thumb is to resort to the medium effect size when the effect size is not reported, known, or that there is lack of consistency from previous studies. Thus, a medium effect size of 0.15 was used in this study (Faul et al., 2009). There are five types of power analysis that are available within G*Power: a priori analysis, compromise analysis, criterion analysis, post hoc analysis, and sensitivity analysis (Faul et al., 2007; Faul et al., 2009; Mayr et al., 2007). An a priori analysis was the preferred method over post hoc analysis, allowing control for both Type I error probability α (i.e., the probability of incorrectly rejecting the null hypothesis when is in fact true) and Type II error probability β (i.e., the probability of incorrectly retaining the null hypothesis when it is in fact false) (Faul et al., 2007).

The following input parameters were entered into G*Power 3.1.9.2 to calculate the desired sample size N : effect size f^2 0.15, alpha level (α) .05, power ($1 - \beta$) .80, and six predictors. G*Power calculated the following output parameters: noncentrality parameter $\lambda = 14.700$, critical $F = 2.200$, numerator degrees of freedom (df) = 6, denominator degrees of freedom (df) = 91, total sample size = 98, and actual power = .80. Therefore, a sample size $n = 98$ was needed for the study to establish a power of .80 based on an alpha level (α) of .05 and a medium effect size.

Quantitative Procedures for Recruitment, Participation, and Data Collection

Research participants for the quantitative study were recruited from a pool of API MSM who are members of Fridae and from other API organizations in the United States. Even though members of Fridae may include those outside of the U.S., only U.S. members of Fridae were recruited. According to Fridae's marketing executive, Stéphane Abela, Global Team Leader (personal communication, September 16, 2015), there were 16,724 U.S. members who could be targeted via an electronic or email direct marketing campaign for the purpose of recruitment. According to The Williams Institute (2013), there are an estimated of 324,600 LGBT API adults in the U.S., which represents 2.8% of all API adults. Extrapolating from this data, there is a potential pool of 468 API MSM (or 2.8% of the 16,724 U.S. Fridae members) who could be eligible to participate in the study.

An EDM campaign can support the geographical target of individuals for a particular country such as the U.S. (S. Abela, Global Team Leader at Fridae, personal communication, September 16, 2015). Electronic or email direct marketing is a tool used to communicate a commercial message to a potential or existing member via emails. In the marketing field, EDM has been shown to generate up to 10% of social network growth through this new medium of electronic word of mouth (Dwyer, 2007). In addition to using the electronic or email direct marketing campaign, U.S. Fridae members who received the email message were encouraged to forward the message to other API MSM to participate in the study. The word of mouth method is an example of a snowball sampling method that was used to recruit additional study participants in the study.

Participants were recruited from Fridae and other API organizations in the United States. To be eligible, participants had to be over 18 years old; have been diagnosed with HIV/AIDS for more than six months, be able to read and write in English, self-identify as API MSM, and have ever engaged in casual sexual behaviors with HIV-negative or unknown serostatus partners in the past that resulted in a decision about whether to disclose their serostatus. Exclusion criteria include: (1) women; (2) men who do not identify as API MSM (e.g., White, Black, or Latino); (3) men who exclusively have sex with women; (4) men who have only been with one primary partner in a committed relationship; (5) men who exclusively have sex with other HIV-positive partners; (6) MSM who have been diagnosed with HIV/AIDS for less than six months because of the great emotional impact of finding out one is HIV positive; (7) MSM under the age of 18 years old; (8) MSM who cannot speak and understand English; (9) regular injection drug users (i.e., used more than once in the past three months); and (10) MSM who have a current major psychiatric diagnosis with active psychotic or suicidal symptoms. The decision to exclude regular injection drug users and participants who have a co-existing substance use/abuse and/or mental or psychiatric condition provided better control of the study and facilitated the ease of interpretation of reported serostatus disclosure rates as these could be confounding variables. Participation in the study was voluntary. For the quantitative phase of the study, participants who completed the anonymous online survey each received a \$5.00 Starbucks gift card. For the follow-up qualitative phase of the study, participants who completed the one-hour open-ended interview each received a \$25.00 Starbucks gift card.

As mentioned previously, an Internet survey was a viable primary data collection method to use for the quantitative portion of the study. The number of Internet users continues to rise coupled with the availability of Internet access in metropolitan cities and rural and remote areas. Cobanoglu, Warde, and Moreo (2005) compared the response speed, response rate, and costs (fixed and variable) of using mail, fax, and web-based surveys and found that the response speed was high for both fax and web surveys; the response rate was 26.27% for mail, 17.0% for fax, and 44.21% for web. The cost for the web method was the least (\$107.50) compared to the fax method (\$119.50) and the mail method (\$260.50). Solomon (2001) suggested that Internet surveys will continue to grow in popularity despite concerns over coverage bias or bias due to sampled people not having or choosing not to access the Internet either by choice or circumstance. Wright (2005) conducted a thorough review of the advantages and disadvantages of conducting online research studies including current features, issues, pricing, and limitations associated with 20 different vendors that offered online survey research products and services. Advantages of online survey research include access to groups or individuals who are difficult to reach or unique populations (i.e., API MSM who are diagnosed with HIV/AIDS); time saving to reach large numbers of people with common characteristics in a short amount of time while allowing researchers to collect data while they work on other tasks; and cost saving by eliminating the incurred costs through postage, printing, and data of a paper format and moving the process to an electronic medium (Wright, 2005). Wright (2005) also discussed the disadvantages associated with online survey research, which include access issues, sampling issues,

generating samples from virtual groups and organizations, and other sampling concerns such as self-selection bias.

Researchers may wish to design and publish survey instruments on the Web to collect data using one of the many commercial online survey research vendors based on pricing and services (Rudestam & Newton, 2015). For reasons of practicality and economy, I used the online service SurveyMonkey to create the web-based questionnaires and survey for the quantitative phase of the study. SurveyMonkey (2015) is the world's most popular online survey tool offering numerous plans and pricing. Some of the analytic features include real-time results, text analysis, SPSS integration, custom reporting, and filter and cross-tabbing (SurveyMonkey, 2015). SurveyMonkey is HIPAA-compliant and allows researchers to create surveys and questionnaires and to collect responses from various users of the Internet. The online survey will be self-administered and anonymous, which will limit researcher bias and facilitate participants' responses on sensitive topics such as HIV-positive serostatus disclosure. The survey will be administered online to reach a broad sample of API MSM in multiple locations and cities with minimum time and expense.

The anonymous, online survey included a cover page that included the following: background information of the study, the purpose and aims of the study, participants' inclusion and exclusion criteria, information about the measures and instruments used and the expected time to complete the survey, the voluntary nature of the study, the potential risks and benefits of participating in the study, privacy information, details of data protection and participant confidentiality, participants' right to withdraw from the study, and contact information for me and Walden University. The cover page could be printed

and saved by the study participants. Participants were able to provide consent online by responding to the statement of consent question on the consent form page by selecting either “I Agree” or “I Do Not Agree” acknowledging that they understood and agreed to the terms described in the consent form. Thus, the participants were required to read the electronic informed consent page and then make the decision to agree or disagree to participate in the study by clicking the “Next” button or by closing the Web page and exiting the survey page, respectively. By clicking the “Next” button, the survey questionnaire will be activated for the participants to complete the survey questions. Participants were encouraged to answer all questions within the survey but had the freedom to skip questions and to move back and forth the pages of the active survey questions as they wish. Participants could access the survey questions multiple times by saving the answers to return at a later time, if needed. However, once the survey was submitted, participants were not able to access the survey questions to make further changes. The last page of the online survey included a “thank you” page thanking the participants for their participation. There were no follow-up or debriefing procedures for this study. However, the results of the online survey were made available online to those who have access to the original survey by accessing another URL link provided in the survey end page. The results of the online survey were delivered in Microsoft Word, PDF, and SPSS document by SurveyMonkey with secured password. Data will be stored on a secure server, only accessible by me.

Data were collected through an anonymous, self-completed online survey. The survey was cross-sectional and was made available for eligible participants for 12 months. No identifying information from the participants was collected allowing for confidential

responses. The confidential format facilitated sample recruitment and limited the potential for participants' response bias that could be associated with the stigma of having HIV/AIDS and other potential stigmatizing sexual behaviors such as having casual sex with HIV-negative or unknown serostatus partners. The online survey was divided into seven sections: (a) Welcome to the HIV-Positive Disclosure and Asian Pacific Islander Men Who Have Sex with Men Survey! Page; (b) Consent Form; (c) Demographics; (d) Culture Orientation Scale; (d) Individual Cultural Values Scale (CVSCALE); (e) Asian American Multidimensional Acculturation Scale (AAMAS); and (f) HIV-Positive Disclosure Scale. The first section was used to assess participant eligibility. Eligible participants were allowed to proceed into the survey, while ineligible participants were directed to the end of the survey and thanked for their time. The demographic characteristics section included questions related to age, race and ethnicity, length of time since HIV-positive diagnosis, casual sexual behavior, level of education, and income level. Details of the demographic characteristics questions of the questionnaire are provided in Appendix A.

Quantitative Instrumentation and Operationalization of Constructs

To answer the research questions in this study, the following instruments were used in addition to the demographic characteristics questions: (a) Culture Orientation Scale (Triandis & Gelfand, 1998) (Appendix B); (b) Individual Cultural Values Scale (CVSCALE) (Yoo et al., 2011) (Appendix C); (c) Asian American Multidimensional Acculturation Scale (AAMAS) (Chung, Kim, & Abreu, 2004) (Appendix D); and (d) an HIV-positive disclosure scale developed by Serovich et al. (2009) (Appendix E) specifically

to target casual sexual partners. Permission to copy, distribute, and use these four scales were obtained from the developers of these instruments for use in the study.

Culture Orientation Scale. Triandis and Gelfand (1998) defined and expanded on Hofstede's individualism-collectivism cultural dimensions by adding the two additional horizontal (emphasizing equality) and vertical (emphasizing hierarchy) constructs. In four studies, Triandis and Gelfand (1998) demonstrated the viability of the four constructs of horizontal collectivism (H-C), vertical collectivism (V-C), horizontal individualism (H-I), and vertical individualism (V-I). The factor loadings for horizontal and vertical individualism and collectivism ranged from .45 to .68 signifying that the orthogonal factors strongly affect the variable using the time-honored rule of thumb that a substantial loading is .40 or higher (Triandis & Gelfand, 1998). Specifically, in Study 1, Triandis and Gelfand (1998) confirmed that the four constructs of H-C, V-C, H-I, and V-I were empirically supported via factor analysis both in the United States and Korea. In Study 2, Triandis and Gelfand (1998) determined that the Culture Orientation Scale has sufficient convergent and divergent validity by measuring the constructs using multitrait-multimethod matrices. For instance, the correlation between the attitude and scenario measurements for H-C was .41, .51 for V-I, .29 for V-C; and .11 for H-I (Triandis & Gelfand, 1998). For divergent validity, there was differentiation between horizontal and vertical aspects within the scenarios ($r = -.50$) and the attitude items ($r = .30$) as well as across methods ($rs = .20$ and $-.20$, respectively) (Triandis & Gelfand, 1998). The convergent and discriminant validity coefficients (rs) help define the construct validity of the measure (Westen & Rosenthal, 2003). Thus, the analysis from Study 2 indicated the constructs of the Culture Orientation

Scale generally had good convergent and divergent validity (Triandis & Gelfand, 1998).

The results of Study 3 provide further support for the distinctions among the four cultural patterns (Triandis & Gelfand, 1998). Finally, in Study 4, Triandis and Gelfand (1998) were able to show the relationships of the measurement of the four constructs to some of the measures used by other researchers.

Appendix B provides the details of the 16-item Culture Orientation Scale developed by Triandis and Gelfand (1998) to measure the four dimensions of individualism and collectivism. The 16 items in the scale provide four scores. The four dimensions of individualism and collectivism (i.e., H-C, H-I, V-C, and V-I) are categorical variables represented on a nominal scale and captured in a Likert format. All items are answered on a 9-point scale, ranging from *1 = strongly disagree* and *9 = strongly agree*. Participants are instructed to enter a 5 if they are unsure or think that the statement does not apply to them. For example, a participant would enter a 5 if he is unsure or think that the following statement does not apply: “Winning is everything.” Each dimension’s items are summed up separately to create a H-C, H-I, V-C, and V-I score. The summed scores of each of the four constructs will be computed. The mean and standard deviation of the 16 scores will be computed and then each score will be converted for each participant by subtracting the mean and dividing by the standard deviation. The resulting score for each participant will be between -3 and $+3$ standard deviations. That is, one high score will emerge for each participant representing one of the four attributes (i.e., H-C, H-I, V-C, and V-I) that is emphasized by the participant in relation to the other three attributes.

Individual Cultural Values Scale (CVSCALE). The Individual Cultural Values Scale (CVSCALE) is a 26-item five-dimensional scale of individual cultural values to assess Hofstede's cultural dimensions at the individual level (Yoo et al., 2011). Before using this instrument, it is important to assess the reliability and validity of the CVSCALE. The authors took the appropriate measures to ensure that the CVSCALE was psychometrically sound so that other researchers could be confident using the scale to measure individual cultural orientations. To generate an appropriate pool of items, Yoo et al. (2011) first chose and modified items from the HERMES values questions, which were Hofstede's original questions, and the Values Survey Module 1994 (an improved and shortened version of the HERMES questions, and Hofstede's other works). Next, Yoo et al. (2011) adopted some of Bochner and Hesketh's (1994) items. The original pool of 230 items was then reviewed for their fit to corresponding dimensions before Yoo et al. (2011) selected 125 items for pilot testing. The cultural orientation items were then evaluated using 5-point Likert-type scales and then administered to 196 undergraduate students in the United States to check for wording (Yoo et al., 2011). After this evaluation, 86 newly worded items were administered to another sample of 116 American undergraduate students to obtain items that provided appropriate reliability (Yoo et al., 2011). A total of 39 reliable candidate items (9 for power distance, 6 for uncertainty avoidance, 6 for masculinity, 8 for collectivism, and 11 for long-term orientation) were retained with satisfactory reliability ranging from .74 to .91 after a series of item-selection procedures (Yoo et al., 2011). During the next phase of scale development, Yoo et al. (2011) used new samples independent of the previous ones to test, purify, and finalize the items of the CVSCALE.

Yoo et al. (2011) then analyzed and compared the data separately by surveying three separate samples of American, Korean-American, and South Korean undergraduate students. Yoo et al. (2011) analyzed the pooled sample using the Leung and Bond technique (1989), called an individual level multicultural factor analysis. This technique includes the two steps of within-subject standardization and within-culture standardization to ensure that the variables have a zero mean and unity standard deviation within each culture, thereby eliminating the patterning effect of culture (Yoo et al., 2011). They then conducted factor analysis using orthogonal rotation for the items and eliminated weakly correlated and cross-loaded items, resulting in the 26-item CVSCALE of five cultural orientation factors for each of the following three individual samples, explaining for 44.5% of the total variance for the pooled data: 49.0% for Americans, 47.9% for Korean-Americans, and 40.7% for Koreans. The developers noted the total variance was similar to Hofstede's (2001) country-level analysis in which 49% of the total variance was explained. To confirm for discriminant and convergent validity of the measures, Yoo et al. (2011) conducted a factor analysis using oblique rotation, which produced similar factor patterns.

Yoo et al. (2011) also conducted a confirmatory factor analysis for the pooled sample "to detect and confirm the clear multidimensionality of the five cultural dimensions as asserted by Hofstede" (p. 199). The authors concluded that the overall fit of the measurement model was "excellent" and that despite the large number of items considered, "no substantial departures from unidimensionality were observed" (Yoo et al., 2011, p. 199). "The composite reliability estimates, which are evidence of convergent validity (Fornell & Larcker, 1981), were acceptable: .62 for power distance, .71 for uncertainty

avoidance, .76 for collectivism, .70 for long-term orientation, and .68 for masculinity” (Yoo et al., 2011, p. 199). Yoo et al. (2011) then validated the CVSCALE by validating the measurement model of the scale, testing the measurement invariance of the scale, and validating the CVSCALE in different countries. For example, Prasongsukarn (2009) tested the reliability and validity of Yoo et al.’s CVSCALE in Thailand using the reliability analysis of Cronbach’s alpha, exploratory factor analysis (EFA) as well as confirmatory factor analysis (CFA) and found high internal consistency and face, convergent, and discriminant validity. As of March 2014, the reliability of CVSCALE has been reported in 34 different journal articles with different sample types (Yoo et al., 2011).

Appendix C provides the details of the 26-item five-dimensional Individual Cultural Values Scale (CVSCALE) to assess Hofstede’s cultural dimensions at the individual level (Yoo et al., 2011: power distance (PO), uncertainty avoidance (UN), collectivism (CO), masculinity (MA), and long-term orientation (LT)). The breakdown of the number of items that assess the five dimensions is as follows: five items for PO, five items for UN, six items for CO, four items for MA, and six items for LT, respectively. The cultural dimension items are evaluated using a 7-point Likert-type scales anchored as *1 = extremely unimportant to me* and *7 = extremely important to me* for the long-term orientation dimension, and *1 = strongly disagree* and *7 = strongly agree* for the remaining four dimensions of power distance, uncertainty avoidance, collectivism, and masculinity. Each dimension’s items are summed up separately to create a PO, UN, CO, MA, and LT score. The summed scores of each of the five dimensions will be computed. The mean and standard deviation of the 26 scores will be computed and then each score will be converted for each participant by

subtracting the mean and dividing by the standard deviation; the score for each participant will be between -3 and $+3$ standard deviations. That is, one high score will emerge for each participant representing one of the five dimensions (i.e., PO, UN, CO, MA, and LT) that is emphasized by the participant in relation to the other four cultural dimensions.

Asian American Multidimensional Acculturation Scale (AAMAS). As the name implies, the Asian American Multidimensional Acculturation Scale is a multidimensional scale to “allow for a more complex assessment of acculturation level of Asian Americans and its relationship to psychological functioning” (Chung et al., 2004, p. 66). There were three principles that guided the development of the AAMAS: (1) to be orthogonal and distinguish between the dimensions of acculturation to host culture and Asian culture of origin; (2) inclusion of pan-ethnic Asian American dimension; and (3) ease of use with multiple Asian ethnic groups (Chung et al., 2004). The specific items for the AAMAS were adapted largely from the Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA) and converted to a multilinear format (Chung et al., 2004). Consequently, the AAMAS comprises three scales: (1) AAMAS – Culture of Origin (AAMAS-CO), (2) AAMAS – Asian American (AAMAS-AA), and (3) AAMAS – European American (AAMAS-EA) (Chung et al., 2004). The pan-ethnic AAMAS-AA is unique to the AAMAS.

The results of three separate studies provide strong and ample evidence of AAMAS’s reliability and validity. The instrument was tested with different Asian-American racial/ethnic groups including Chinese, Filipino, Japanese, Korean, and Vietnamese (Chung et al., 2004; Zhang & Tsai, 2014). In an extensive review that included 15 different assessments of acculturation, Zhang and Tsai (2014) noted that the AAMAS was cited 159

times based on PsychInfo data gathered through April 2014, indicating the popularity of the assessment. To examine the psychometric properties of the AAMAS, Chung et al. (2004) prepared a questionnaire that consisted of the three AAMAS scales, the Cultural Identification Scale (CIS; Oetting & Beauvais, 1991), and the Intergenerational Conflict Inventory (ICI; Chung, 2001). The validity of the AAMAS was tested and it was found that the concurrent validity was moderately correlated with SL-ASIA, convergent validity was correlated with generational status, and discriminant validity was not correlated with Intergenerational Conflict Inventory (Chung et al., 2004; Zhang & Tsai, 2014). The reliability of the AAMAS ranged from 0.78 to 0.87 (Chung et al., 2004; Zhang & Tsai, 2014). Chung et al. (2004) concluded that “the combined evidence of the exploratory and confirmatory factor analyses with the alpha coefficients suggests that the four-factor structure within each of the AAMAS cultural dimensions is reliable and valid” (p. 79).

Appendix D provides the details of the 45-item AAMAS to measure the level of acculturation using a multidimensional model that is applicable across multiple Asian American ethnicities including the description of the scale, reliability data for the three AAMAS scales, and scoring instructions. The level of acculturation variable is represented on an ordinal scale and captured in a Likert format. The AAMAS scale consists of 15 items and uses a 6-point Likert type scale ranging from *1 = not very well* to *6 = very well*. One of the items (item #15) is worded in a reverse direction and therefore needs to be reverse-coded before scoring. There are four subscales within the AAMAS scale assessing specific domains of acculturation: language (4 items; items #1 – #4), food consumption (2 items; items #5 – #6), cultural knowledge (3 items; items #7 – #9), and cultural identity (6 items;

items #10 – #15). The total score for each of the three AAMAS scales (i.e., AAMAS-CO, AAMAS-AA, and AAMAS-EA) will be tabulated by adding together all of the responses to “a” (*your own Asian culture of origin*), “b” (*other Asian groups in America*), and “c” (*the White mainstream groups*) for all 15 items. Finally, to obtain the scale score for each participant, the total score for each cultural dimension will be divided by 15.

HIV-Positive Disclosure Scale. Serovich et al. (2009) developed a scale that is used specifically to assess the disclosure behaviors, attitudes, and intentions to casual sexual partners. The author-derived instrument is comprised of three 14-item scales, one for each of the primary outcomes of behaviors, attitudes, and intentions. “I should disclose when ... [specific sexual situation]” is an example question that assesses attitudes; “I intend to disclose when ... [specific sexual situation]” is an example question that assesses intention; and “I disclosed when ... [specific sexual situation]” is an example question that assesses disclosure behavior (Serovich et al., 2009, p. 210). The scale uses a 5-point Likert-type format.

Disclosure Behaviors: Disclosure behaviors were operationalized by the 14 items using Serovich et al.’s (2009) HIV-Positive Disclosure Scale asking API MSM participants about their HIV-positive disclosure behavior to casual sexual partners. For example, “I have disclosed my HIV status to ... of my sexual partners to whom I gave oral sex with a condom.” Items will be scored using a 5-point Likert-type scale with values ranging from *None* (1) to *All* (5). Thus, the HIV-positive disclosure behavior is a categorical variable represented on an ordinal scale and captured in a Likert format.

Disclosure Attitudes: Disclosure attitudes were operationalized by the 14 items using Serovich et al.'s (2009) HIV-Positive Disclosure Scale asking API MSM participants about their HIV-positive disclosure behaviors to casual sexual partners. For example, "People with HIV should disclose their status to sexual partners to whom they give oral sex with a condom." Items will be scored using a 4-point Likert-type scale with values ranging from *Strongly disagree* (1) to *Strongly agree* (4). Thus, the HIV-positive disclosure attitude is a categorical variable represented on an ordinal scale and captured in a Likert format.

Disclosure Intentions: Disclosure intentions were operationalized by the 14 items using Serovich et al.'s (2009) HIV-Positive Disclosure Scale asking API MSM participants about their HIV-positive disclosure intentions to casual sexual partners. For example, "I plan to tell my future sexual partners to whom I give oral sex with a condom about my HIV status." Items will be scored using a 4-point Likert-type scale with values ranging from *Strongly disagree* (1) to *Strongly agree* (4). Thus, the HIV-positive disclosure intention is a categorical variable represented on an ordinal scale and captured in a Likert format.

For the measurement of attitudes and intentions, the Likert-responses ranged from *strongly disagree* to *strongly agree*; while the scale responses include the five frequency-based alternatives (*1 = none, 2 = a few, 3 = about half, 4 = most, 5 = all*) for the behavior items (Serovich et al., 2009). Serovich et al. (2009) conducted an analysis of the internal consistency reliability of each scale utilizing Cronbach's alpha and found that initial results indicated a high reliability (.95 – .98) for each of the three disclosure risk scales. Serovich et al. (2009) also published the following psychometric properties for the three scales:

Item/total correlations for each item on each scale were also high. A principal components analysis using oblique rotation (direct oblimin) was used in light of the anticipated correlation between the scales. The three-factor solution accounted for 55% of the total variance. Examination of the pattern matrix confirmed that each of the scale items loaded solely on the hypothesized construct. (pp. 210-211).

Brown et al. (2015) used Serovich et al.'s (2009) HIV-Positive Disclosure Scale in a recent study to assess the associations between being 50 and older, and disclosure behaviors, attitudes, and intentions. The 340 MSM participants who participated in the study were recruited from two metropolitan areas (Columbus, OH, and Tampa, FL) among a pool of 830 people who were screened (Brown et al., 2015). In this study, Brown et al. (2015) reported that the standardized Cronbach's alpha for the disclosure behavior measure was 0.97, for the disclosure attitude was 0.94, and for the disclosure intention measure was 0.95.

Appendix E provides the details of Serovich et al. (2009) HIV-Positive Disclosure Scale to measure disclosure behaviors, attitudes, and intentions to sexual partners. Total scores for each measure will be the summed scores of the 14 items for each disclosure measure for behaviors, attitudes, and intentions. That is, each participant will have three separate summed scores for each disclosure measure of behaviors, attitudes, and intentions.

Operationalization

To answer the three research questions, participants provided responses to five demographic questions (Appendix A). Race, age, length of time since diagnosis, and level of education are categorical variables represented as ordinal scales and divided into 12, five,

six, and eight groups, respectively. While, income level of participants is a categorical variable represented as a nominal scale and divided into six groups. The demographic questions, responses, and the corresponding coding for each demographic question are depicted in Table 1.

Table 1

Demographic Questions, Responses, and Corresponding Coding Variables

Question Number	Question	Responses	Coding Variables
1	What is your race?	Asian Indian	1
		Cambodian	2
		Chinese	3
		Filipino	4
		Japanese	5
		Korean	6
		Native Hawaiian and Other Pacific Islander – Hawaiian, Guamanian or Chamorro, Samoan, or other Pacific Islanders	7
		Thai	8
		Vietnamese	9
		Other Asian – Hmong, Indonesian, Laotian, Malaysian, Pakistani, etc.	10
		Other Pacific Islander – Fijan, Tongan, etc.	11
		Two or more races	12
2	What is your current age?	18-30 years old	1
		31-40 years old	2
		41-50 years old	3
		51-60 years old	4
		61 years old and above	5
3	How long ago since you have been diagnosed with HIV/AIDS?	6 months – 1 year	1
		2 years – 5 years	2
		6 years – 10 years	3
		11 years – 15 years	4
		16 years – 20 years	5
		More than (>) 21 years	6

Table 1 Continued

Question Number	Question	Responses	Coding Variables
4	What is the highest degree or level of education you have completed?	Some high school, no diploma	1
		High school graduate, diploma, or equivalent (e.g., GED)	2
		Some college credit, no degree	3
		Trade / technical / vocational training	4
		Associate's degree	5
		Bachelor's degree	6
		Master's degree	7
		Doctoral degree	8
5	What is your current annual income?	\$0 to \$19,999	1
		\$20,000 to \$39,999	2
		\$40,000 to \$59,999	3
		\$60,000 to \$79,999	4
		\$80,000 to \$99,999	5
		\$100,000 or higher	6

The six income groups were used to facilitate ease of data analysis as compared to the more granular 20 groups that have been cited by the Congressional Research Service (Elwell, 2014). There is also no consistency in the number of income groups used by previous researchers (Crepaz & Marks, 2003; Marks & Crepaz, 2001; Klitzman, 1999; Obermeyer et al., 2011; Sullivan, 2005; Zea et al., 2003; Zea et al., 2004) to assess level of income.

Quantitative Data Analysis Plan

The survey responses were accessed online through a secure uniform resource locator (URL) dedicated specifically for this study. The results from the online survey were entered and analyzed using the IBM Statistical Package for the Social Sciences (SPSS) Version 21 data set. The SPSS software is widely used by health researchers to manage data

and to conduct statistical analysis in social science. The SPSS software was selected because the tool has the ability to analyze and manipulate data quickly; has a variety of statistical methods and graphs available to investigators; and has the capability of storing output results in separate files. The SPSS software can automate the data screening and data cleaning process of identifying and rectifying potential errors in survey data before performing final statistical analysis of the data collected. Data from the online SurveyMonkey website did not include any potential personal identifiers such as Internet Protocol (IP) addresses, names, or email addresses of research participants before transferring them to the SPSS software.

It is necessary to conduct a manual, initial data screening and data cleaning exercises before conducting descriptive and statistical analyses. The issue of missing data is particularly relevant when participants have to complete long questionnaires (Field, 2013). To address for missing data, a value of 99 was assigned to indicate that the participant failed to provide a response for a particular question, statement, or item of the scale. The value of 99 was selected because this value cannot occur in the data that were collected. I used SPSS to specify missing values by clicking in the column labeled *Missing* in the variable view and then clicked on “...” to activate the *Missing Values* dialog box (Field, 2013). The SPSS software performed final data cleaning using the frequency technique to detect transcription errors that may have occurred during data entry into the SPSS. If there are errors, I repeated the process of importing data into SPSS. Missing data were eliminated from the analysis.

The overarching aim of this study was to determine what factors may influence HIV-positive serostatus disclosure behaviors, attitudes, and intentions to casual sexual

partners in API MSM. Three research questions with their hypotheses testing and statistical methods for analysis were addressed as noted earlier in this chapter. Descriptive statistics including frequencies, percentages, means, standard deviations, and ranges were used to describe the participants and disclosure behaviors, attitudes, and intentions based on cultural values, level of acculturation, length of time since HIV diagnosis, age, level of education, and income level.

Linear multiple regression was appropriate when there are multiple independent variables (i.e., cultural values, level of acculturation, length of time since HIV diagnosis, age, level of education, and income) and one dependent variable (i.e., HIV-positive disclosure behaviors, attitudes, and intentions) for each of the three research questions. Multivariate analyses using linear multiple regression were employed to assess the association between cultural values, level of acculturation, length of time since HIV diagnosis, age, level of education, and income and HIV-positive disclosure behaviors, attitudes, and intentions, respectively. For example, to examine predictors of HIV-positive disclosure behaviors, a multiple regression analysis of the overall disclosure index was conducted by entering the following independent variables into the equation simultaneously: cultural values, level of acculturation, length of time since HIV diagnosis, age, level of education, and income. This process was repeated for the HIV-positive disclosure attitudes and intentions multiple regression models, respectively.

There are several ways in which variables can be entered into a multiple regression model. Field (2013) discussed the following three methods of regression: hierarchical regression (blockwise entry), forced entry, and stepwise methods. According to Field

(2013), stepwise regressions are not recommended and frowned upon by statisticians because this method relies on the computer selecting variables based upon mathematical criteria. Hierarchical regression predictors are selected based on theories and previous research studies. That is, known predictors were entered first into the model in order of their importance in predicting the outcome (Field, 2013). Based on the review of the literature, the following independent variables were entered first: length of time since HIV diagnosis, age, level of education, and income. Next, the two new predictors of cultural values and level of acculturation that are unique to this study were entered next into the multiple regression model. Alternatively, the forced entry method may be used in which all predictors are forced or entered into the model simultaneously (Field, 2013). Similar to the hierarchical regression, the forced entry method relies on sound theoretical reasons for including the chosen predictors (Field, 2013).

Once the multiple regression model was constructed, it was appropriate to assess how well the model fit the data from which it was generated. To do this, it was necessary to confirm the goodness of fit of the model and the statistical significance of the estimated parameters. Stated differently, the goodness of fit is an index to measure how well the data predicted by the model correspond to the data that were actually collected (Field, 2013). One commonly used test to confirm for the goodness of fit of the model is to examine the R -squared coefficient of determination. Using SPSS, the R^2 value can be calculated in the multiple regression model. Therefore, R^2 provides a useful measure of how well a model fits in terms of squared distance from points to the best fitting line (Field, 2013).

The main underlying assumptions when using multiple regression or multivariate analysis method include the following: additivity and linearity, independent errors, homoscedasticity, and normally distributed errors (Field, 2013). For additivity and linearity, the outcome variable should be linearly related to any of the predictor variables. In this study with multiple predictor variables, the combined effect should be additive. If this assumption is not met, then the model is invalid. When this assumption is violated, then it is necessary to transform the outcome and predictor variables to make their relationships linear (Field, 2013).

The assumption of independent errors requires that the residual terms for any two observations should uncorrelated, which is sometimes described as a lack of autocorrelation (Field, 2013). When the assumption of independent errors is violated, then the confidence intervals and significance tests will be invalid. This assumption can be tested with the Durbin-Watson test, which tests for serial correlations between errors (Field, 2013). When using the Durbin-Watson test, the value can range between 0 and 4. Specifically, a value greater than 2 indicates a negative correlation, where a value below 2 indicates a positive correlation between adjacent residuals, respectively (Field, 2013). Even if the assumption of independent errors is violated, the estimates using the method of least squares will still be valid but not optimal in terms of the model parameter themselves (Field, 2013).

The third assumption is homoscedasticity. This means that the residuals at each level of the predictors should have the same variance (Field, 2013). When this assumption is violated, then the confidence intervals and significance tests will be invalid. Similar to the assumption of independent errors, when homoscedasticity is violated, the estimates using

the method of least squares will still be valid but not optimal in terms of the model parameter themselves (Field, 2013). Additionally, “this problem can be overcome using weighted least squares regression in which each case is weighted by a function of its variance” (Field, 2013, p. 311).

The fourth assumption that needs to be considered when using multiple regression or multivariate analysis method is to ensure that there are normally distributed errors. “This assumption simply means that the differences between the model and the observed data are most frequently zero or very close to zero” (Field, 2013, p. 311). It is important to not confuse this assumption with the idea that predictors have to be normally distributed. For this study, it is assumed that the residuals and the variables in the model are random and normally distributed with a mean of 0. This assumption can easily be addressed by bootstrapping the confidence intervals, which is a technique from which the sampling distribution of a statistic is estimated by taking repeated samples (with replacement) from the data set (Field, 2013).

Violating any of the above assumptions will have implications mainly for significance tests and confidence intervals. That is, if confidence intervals are inaccurate, then it is not possible to accurately estimate the likely population value when these assumptions are broken (Field, 2013). Consequently, the multiple regression model cannot be generalized to the population. Conversely, when the assumptions are met, then, “on average the regression model from the sample is the same as the population model” (Field, 2013, p. 312).

Qualitative Procedures for Recruitment and Sampling Procedures

For the qualitative phase of the study, participants were recruited from API MSM organizations in Los Angeles County and Orange County, California. Participants did not have to initially complete the anonymous, online survey from the quantitative phase of the study. That is, participants could participate only in the qualitative phase of the two-phase, mixed methods sequential explanatory study without having participated in the initial quantitative phase of the study and vice versa.

It is appropriate to consider the research questions or purpose, time frame of the study, and resources available when deciding on the most appropriate sampling strategy for a phenomenology study. The following are several common qualitative sampling strategies for purposefully recruiting information-rich cases: extreme or deviant case sampling, intensity sampling, maximum variation sampling, homogeneous sampling, typical case sampling, critical case sampling, snowball or chain sampling, criterion sampling, theory-based or operational conduct or theoretical sampling, confirming and disconfirming sampling, stratified purposeful sampling, opportunistic or emergent sampling, purposeful random sampling, sampling politically important cases, convenience sampling, and combination or mixed purposeful sampling (Patton, 2002). Onwuegbuzie and Leech (2007) provided a framework for developing sampling designs in qualitative research. Specifically, they argued that there are three distinct sampling strategies of inquiry: (1) parallel sampling designs, (2) nested sampling designs, and (3) multilevel sampling designs. Furthermore, they discussed the following types of generalization in qualitative research: statistical generalization, case-to-case transfer, analytical generalization, external statistical

generalization, and internal statistical generalization. After reviewing the numerous options and recommendations of non-probabilistic sampling strategies to target the population for this study, a purposeful convenience sampling coupled with snowball sampling was selected. Similar to the quantitative phase of the study, this sampling method was comparatively inexpensive, less time consuming, and less cumbersome compared to other sampling methods to arrive at the study results and conclusions and to target the difficult to reach and hidden population of API MSM who have been diagnosed with HIV and have experienced the complex decision regarding self-disclosure of their HIV serostatus to casual sexual partners.

Qualitative Sample Size

The sample size that would be used for this phenomenology research study had to be determined. Even though the need to generalize to a (larger) population was not paramount in the decision-making process, it was important to determine the sample size prior to the commencement of the study. Patton (2002) argued that there are no true rules for sample size in qualitative inquiry. Instead, it was important to consider the validity, meaningfulness, and insights generated from qualitative inquiry and focus more on the information richness of the participants recruited and observational/analytical capabilities of the researcher than with sample size (Patton, 2002). When it comes to deciding the number of participants to be interviewed or studied in qualitative research, Guest, Bunce, and Johnson (2006) recommend that researchers should rely on the concept of “saturation,” or “the point at which no new information or themes are observed in the data” (p. 59). To attain the saturation or redundancy point, researchers should determine when the sample

size is large enough that there is nothing left to learn from adding more participants. When a researcher realizes that there are no new emerging concepts or themes, the sample size should be sufficient. When determining the appropriate sample size, qualitative researchers also need to consider that the present sample size should represent the variation within the target population of interest. Mason (2010) examined 560 Ph.D. studies using qualitative approaches and found that the mean sample size was 31 and the “distribution was non-random, with a statistically significant proportion of studies, presenting sample sizes that were multiples of ten” (p. 1). In phenomenological studies, data collection often consists of in-depth and multiple interviews with participants. Polkinghorne (1989) recommends that researchers interview from 5 to 25 individuals who have all experienced the phenomenon. Using this as a rule of thumb, it would be logical to conduct in-depth interviews of 8 to 10 API MSM participants (i.e., sample size) for the phenomenology phase of the study as these numbers were the median numbers between the recommended 5 to 25 individuals according to Polkinghorne (1989).

Qualitative Instrumentation

To further expand, explore, explain, build, and connect on the quantitative results, eight, in-depth semistructured interviews lasting no longer than 60 minutes were conducted for API MSM individuals who have experienced the phenomenon of HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners.

The participants were asked two broad, general questions: What have you experienced in terms of the HIV-positive disclosure to casual sexual partners phenomenon? What contexts or situations have typically influenced or affected your experiences of the

phenomenon? Other open-ended questions were also asked to further expand, explore, explain, build, and connect on the quantitative results. The questions asked helped participants to express themselves freely in their own words; facilitated a deeper exploration into the complex phenomenon of HIV-positive disclosure to casual sexual partners; and led to a richer description, explanation, understanding, and connection to the quantitative results. Appendix F provides the details of the Qualitative Study Interview Guide.

Qualitative Data Analysis Plan

Unquestionably, data analysis in qualitative research is the most complex and mysterious of all of the phases of a qualitative project. Before diving into the minutia of the data analysis strategies, it is necessary to discuss the overarching strategies and the data analysis spiral coined by Creswell (2013). Creswell discussed three different qualitative data analysis strategies from three different authors: Madison (2005), Huberman and Miles (1994), and Wolcott (1994). The data analysis strategies that these qualitative authors proposed have many similarities: coding the data, combining the codes into broader categories, and displaying and making comparisons in the data, tables, and charts (Creswell, 2013). From this, Creswell (2013) coined the concept of the data analysis spiral. The interrelated steps or processes of data analysis suggested by Creswell include data collection; data management; reading and memoing; describing, classifying, and interpreting data into codes and themes; interpreting the data; and representing and visualizing the data.

Specific to the phenomenology approach or tradition of qualitative inquiry, interview transcripts and field notes from open-ended, semistructured, and exploratory

interviews were analyzed. According to Moustakas (1994), this step is called horizontalization. Next, clusters of meaning were developed from significant statements into themes. From there, description of what the participants experienced (or textural description) and description of the context or setting that influenced how the participants experienced the HIV-positive disclosure phenomenon (or imaginative variation or structural description) were written (Creswell, 2013). Finally, a composite description was composed to capture the essence of the phenomenon, called the essential, invariant structure (or essence) (Creswell, 2013). The output of this process was a descriptive passage of the underlying structure of the phenomenon “that discusses the *essence* of the experience for individuals incorporating ‘what’ they have experienced and ‘how’ they experienced it”, which is a defining feature and culminating aspect of a phenomenological study (Creswell, 2013, p. 79).

Similar to the qualitative data analysis plan described above, Colaizzi’s method of phenomenological analysis has been successfully used by other authors. The following steps represent Colaizzi’s seven-step method for phenomenological data analysis:

1. Transcribing all the subjects’ descriptions.
2. Extracting significant statements [statements that directly relate to the phenomenon under investigation].
3. Creating formulated meanings.
4. Aggregating formulated meanings into theme clusters.
5. Developing an exhaustive description [that is, a comprehensive description of the experience as articulated by participants].

6. Identifying the fundamental structure of the phenomenon.
7. Returning to participants for validation (cited in Edward & Welch, 2011).

Shosha (2012) summarized the flow of Colaizzi's strategy for phenomenological data analysis in Figure 2.

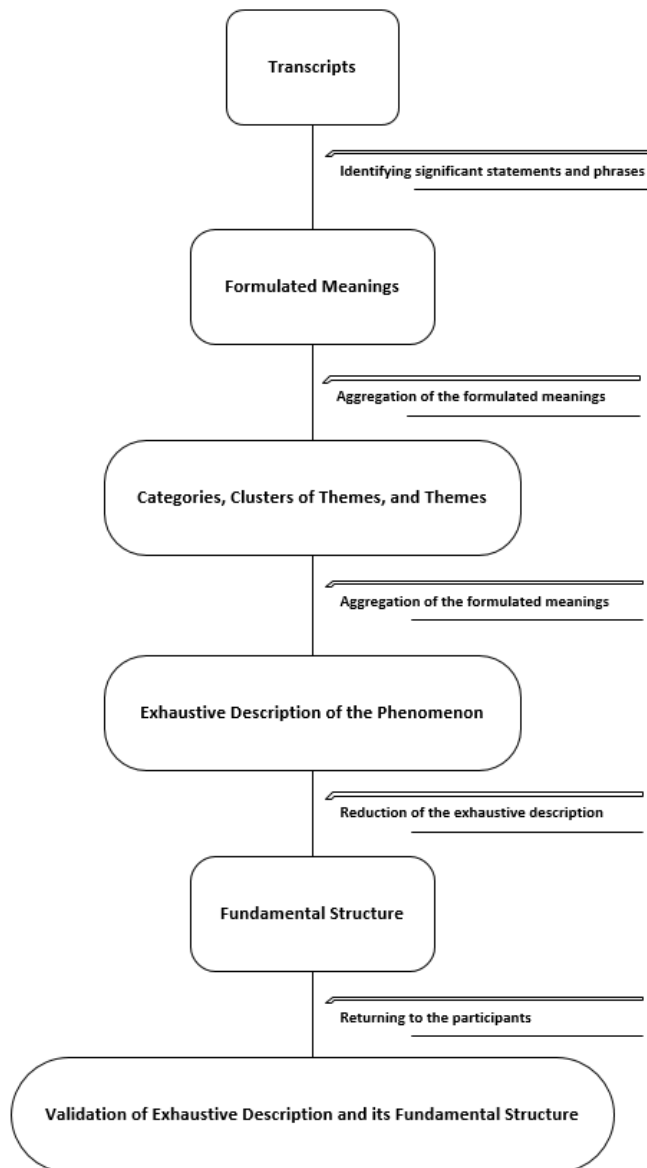


Figure 2. A summary of Colaizzi's strategy for phenomenological data analysis (created by Shosha, 2012; Permission was obtained from the author to use the figure above.)

Given the anonymous and confidential nature of this phenomenological study, participants' names or other identifiable information were not collected. Therefore, step 7 of Collazzi's method for phenomenological data analysis was eliminated. That is, a follow-up appointment returning to participants for validation of exhaustive description and its fundamental structure was not implemented.

To organize and manage the volume of interview transcripts and field notes, I used QSR NVivo, a qualitative data management computer software, to facilitate the data management process. The interview responses were organized, coded, analyzed, and interpreted both by hand and by using QSR NVivo 11, a qualitative data analysis (QDA) software (QSR International, 2016) to assess for consistency. NVivo was intended to help researchers organize and analyze non-numerical or unstructured data. The software allowed me to classify, sort, and arrange information; examine relationships in the data; and combine analysis with linking, shaping, searching, and modeling.

Threats to Validity

Quantitative

In any study, there are threats to validity that need to be considered. There are eight threats to internal validity including history, maturation, testing, instrumentation, regression, selection, experimental mortality (attrition), and interaction of threats (Campbell & Stanley, 1963). Shadish, Cook, and Campbell (2002) also discussed the ninth threat to internal validity, which is ambiguous temporal precedence. Internal validity is the degree to which conclusions can be attributed to the cause and effect relationship between the treatment and

the observed outcome. Conversely, it is the degree to which the absence of a relationship implies the absence of a cause. In a correlational design, observations and comparisons are made using two naturally occurring units or phenomena. Therefore, correlation does not necessarily infer causation (Campbell & Stanley, 1963).

For this study, a quasi-experimental, cross-sectional, correlational design was used. With this design, the threats to internal validity that relate to history, maturation, testing, instrumentation, regression, and ambiguous temporal precedence are not applicable (Campbell & Stanley, 1963). However, the threat of differential selection was a concern in this study as participants were not randomly assigned to treatment and control groups resulting in systematic differences across conditions, but rather were self-selected if the inclusion criteria are met. One way to minimize the threat of selection was to include the inclusion criteria in the cover page of the online survey before participants begin responding to the questionnaire. Therefore, any differences between the six independent variables (i.e., cultural dimensions, level of acculturation, length of time since HIV diagnosis, age, level of education, and income) and HIV-positive serostatus disclosure behaviors, attitudes, and intentions may be confounded by the fact that the API MSM who met the inclusion criteria were not equal at the time when participants completed the online survey. Experimental mortality refers to attrition, withdrawal, or dropout of participants. To address this threat to internal validity, participants who did not complete all of the questions within the online surveys will not be included in the data analysis. Another threat to internal validity is the additive or interactive effects of threats to validity. That is, single threats may occur in tandem with other threats such as selection or experimental mortality (attrition), creating

an additive effect. Given the correlational and cross-sectional design of the study, it was not expected that this threat to internal validity would apply.

There are also external threats to validity that need to be addressed. The four threats to external validity include: reactive or interaction effects of testing, interaction of selection and the experimental variable, reactive effects of experimental arrangements (or reactive arrangements), and multiple treatment interference (Campbell & Stanley, 1963). For this study, participants were not tested and therefore many of these threats to external validity did not apply. By definition, quasi-experimental designs pose threats to external validity because of the inability to assign random sampling, making it difficult to generalize results to a larger population. In this study, participants were not randomly selected or assigned but were self-identified or selected. Thus, the selective nature of the sample places limits on the generalizability of the findings to a larger, more inclusive, and representative API MSM population in the United States.

There are other threats to construct validity and threats to statistical conclusion validity that need to be considered. The former refers to reasons why inferences about the constructs that characterize study operations may be incorrect; while the latter refers to reasons why conclusions based on a statistical analysis may be incorrect (Shadish et al., 2002). Threats to construct validity may include the following: inadequate explication of constructs, construct confounding, mono-operation bias, mono-method bias, confounding constructs with levels of constructs, treatment sensitive factorial structure, reactive self-report changes, reactivity to the experimental situation, experimenter expectancies, novelty and disruption effects, compensatory equalization, compensatory rivalry, resentful

demoralization, and treatment diffusion (Shadish et al., 2002). Of these threats to construct validity, the mono-operation bias may apply because only one operationalization of each construct was used to measure cultural dimensions (i.e., individualism-collectivism) and level of acculturation. To address this potential threat to construct validity, it is important to consider how measuring cultural orientation with acculturation and enculturation and not singularly or independently as these concepts may interact or intersect with environmental factors, including socioeconomic status (Zhang & Tsai, 2014). Therefore, a cultural orientation scale and an acculturation scale that is multidimensional in its approach that can be applied to all APIs were used in this study.

Threats to statistical conclusion validity include the following: low statistical power, violated assumptions of statistical tests, fishing and the error rate problem, unreliability of measures, restriction of range, unreliability of treatment implementation, extraneous variance in the experimental setting, heterogeneity of units, and inaccurate effect size estimation (Shadish et al., 2002). To address these relevant threats to statistical conclusion validity, sufficient statistical power was used (i.e., $p < 0.5$), assumptions of statistical tests were confirmed (i.e., additivity and linearity, independent errors, homoscedasticity, and normally distributed errors), and the appropriate medium effect size estimation was calculated and used for sampling size estimation.

There are steps that can be taken to establish internal and external validity. Slack and Draugalis (2001) suggested using a three-step process to assess the validity of a study's findings and determine if they are relevant to researchers and practitioners in the field. The first step was to assess the validity of statistical conclusions to ensure that there was

sufficient power ($p < 0.5$) and statistical results were valid (Slack & Draugalis, 2001). The decision here was to assess whether the results or outcomes were likely due to chance variation. If the difference was likely due to chance variation, then the process stopped here. If not, then step two was addressed which was to assess the internal validity on the basis of research design and operational procedures (Slack & Draugalis, 2001). The decision to make here was to assess whether the difference was most likely due to the treatment or to the effects of confounding factors or bias. If it was found that the difference was due to the effects of confounding factors or bias, then the process stopped here. If not, then the third step was to examine inclusion and exclusion criteria and characteristics of study participants (Slack & Draugalis, 2001). If the study participants were similar to the target population, then the treatment should be useful. If the study participants were very different from the target population, then the treatment may or may not be useful.

Qualitative

Investigators must ensure and implement quality standards through the process of validation and evaluation. In quantitative research, investigators must acknowledge and mitigate potential threats to internal and external validity to ensure objectivity, reliability, and generalizability. Specific to qualitative research, quality in research methodology and data reporting is related to and can be assessed by using numerous criteria: trustworthiness, credibility, transferability, dependability, confirmability, structural corroboration, consensual validation, referential adequacy, ironic validity, paralogic validity, rhizomatic validity, situated/embedded voluptuous validity, strength of evidence, authenticity, triangulation, reflexivity, praxis, particularity, creativity, and among other perspectives

(Creswell, 2013; Patton, 2002). It is no surprise that investigators may be overwhelmed with the numerous, available criteria to assess and evaluate evidence of quality in qualitative research.

One way to ensure evidence of quality was to enhance the reliability of the data collected. Detailed interview notes and good transcription of notes were two of the many ways to ensure that rigorous methods for conducting interviews, which facilitated systematic data collection, analysis, and interpretation. Adequate training and gaining experience with conducting interviews and data collection enhanced the credibility and reliability of qualitative inquiry. I implemented an intercoder agreement process to analyze interview data to help enhance the reliability and subsequently the quality of the phenomenology study. Seeking agreement with other coders improved the concordance rate or confidence level that the codes, categories, and emerging themes were credible and representative of the interview data collected. Finally, having appreciation and an openness to the inductive analysis process and naturalistic inquiry tendency also enhanced the credibility and quality of the study.

When using a phenomenological approach to inquiry, it is important to be aware of its challenges. Creswell (2013) suggested that researchers need to have some understanding of the broader philosophical assumptions. Although there are structured approaches for novice researchers to analyze the data collected from interviews, other more experienced qualitative researchers may find them to be restrictive. Additionally, the need to bracket (epoche or bracketing) one's personal experiences may present difficulties for some phenomenological researchers to implement because the interpretations of data will

undoubtedly require the researchers to incorporate some assumptions that they bring to the topic (van Manen, 1990). At the very least, it is necessary to temporarily suspend our understandings in a reflective move to cultivate curiosity (LeVasseur, 2003).

Ethical Procedures

When sampling hidden and hard-to-reach populations such as HIV-positive API MSM to examine the factors that influence HIV positive disclosure, it was important to consider ethical issues. Two common ethical principles include the need to obtain informed consent and the protection of participants' confidentiality. Rudestam and Newton (2015) discussed other ethical principles including the need to not coerce participants into volunteering to participate in the study. Care, communication, deception, and the need to debrief participants are other ethical issues relating to sampling methods. Clinical and ethical issues related to sex and HIV research include confidentiality, data safety, and protection of participants.

To ensure that IRB approval would be granted and that the process of obtaining such approval was smooth, the following best practices were implemented: the use of anonymous methods, confirmation that application will reflect the final set of questions and procedures, only data that directly addresses the research questions will be collected, and the use of existing measures or instruments (Endicott, 2010).

For this two-phase, mixed methods, sequential explanatory study, the research questions were focused on cultural factors (i.e., individualism/collectivism) that might influence HIV disclosure behaviors, attitudes, and intentions among API MSM. Data were collected from API MSM who have been diagnosed with HIV/AIDS. The population of API

and the diagnosis of HIV/AIDS warranted an ethics consultation. I needed to articulate the validity of the research, the value of the study, the special population involved, and the elements of informed consent in the IRB application (Rudestam & Newton, 2015). The elements of informed consent included the following: (a) the name of the principal investigator conducting the study, (b) the expected time commitment, (c) potential risks and how they would be managed, (d) the voluntary nature of participation and the freedom to withdraw from the study at any time, (e) information regarding the lack of payment or incentives to participate in the study, and (f) explanation of the limits of confidentiality and protection of sensitive information. Walden University's approval number for this study is 01-19-16-0389056.

Confidentiality, privacy, and anonymity were maintained throughout the study. Survey responses were anonymous given the sensitive subject matter and questions that were asked. Participants were reassured that the information they provided would not be traceable to them because their names, email addresses, and other personal identifier information were not collected in the study. The participants were further informed that they had the right to refuse to participate or to withdraw from the study when completing the online anonymous survey at any time during the course of the study without consequence.

Summary and Conclusion

In Chapter 3, I provided detailed descriptions of this two-phase, mixed methods sequential explanatory study to examine the influence of cultural factors on HIV-positive serostatus disclosure behaviors, attitudes, and intentions among API MSM. A discussion of the research design and its rationale for both the quantitative and qualitative phases of the

study and its connection to the research questions were offered including the independent variables of cultural dimensions, level of acculturation, length of time since HIV diagnosis, age, level of education, and income and the dependent variable of HIV-positive serostatus disclosure behaviors, attitudes, and intentions to casual sexual partners. The target population was identified followed by a description of the sampling and sampling procedures. The sample size was calculated including the justification for the effect size, alpha level, and the power level chosen. Next the procedures for recruitment, participation, and data collection were described. The four instruments that were used in the study were discussed including their psychometric properties and how they helped to answer the research questions. The qualitative study interview guide was also provided. Then, the threats to validity were described and how they were addressed in the study. Finally, ethical procedures, concerns, and other considerations were outlined including a discussion on the need to obtain IRB approval, informed consent, and the need to protect participants and their confidential data. The three chapters presented above addressed the required elements of the introduction to the study, literature review, and the research design and methodology, respectively.

Chapter 4: Results

Introduction

The purpose of this two-phase, mixed methods, sequential explanatory study was to learn about HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners for API MSM. In the first phase, I posed three quantitative research questions to examine the influence of cultural factors, level of acculturation, length of time since diagnosis, age, level of education, and income. Using the obtained information from this first phase, I deployed a second qualitative phase to probe significant quantitative results by exploring aspects of the HIV-positive disclosure behaviors, attitudes, and intentions with a few participants.

For the quantitative phase of the study, RQ1 was as follows: What was the association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure behaviors in API MSM? RQ2 was as follows: What was the association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure attitudes in API MSM? RQ3 was as follows: What was the association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure intentions in API MSM?

For the follow-up qualitative portion of the study, the central research question was: What factors influenced the HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners in API MSM? The subquestions included the following:

- a) How may cultural values have influenced HIV-positive disclosure?
- b) How may level of acculturation have influenced HIV-positive disclosure?
- c) How did length of time since diagnosis influence HIV-positive disclosure?
- d) How may age have influenced HIV-positive disclosure?
- e) How may level of education have influenced HIV-positive disclosure?
- f) How may income have influenced HIV-positive disclosure?

Finally, the overarching research question for the mixed methods study was: To what extent did the qualitative data help to explain, build, or connect upon initial quantitative results?

Chapter 4 is organized in two main sections: quantitative and qualitative. The first portion of Chapter 4 provides detailed information on the data collection period and response rate for the quantitative survey by each of the API demographic groups represented in the study sample. The differences between the data collection plans proposed in Chapter 3 and the data collection plans implemented in Chapter 4 are highlighted to expose discrepancies between them. Statistical assumptions and analytical findings are reported in this chapter and findings discovered during the analysis were organized to provide answers to each research question and hypothesis. Tables generated during statistical analysis are presented to simplify understanding of the statistical results at a glance. Finally, summary of the answers to all the research questions and hypotheses, as well as the statistical significance of the results are discussed.

The second portion of Chapter 4 provides detailed information on the data collection period and locations of the qualitative interviews, the demographics and characteristics of

the participants, qualitative data management, qualitative data analysis, results of qualitative inquiry, and triangulation matrix. Tables and figures generated during the qualitative data analysis are presented to depict clusters and themes. Relevant quotations were included to highlight these themes. Finally, summary of the answers to the qualitative research questions and significant findings are discussed.

Quantitative

Recruitment and Response Rate

Participants for the quantitative study were initially recruited from a pool of API MSM who are members of Fridae using an electronic or EDM campaign. The emails were sent to only API MSM Fridae members who reside in the United States. The email contained a custom web link that was created to redirect potential participants to the survey page where they could access and complete the survey by clicking on the link or copying and pasting the link to the Web browser.

The recruitment period lasted for 10 months. Seven participants completed the online survey in the first month followed by two more in the second month, six more in the third and fourth months, and then three in the fifth and sixth months. Starting in the fourth month, I offered a \$5 Starbucks gift card incentive to address the declining trend in the response rate. Thereafter, Fridae sent out a second EDM campaign to all API MSM members who reside in the United States on the fourth month. When the incentive was introduced, there was an increase in responses to the online survey so much so that it caused some concerns. Upon further investigation, there were 79 new responses within 4 days but all of these responses were originated from the same town (Manassas, Virginia) with similar

IP addresses. SurveyMonkey confirmed this finding using <http://ip-tracker.com>. Apparently, someone was spamming the online survey in an attempt to receive the \$5 Starbucks gift cards. In order to track and prevent this going forward, the online survey setting was changed to “Anonymous responses” off, which allowed for tracking of IP addresses.

It is important to note that tracking IP address did not jeopardize the identity of the individual as IP addresses can be traced to a computer but not a person. People who share a computer share an IP address. Additionally, some IP addresses are tied to proxy servers, which means multiple computers can share the same IP address. Changing the online survey setting to track the IP addresses allowed for quick confirmation of whether new online responses were being spammed. If identified, then I would be able to block the offending IP addresses. Additionally, the change in IP configuration setting also necessitated a change in the original URL of the online survey. By the end of the seven month data collection period, 18 participants completed the online survey.

Initially, the target population for this study was API MSM who are members of Fridae. As stated above, 18 participants completed the online survey in the first seven months of data collection. This necessitated a review of the target population and study procedure. In order to enhance the chances of recruiting more API MSM who are HIV-positive, the target population was expanded to include other API organizations across the United States. This expansion added six additional participants in the next 3 months. At the end of the quantitative data collection phase, 24 participants completed the online survey from the originally planned sample size of 98 participants.

Data Collation

To manage the data received from participants' responses to the survey questions, I downloaded an Excel file made available from SurveyMonkey and saved it on my computer hard drive. There were no missing data as all 24 participants completed all of the questions in the online survey about their demographic information and responses from the four surveys (i.e., Culture Orientation Scale, Individual Cultural Values Scale, Asian American Multidimensional Acculturation Scale, and HIV-Positive Disclosure Scale) matching the coding variables outlined in Table 1. The online survey included 112 questions and displayed on seven separate online pages. The data for each variable for all of the 24 participants were entered into the data view of the SPSS software.

Descriptive Statistics

The 24 participants involved in this study were HIV-positive API MSM who reside in the United States. Table 2 shows the racial background distribution of the participants. Despite the small sample in this study, there was representation from the nine API racial groups as defined by the United States Census Bureau (2011). The majority of the participants were Chinese and Filipino while Korean and Thai participants were least representative.

Table 2

Race Distribution of Participants

Race	Frequency	Percent	Valid Percent	Cumulative Percent
Asian Indian	2	8.3	8.3	8.3
Chinese	6	25.0	25.0	33.3
Filipino	6	25.0	25.0	58.3
Korean	1	4.2	4.2	62.5
Native Hawaiian and Other Pacific Islander – Hawaiian, Guamanian or Chamorro, Samoan, or other Pacific Islanders	2	8.3	8.3	70.8
Other Asian – Hmong, Indonesian, Laotian, Malaysian, Pakistani, etc.	2	8.3	8.3	79.1
Thai	1	4.2	4.2	83.3
Two or more races	1	4.2	4.2	87.5
Vietnamese	3	12.5	12.5	100.0
Total	24	100.0	100.0	

None of the participants who completed the online survey was over 50 years of age.

The majority of the participants (41.7% or $n = 10$) were diagnosed with HIV within 6 months to 1 year. The remaining participants were diagnosed with HIV within 2-5 years (29.2% or $n = 7$), within 6-10 years (25.5% or $n = 6$), and within 11-15 years (4.2% or $n = 1$). Participants who completed the online survey were highly educated with 66.7% ($n = 16$) having completed a bachelor's, a master's, or a doctoral degree. This information is consistent with the latest portrait of educational attainment in the United States based on data collected from the Current Population Survey (CPS) where more than half (54%) of Asians aged 25 and older had a bachelor's degree or higher in 2015 (U.S. Census Bureau, 2016a). As far as income, 33.3% ($n = 8$) earned between \$40,000 and \$59,999 while 8.3%

($n = 2$) earned \$100,000 or higher. Income information reported in this small sample is consistent with the latest U.S. Census Bureau where 25.8% of Asians earned between \$35,000 to \$49,999 (10.3%) and \$50,000 to \$74,999 (15.5%) (U.S. Census Bureau, 2016b).

Table 3 displays the frequency distributions of categorical variables.

Table 3

Frequency Distributions of Categorical Variables

		Column N %
What is your current age?	18 – 30 years old	33.3%
	31 – 40 years old	50.0%
	41 – 50 years old	16.7%
How long ago since you have been diagnosed with HIV/AIDS?	6 months – 1 year	41.7%
	2 years – 5 years	29.2%
	6 years – 10 years	25.0%
	11 years – 15 years	4.2%
What is the highest degree or level of education you have completed?	High school graduate, diploma, or equivalent (e.g., GED)	20.8%
	Some college credit, no degree	4.2%
	Trade / technical / vocational training	4.2%
	Associate's degree	4.2%
	Bachelor's degree	50.0%
	Master's degree	12.5%
Higher education	No	45.8%
	Yes	54.2%
What is your current annual income?	\$0 to \$19,999	12.5%
	\$20,000 to \$39,999	25.0%
	\$40,000 to \$59,999	33.3%
	\$60,000 to \$79,999	20.8%
	\$80,000 to \$99,999	0.0%
	\$100,000 or higher	8.3%

Statistical Assumptions

As part of the preprocessing stage, items from the various scales were averaged out to obtain scores, representing cultural factors, level of acculturation, and disclosure of HIV-positive status. Summary statistics for all scale variables involved in the analysis are presented in Table 4. These summary statistics were used to summarize a set of observations for the various independent variables (e.g., horizontal collectivism, acculturation to host society's European American culture, disclosure behaviors, etc.). The observations for the majority of the independent variables hovered around within one standard deviation of the mean.

Table 4

Summary Statistics for Scale Variables

	Mean	Standard Deviation	Median	Minimum	Maximum
Horizontal collectivism	6.7	1.3	6.6	4.0	8.8
Horizontal individualism	6.8	1.1	7.0	4.8	9.0
Vertical collectivism	6.6	1.6	6.6	3.0	8.8
Vertical individualism	5.9	1.2	6.0	3.5	8.0
Power distance	3.3	1.2	3.0	1.2	5.4
Uncertainty avoidance	5.2	1.0	5.4	3.0	6.4
Collectivism	4.3	1.0	4.5	1.5	5.8
Masculinity	3.8	1.1	3.5	2.3	5.8
Long-term orientation	5.4	.8	5.4	3.7	6.8
Acculturation to one's own Asian culture of origin	4.8	.7	4.7	3.3	5.8
Acculturation to pan-ethnic Asian American culture	3.6	1.0	3.5	1.7	5.7
Acculturation to host society's European American culture	4.4	.9	4.4	2.8	5.7
Disclosure Behaviors	3.2	1.4	2.8	1.0	5.0
Disclosure Attitudes	3.5	.6	3.7	2.2	4.0
Disclosure Intentions	3.4	.7	3.7	1.1	4.0

To standardize the numerous variables, it is necessary to rescale to have a mean of zero and a standard deviation of 1.0. The main reason why it is necessary to standardize the variables was to make sure that all variables contribute evenly to a scale when items are added together. In addition, standardizing the variables also facilitate easier to interpret results of a regression or other analysis. Table 5 presents the summary statistics of z-standardized scale variables involved in the analysis.

Table 5

Summary Statistics of z-Standardized Scale Variables

	Mean	Standard Deviation	Median	Minimum	Maximum
Horizontal collectivism	.0	1.0	-.1	-2.1	1.5
Horizontal individualism	.0	1.0	.1	-1.9	1.9
Vertical collectivism	.0	1.0	.0	-2.3	1.4
Vertical individualism	.0	1.0	.1	-2.0	1.7
Power distance	.0	1.0	-.3	-1.7	1.7
Uncertainty avoidance	.0	1.0	.2	-2.3	1.3
Collectivism	.0	1.0	.2	-2.9	1.6
Masculinity	.0	1.0	-.3	-1.4	1.8
Long-term orientation	.0	1.0	.1	-2.2	1.9
Acculturation to one's own Asian culture of origin	.0	1.0	-.1	-2.0	1.4
Acculturation to pan-ethnic Asian American culture	.0	1.0	-.1	-1.8	2.1
Acculturation to host society's European American culture	.0	1.0	.1	-1.8	1.4
Disclosure Behaviors	.0	1.0	-.3	-1.6	1.3
Disclosure Attitudes	.0	1.0	.4	-2.3	.9
Disclosure Intentions	.0	1.0	.4	-3.2	.8

Quantitative Instrumentation Measure Scores

To answer the research questions in this study, the following instruments were used in addition to the demographic characteristics questions: (a) Culture Orientation Scale (Triandis & Gelfand, 1998) (Appendix B); (b) Individual Cultural Values Scale (CVSCALE) (Yoo et al., 2011) (Appendix C); (c) Asian American Multidimensional Acculturation Scale (AAMAS) (Chung, Kim, & Abreu, 2004) (Appendix D); and (d) an HIV-positive disclosure scale developed by Serovich et al. (2009) (Appendix E) specifically to target casual sexual partners.

Culture Orientation Scale

The Cultural Orientation Scale includes 16 items with four items per each of each subscales: Cultural Orientation Horizontal Individualism Scale (COHISCALE), Cultural Orientation Horizontal Collectivism Scale (COHCSCALE), Cultural Orientation Vertical Collectivism Scale (COVCSCALE), and Cultural Orientation Vertical Individualism Scale (COVISCALE). There were no missing on any of the following four scales across the 24 participants. The following Table 6 provides the descriptive statistics and Cronbach's alpha for COHISCALE, COHCSCALE, COVCSCALE, and COVISCALE, respectively.

Table 6

Descriptive Statistics and Cronbach's Alphas for the 4 Cultural Orientation Subscales

Descriptive Statistics							
	# of items	<i>N</i>	Minimum	Maximum	Mean	Std. Deviation	Cronbach's alpha
COHISCALE	4	24	-1.21	1.33	.0000	.67836	0.62
COHCSCALE	4	24	-1.66	1.21	.0000	.78609	0.79
COVCSCALE	4	24	-1.75	1.10	.0000	.79155	0.80
COVISCALE	4	24	-1.19	1.19	.0000	.61945	0.50

Cronbach's alpha reliability coefficient normally ranges between 0 and 1. In social sciences, an acceptable range of Cronbach's alpha of .70 and greater demonstrates a desirable internal consistency (Cortina, 1993; Gliem & Gliem, 2003). However, the precision estimates for scales differ with number of dimensions and different number of items (Cortina, 1993). Each of the four above scales (i.e., COHISCALE, COHCSCALE, COVCSCALE, and COVISCALE) contains four items. The COVCSCALE has the highest Cronbach's alpha of 0.80 and the COVISCALE has the lowest Cronbach's alpha of 0.50. In applying the logic of Cortina's (1993) interpretation of Cronbach's alpha, it appears that the COVCSCALE, COHCSCALE, and COHISCALE reflect one dimension while the COVISCALE with the lowest Cronbach's alpha may be reflective of two dimensions.

When comparing the correlations of the four Cultural Orientation Scales (see Table 7), the Cultural Orientation Horizontal Collectivism Scale (COHCSCALE) and the Cultural Orientation Vertical Collectivism Scale (COVCSCALE) have high multicollinearity, which means that they are really tapping into the same dimensions in this sample even though they are supposed to be theoretically distinct. That is, participants are answering similarly for

COHCSCALE and COVCSCALE likely because this sample includes only HIV-positive men with similar level of education. When interpreting the results, it may be more important to differentiate between the two broad cultural dimensions of collectivism versus individualism rather than the four specific cultural dimensions. Perhaps the Cultural Orientation Scale (COS) does a better job at differentiating collectivism versus individualism rather than differentiating the four distinct cultural dimensions of COHISCALE, COHCSCALE, COVCSCALE, and COVISCALE in this particular population.

Table 7

Cultural Orientation Scale Correlations

		Correlations			
		COHISCALE	COHCSCALE	COVCSCALE	COVISCALE
COHISCALE	Pearson Correlation	1			
	Sig. (2-tailed)				
	<i>N</i>	24			
COHCSCALE	Pearson Correlation	.303	1		
	Sig. (2-tailed)	.150			
	<i>N</i>	24	24		
COVCSCALE	Pearson Correlation	.291	.705	1	
	Sig. (2-tailed)	.167	.000		
	<i>N</i>	24	24	24	
COVISCALE	Pearson Correlation	.196	.178	.050	1
	Sig. (2-tailed)	.357	.404	.818	
	<i>N</i>	24	24	24	24

Individual Cultural Values Scale (CVSCALE)

The Individual Cultural Values Scale includes 26 items. There were no missing data in any of these scales either. The following Table 8 provides the descriptive statistics and Cronbach's alpha for Power Distance (PO), Uncertainty Avoidance (UN), Collectivism (CO), Masculinity (MA) and Long-Term Orientation (LT), respectively. All five scales have sufficient Cronbach's alpha greater than 0.70 reflecting satisfactory internal consistency per Cortina's (1993) rule of thumb.

Table 8

Descriptive Statistics and Cronbach's Alphas for the 5 Individual Cultural Values (CVSCALE) Subscales

Descriptive Statistics							
	# of Items	<i>N</i>	Minimum	Maximum	Mean	Std. Deviation	Cronbach's alpha
POSCALE	5	24	-1.38	1.32	.0000	.77566	0.83
UNSCALE	5	24	-1.67	.93	.0000	.73284	0.78
COSCALE	6	24	-1.98	1.09	.0000	.69279	0.78
MASCALE	4	24	-1.07	1.56	.0000	.77317	0.77
LTSCALE	6	24	-1.55	1.36	.0000	.70990	0.80

The five subscales (i.e., PO, UN, CO, MA, and LT) within the Individual Cultural Values Scale (CVSCALE) were highly correlated (see Table 9). For example, power distance (PO) was highly correlated with masculinity (MA). However, power distance (PO) and uncertainty avoidance (UN) were not highly correlated. It is unclear whether Asian males in this sample interpreted the power distance and masculinity constructs similarly. In contrast, the participants in this sample interpreted the constructs of power distance and uncertainty avoidance as different.

Table 9

Individual Cultural Values Scale (CVSCALE) Correlations

		Correlations				
		POSCALE	UNSCALE	COSCALE	MASCALE	LTSCALE
POSCALE	Pearson					
	Correlation	1				
	Sig. (2-tailed)					
	<i>N</i>	24				
UNSCALE	Pearson					
	Correlation	-.097	1			
	Sig. (2-tailed)	.651				
	<i>N</i>	24	24			
COSCALE	Pearson					
	Correlation	.303	.588	1		
	Sig. (2-tailed)	.150	.002			
	<i>N</i>	24	24	24		
MASCALE	Pearson					
	Correlation	.623	-.176	.136	1	
	Sig. (2-tailed)	.001	.412	.527		
	<i>N</i>	24	24	24	24	
LTSCALE	Pearson					
	Correlation	-.353	.471	.217	-.235	1
	Sig. (2-tailed)	.091	.020	.308	.269	
	<i>N</i>	24	24	24	24	24

Asian American Multidimensional Acculturation Scale (AAMAS)

The Asian American Multidimensional Acculturation Scale (AAMAS) includes 15 items. There were no missing data in any of these scales either. Table 10 provides the descriptive statistics and Cronbach's alpha for the three cultural dimension scales: Culture of Origin (AAMAS-CO), Asian Americans (AAMAS-AA), and European Americans (AAMAS-EA), respectively.

Table 10

Descriptive Statistics and Cronbach's Alphas for the 3 Asian American Multidimensional Acculturation (AAMAS) Subscales

Descriptive Statistics							
	# of items	<i>N</i>	Minimum	Maximum	Mean	Std. Deviation	Cronbach's alpha
AAMAS-CO	15	24	-1.99462	1.44464	.0000000	1.0000000	0.86
AAMAS-AA	15	24	-1.82498	2.11131	.0000000	1.0000000	0.90
AAMAS-EA	15	24	-1.76139	1.43326	.0000000	1.0000000	0.91

The correlations of the three subscales (i.e., AAMAS-C, AAMAS-AA, and AAMAS-EA) within the Asian American Multidimensional Acculturation Scale (AAMAS) were highly correlated (see Table 11).

Table 11

Asian American Multidimensional Acculturation Scale (AAMAS) Correlations

		Correlations		
		AAMAS-CO	AAMAS-AA	AAMAS-EA
AAMAS-CO	Pearson Correlation	1	.348	-.347
	Sig. (2-tailed)		.095	.096
	<i>N</i>	24	24	24
AAMAS-AA	Pearson Correlation	.348	1	-.048
	Sig. (2-tailed)	.095		.822
	<i>N</i>	24	24	24
AAMAS-EA	Pearson Correlation	-.347	-.048	1
	Sig. (2-tailed)	.096	.822	
	<i>N</i>	24	24	24

HIV-Positive Disclosure Scale

The HIV-Positive Disclosure Scale includes 42 items. For the Disclosure Behaviors Scale (DBS), 22 out of the 24 participants answered these questions. The two participants who did not answer these questions responded with “N/A” (not applicable) for all items. For the Disclosure Attitudes Scale (DAS), all 24 participants answered the majority of these questions; therefore, an average was computed for each participant. Finally, for the Disclosure Intentions Scale (DIS), 23 out of 24 participants answered the majority of questions in order to create an average score. The following Table 12 provides the descriptive statistics and Cronbach’s alpha for the three HIV-Positive Scales: Disclosure Behaviors Scale (DBS), Disclosure Attitudes Scale (DAS), and Disclosure Intentions Scale (DIS), respectively.

Table 12

Descriptive Statistics and Cronbach’s Alphas for the 3 HIV-Positive Disclosure Subscales

Descriptive Statistics							
	# of items	N	Minimum	Maximum	Mean	Std. Deviation	Cronbach’s alpha
DBSSCALE	14	22	1.00	5.00	3.2493	1.37718	0.96
DASSCALE	14	24	2.14	4.00	3.0923	.57510	0.91
DISSCALE	14	23	1.07	4.00	2.9614	.67979	0.97

The three subscales (i.e., DBS, DAS, and DIS) within the HIV-Positive Disclosure Scale were highly correlated (see Table 13). For example, both attitudes and intentions were very highly correlated with each other. It is difficult to ascertain whether the HIV-Positive Disclosure Attitudes Scale (DAS) and HIV-Positive Disclosure Intentions Scale (DIS) are measuring similar concepts or that participants in this small sample may not have been able

to differentiate the difference between HIV-positive disclosure attitudes and intentions. In the original validation study, Serovich et al. (2009) did compute an estimate of effect size for each scale with medium large for behavior scores (0.69), moderate for attitude scores (0.44), and small for intention scores (0.25), respectively. HIV-Positive Disclosure Attitudes Scale (DAS) and HIV-Positive Disclosure Intentions Scale (DIS) subscales were more similar when compared to HIV-Positive Disclosure Behavior Scale (DBS).

Table 13

HIV-Positive Disclosure Scale Correlations

		Correlations		
		DBSSCALE	DASSCALE	DISSCALE
DBSSCALE	Pearson Correlation	1		
	Sig. (2-tailed)			
	<i>N</i>	22		
DASSCALE	Pearson Correlation	.560	1	
	Sig. (2-tailed)	.007		
	<i>N</i>	22	24	
DISSCALE	Pearson Correlation	.708	.859	1
	Sig. (2-tailed)	.000	.000	
	<i>N</i>	22	23	23

Tests for Assumptions

To test for normality assumptions, a normal probability plot was used, as it is more precise than a histogram. Compared to a histogram, a normal probability can pick up subtle deviations and does not suffer too much or too little power (Grace-Martin, 2016). There are

two versions of normal probability plots: Q-Q and P-P (Grace-Martin, 2016). Grace-Martin (2016) argued that the P-P plot is preferred over the Q-Q plot as the former plots the corresponding areas under the curve (i.e., cumulative distribution function) for those values; while the latter plots every observed value against a standard normal distribution with the same number of points (Grace-Martin, 2016). Consequently, the normal P-P plot is better at finding deviations from normality in the center of the distribution, while the normal Q-Q plot is better at finding deviations in the tails (Grace-Martin, 2016).

Figure 3, Figure 4, and Figure 5 below illustrate the normal P-P plots for the three regressions, suggesting that the data does not line up completely linearly. In a perfect P-P plot, the 24 participants would line up perfectly on the straight line. With the small sample size, it is difficult to determine whether the normality test assumption has been violated due to outliers representative of departures from normality. Conversely, even if the normality test assumption was not violated, there is insufficient power to detect a significant departure from normality, even if it is present.

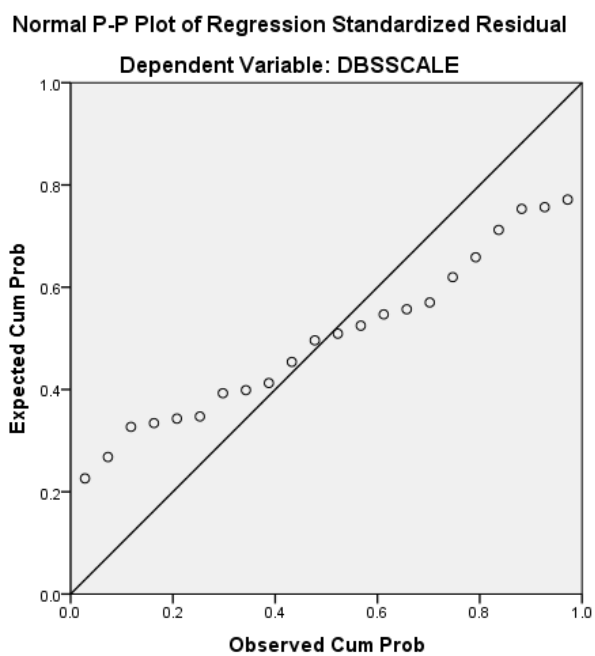


Figure 3. Normal P-P plot of regression standardized residual for the HIV-Positive Disclosure Behaviors Scale (DBSSCALE).

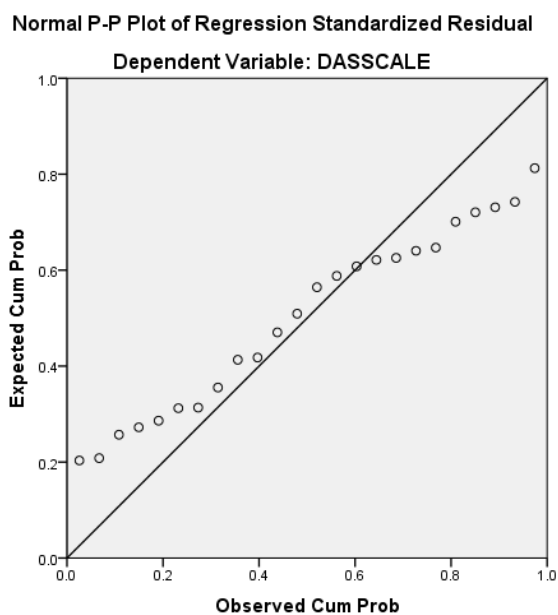


Figure 4. Normal P-P plot of regression standardized residual for the HIV-Positive Disclosure Attitudes Scale (DASSCALE).

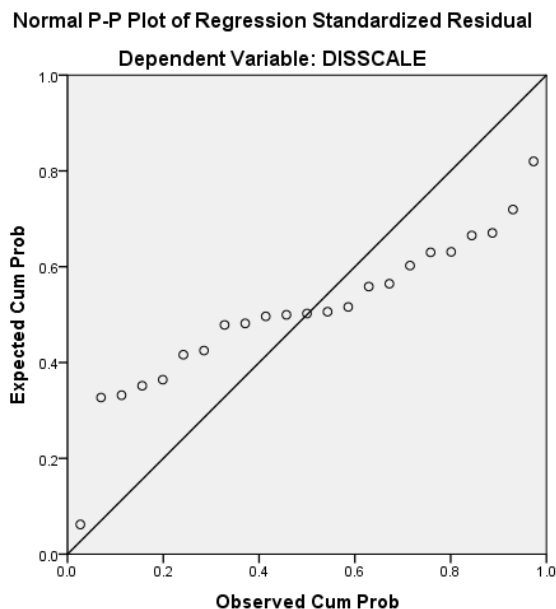


Figure 5. Normal P-P plot of regression standardized residual for the HIV-Positive Disclosure Intentions Scale (DISSCALE).

Durbin-Watson tests were run as part of the regressions to detect autocorrelation in time series data. Because this was a cross-sectional study, other tests were run to check heteroscedasticity. Specifically, Breusch-Pagan and Koenker tests were run to check for heteroscedasticity (Koenker, 1981; Koenker & Bassett, 1982). These tests were run by adapting a syntax macro to the dataset as SPSS does not normally have the capability to run Breusch-Pagan or Koenker tests (Koenker, 1981; Koenker & Bassett, 1982). The Breusch-Pagan and Koenker tests found no evidence of heteroscedasticity; thus, justifying the use of the normal linear regression methods employed.

Hypothesis Testing Results

The results from the online survey were entered and analyzed using the IBM Statistical Package for the Social Sciences (SPSS) Version 21 data set. Linear multiple

regressions for all three research questions were run in blocks. The first block included the demographic variables (i.e., length of time since HIV diagnosis, age, level of education, and income). Then a second block was run adding in the 12 generated variables representing cultural values and level of acculturation. Frequencies, descriptive statistics, and correlations were also run and made available. None of the regressions produced significant findings at the requested significance level (i.e., $p < .05$). However, some effects were significantly below, or close to, the ten percent level (i.e., $p < .10$). Although the *a priori* significance level was set at $p < .05$, it would be appropriate to provide regression analyses where the p value was $< .10$ as they may be of interest to future research suggesting that these significant associations might have been robust enough if the sample size was larger.

Linear Multiple Regression Analysis

Research Question 1 (RQ1): What was the association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure behaviors in API MSM?

The regressed predictors (see Table 14) appear to adequately explain the variation in disclosure behaviors patterns (adjusted R -squared = 0.175). The regression analysis suggested potential strong association and effect size were reported for length of HIV/AIDS diagnosis ($\beta = -1.787$, $p < 0.10$) and annual income ($\beta = +1.192$, $p < 0.10$) if the sample size might have been larger. These findings suggest a negative association between disclosure behavior and the length of time that has passed since testing positive for HIV, with each five-year period since testing positive correlating to a nearly 2-point drop in the respondent's average Likert score. On the other hand, income is positively associated with

disclosure, suggesting that addressing disclosure may be more relevant at lower income levels. Lastly, a notably strong negative effect ($\beta = -1.000$) was estimated for the average score of AAMAS-CO variable. Although the effect is insignificant (p -value = 0.208), this result stands out enough to potentially warrant further exploration.

Table 14

Summary of Hierarchical Regression Analysis for Variables Predicting Disclosure Behaviors (N = 24)

Variable	Model 1			Model 2		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Age	-0.23	0.48	-0.12	-0.78	0.78	-0.42
HIV/AIDS	-0.32	0.48	-0.18	-1.79	0.80	-0.97 *
Education	-0.07	0.19	-0.10	-0.18	0.37	-0.26
Income	0.21	0.34	0.16	1.19	0.52	0.93 *
CV-COS-HC				1.00	0.74	0.73
CV-COS-HI				0.79	0.52	0.53
CV-COS-VC				0.15	0.80	0.01
CV-COS-VI				-0.15	0.54	-0.11
CVSCALE_PO				-0.52	0.61	-0.36
CVSCALE-UN				-1.23	0.96	-0.86
CVSCALE-CO				0.16	0.63	0.12
CVSCALE-MA				-0.73	0.87	-0.54
CVSCALE-LT				0.33	0.49	0.24
AAMAS-CO				-1.00	0.69	-0.52
AAMAS-AA				0.73	0.72	0.53
AAMAS-EA				0.46	0.69	0.31
R^2		.08			.80	
Adjusted R^2		-.14			0.18	

Note: All variables were centered at their means.

* $p < .10$. ** $p < .05$.

Research Question 2 (RQ2): What was the association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure attitudes in API MSM?

The regressed predictors (see Table 15) appear to adequately explain the variation in disclosure intentions patterns (adjusted R -squared = 0.182). Mild association and effect size were reported for vertical individualism ($\beta = +0.455$, $p < 0.10$) and power distance ($\beta = -0.479$, $p < 0.10$). The suggestion of an association for both of these parameters may warrant further exploration.

Table 15

Summary of Hierarchical Regression Analysis for Variables Predicting Disclosure Attitudes (N = 24)

Variable	Model 1			Model 2		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Age	-0.06	0.19	-0.07	-0.06	0.31	-0.07
HIV/AIDS	-0.18	0.17	-0.26	-0.07	0.33	-0.11
Education	-0.03	0.08	-0.09	-0.20	0.15	-0.68
Income	0.11	0.13	0.22	0.17	0.15	0.35
CV-COS-HC				0.05	0.29	0.09
CV-COS-HI				-0.10	0.15	-0.17
CV-COS-VC				-0.13	0.29	-0.22
CV-COS-VI				0.46	0.22	0.79 *
CVSCALE_PO				-0.48	0.23	-0.83 *
CVSCALE-UN				0.40	0.25	0.70
CVSCALE-CO				-0.26	0.24	-0.45
CVSCALE-MA				0.34	0.36	0.59
CVSCALE-LT				0.23	0.19	0.40
AAMAS-CO				-0.25	0.26	-0.32
AAMAS-AA				0.09	0.26	0.15
AAMAS-EA				0.07	0.27	0.11
R^2		.09			.75	
Adjusted R^2		-.10			0.18	

Note: All variables were centered at their means.

* $p < .10$. ** $p < .05$.

Research Question 3 (RQ3): What was the association between cultural values (individualism-collectivism), level of acculturation, length of time since diagnosis, age, level of education, and income to HIV-positive disclosure intentions in API MSM?

The regressed predictors (see Table 16) appear to strongly explain the variation in disclosure attitudes patterns (adjusted R -squared = 0.269). No significant effects were reported for this research question. However, two variables were closely associated: vertical individualism ($\beta = +0.382$, p -value = 0.177) and power distance ($\beta = -0.495$, p -value = 0.107). Since these are the same two variables that were found to be highly associated in Research Question 2 (i.e., with effects of similar magnitude and direction), this finding strengthens the level of interest that could be developed around further exploring the potential impact these variables may have on both disclosure attitudes and intentions. Stated differently, vertical individualism and power distance are related to HIV-positive disclosure attitudes and intentions, but not for actual disclosure behaviors.

Table 16

Summary of Hierarchical Regression Analysis for Variables Predicting Disclosure Intentions (N = 24)

Variable	Model 1			Model 2		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Age	0.03	0.23	0.03	0.18	0.35	0.19
HIV/AIDS	-0.13	0.21	-0.16	-0.25	0.37	-0.31
Education	-0.06	0.09	-0.16	-0.30	0.17	-0.85
Income	0.01	0.16	0.02	0.20	0.21	0.32
CV-COS-HC				0.30	0.33	0.45
CV-COS-HI				-0.03	0.21	-0.04
CV-COS-VC				0.09	0.36	0.14
CV-COS-VI				0.38	0.25	0.58
CVSCALE_PO				-0.50	0.26	-0.73
CVSCALE-UN				-0.20	0.44	-0.28
CVSCALE-CO				-0.32	0.29	-0.47
CVSCALE-MA				0.37	0.41	0.55
CVSCALE-LT				0.22	0.23	0.33
AAMAS-CO				-0.33	0.30	-0.35
AAMAS-AA				0.10	0.33	0.14
AAMAS-EA				0.37	0.31	0.50
R^2		.07			.80	
Adjusted R^2		-.14			0.27	

Note: All variables were centered at their means.

* $p < .10$. ** $p < .05$.

Correlational Analysis

Despite the extremely small sample size of 24 participants, there were interesting correlations across variables. Arguably, these correlations are even more important than the linear multiple regressions because they facilitate explanations about the patterns between scales.

Linear regression analysis assumed linear relationship between the dependent and independent variables, which may have resulted in missing certain non-linear relationships. In order to identify such correlations, a non-parametric Spearman correlation coefficient was used. Correlation coefficients significant at 10% level are highlighted in yellow in Table 17 below. Acculturation to host society's European American culture and vertical collectivism are significantly positively associated with HIV-positive disclosure attitudes and intentions, while higher power distance, on the contrary, is associated with lower HIV-positive disclosure attitudes and intentions scores. Uncertainty avoidance and long-term orientation are significantly positively associated with HIV-positive disclosure attitudes only.

Table 17

Correlation Analyses of HIV-Positive Disclosure Behaviors, Attitudes, and Intentions

		Disclosure Behaviors	Disclosure Attitudes	Disclosure Intentions
Acculturation to one's own Asian culture of origin	Correlation Coefficient	-.334	-.079	-.095
	Sig. (2-tailed)	.128	.714	.667
	<i>N</i>	22	24	23
Acculturation to pan-ethnic Asian American culture	Correlation Coefficient	-.108	-.061	-.003
	Sig. (2-tailed)	.633	.777	.990
	<i>N</i>	22	24	23
Acculturation to host society's European American culture	Correlation Coefficient	.334	.459*	.389
	Sig. (2-tailed)	.129	.024	.067
	<i>N</i>	22	24	23
Horizontal collectivism	Correlation Coefficient	-.073	.308	.112
	Sig. (2-tailed)	.747	.143	.610
	<i>N</i>	22	24	23
Horizontal individualism	Correlation Coefficient	.059	.205	.296
	Sig. (2-tailed)	.796	.338	.171
	<i>N</i>	22	24	23
Vertical collectivism	Correlation Coefficient	-.078	.531**	.462*
	Sig. (2-tailed)	.730	.008	.026
	<i>N</i>	22	24	23
Vertical individualism	Correlation Coefficient	-.092	-.121	-.028
	Sig. (2-tailed)	.685	.573	.898
	<i>N</i>	22	24	23
Power distance	Correlation Coefficient	-.345	-.575**	-.603**
	Sig. (2-tailed)	.116	.003	.002
	<i>N</i>	22	24	23
Uncertainty avoidance	Correlation Coefficient	-.166	.446*	.268
	Sig. (2-tailed)	.461	.029	.217
	<i>N</i>	22	24	23
Collectivism	Correlation Coefficient	-.182	.055	-.065
	Sig. (2-tailed)	.416	.798	.767
	<i>N</i>	22	24	23

Table 17 Continued

		Disclosure Behaviors	Disclosure Attitudes	Disclosure Intentions
Masculinity	Correlation Coefficient	-.168	-.219	-.214
	Sig. (2-tailed)	.455	.304	.326
	N	22	24	23
Long-term orientation	Correlation Coefficient	.075	.365	.196
	Sig. (2-tailed)	.742	.079	.370
	N	22	24	23
How long ago since you have been diagnosed with HIV/AIDS?	Correlation Coefficient	.076	.234	.257
	Sig. (2-tailed)	.738	.271	.236
	N	22	24	23
What is your current annual income?	Correlation Coefficient	.069	.118	-.085
	Sig. (2-tailed)	.761	.582	.700
	N	22	24	23

Note: All variables were centered at their means.

* $p < .10$. ** $p < .05$.

In order to check the robustness of the findings and identify more associations between dependent and independent variables, each of the independent (X) and dependent variables (Y) were recoded into binary indicators (1 – “above median”, 0 – “equal to or below median”). Next, the following question for each of the independent variable was answered: “Is level of X (low/high) associated with level of Y (low/high)?” For example, it was clear from the cross tabulation below that HIV-positive disclosure attitudes and intentions scores were observed for 75.0% and 83.3% of those whose vertical collectivism score was high, respectively. Similarly, high HIV-positive disclosure behaviors scores were observed for 72.7% of those whose power distance score was low and only for 27.3% of those whose power distance was above median. This gap was even larger in the case of

HIV-positive disclosure intentions. Finally, high HIV-positive disclosure behaviors, attitudes, and intentions scores were observed for 70.0%, 75.0%, and 81.8% of those whose acculturation to host society's European American was high, respectively. Table 18 below displays all associations that were relevant to the three research questions for which the test statistic of the Fisher's exact test is significant at 10% level (either 2-sided or 1-sided p -value < 0.1).

Table 18

Analysis of Associations Relevant to the Three Research Questions

		Disclosure Behaviors		Disclosure Attitudes		Disclosure Intentions	
		low	high	low	high	low	high
		Row N %	Row N %	Row N %	Row N %	Row N %	Row N %
Horizontal collectivism	low	36.4%	63.6%	58.3%	41.7%	54.5%	45.5%
	high	63.6%	36.4%	41.7%	58.3%	33.3%	66.7%
Horizontal individualism	low	57.1%	42.9%	57.1%	42.9%	57.1%	42.9%
	high	37.5%	62.5%	40.0%	60.0%	22.2%	77.8%
Vertical collectivism	low	45.5%	54.5%	75.0%	25.0%	72.7%	27.3%
	high	54.5%	45.5%	25.0%	75.0%	16.7%	83.3%
Vertical individualism	low	50.0%	50.0%	50.0%	50.0%	38.5%	61.5%
	high	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
Power distance	low	27.3%	72.7%	30.8%	69.2%	16.7%	83.3%
	high	72.7%	27.3%	72.7%	27.3%	72.7%	27.3%
Uncertainty avoidance	low	41.7%	58.3%	61.5%	38.5%	50.0%	50.0%
	high	60.0%	40.0%	36.4%	63.6%	36.4%	63.6%
Collectivism	low	50.0%	50.0%	53.8%	46.2%	41.7%	58.3%
	high	50.0%	50.0%	45.5%	54.5%	45.5%	54.5%
Masculinity	low	36.4%	63.6%	38.5%	61.5%	33.3%	66.7%
	high	63.6%	36.4%	63.6%	36.4%	54.5%	45.5%
Long-term orientation	low	58.3%	41.7%	50.0%	50.0%	50.0%	50.0%
	high	40.0%	60.0%	50.0%	50.0%	36.4%	63.6%
Acculturation to one's own Asian culture of origin	low	30.0%	70.0%	50.0%	50.0%	45.5%	54.5%
	high	66.7%	33.3%	50.0%	50.0%	41.7%	58.3%

Table 18 Continued

		Disclosure Behaviors		Disclosure Attitudes		Disclosure Intentions	
		low	high	low	high	low	high
		Row N %	Row N %	Row N %	Row N %	Row N %	Row N %
Acculturation to pan-ethnic Asian American culture	low	45.5%	54.5%	41.7%	58.3%	36.4%	63.6%
	high	54.5%	45.5%	58.3%	41.7%	50.0%	50.0%
Acculturation to host society's European American culture	low	66.7%	33.3%	75.0%	25.0%	66.7%	33.3%
	high	30.0%	70.0%	25.0%	75.0%	18.2%	81.8%
What is your current age?	18-30 years old	50.0%	50.0%	62.5%	37.5%	50.0%	50.0%
	31-40 years old	40.0%	60.0%	50.0%	50.0%	45.5%	54.5%
	41-50 years old	75.0%	25.0%	25.0%	75.0%	25.0%	75.0%
How long ago since you have been diagnosed with HIV/AIDS?	6 months – 1 year	70.0%	30.0%	70.0%	30.0%	60.0%	40.0%
	2 years – 5 years	28.6%	71.4%	28.6%	71.4%	28.6%	71.4%
	6 years – 10 years	40.0%	60.0%	50.0%	50.0%	40.0%	60.0%
	11 years – 15 years	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%
Higher education	No	37.5%	62.5%	50.0%	50.0%	37.5%	62.5%
	Yes	57.1%	42.9%	50.0%	50.0%	46.7%	53.3%
What is your current annual income?	\$0 to \$19,999	33.3%	66.7%	33.3%	66.7%	33.3%	66.7%
	\$20,000 to \$39,999	66.7%	33.3%	66.7%	33.3%	50.0%	50.0%
	\$40,000 to \$59,999	25.0%	75.0%	37.5%	62.5%	37.5%	62.5%
	\$60,000 to \$79,999	100.0%	0.0%	60.0%	40.0%	60.0%	40.0%
	\$80,000 to \$99,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	\$100,000 or higher	0.0%	100.0%	50.0%	50.0%	0.0%	100.0%

Overall, the results of the analysis of associations support our findings from the correlation analysis and emphasize the role of vertical collectivism, power distance, and acculturation to host society's European American culture in explaining HIV-positive disclosure behaviors, attitudes, and intentions.

Stepwise Linear Regression Analysis

As discussed in Chapter 3 above, variables can be entered into a multiple regression model in several ways including hierarchical regression (blockwise entry), forced entry, and stepwise methods. Given the extremely small sample size of 24 participants, a stepwise regression was conducted for exploratory purposes to assess which factors are predictive of HIV-positive disclosure behaviors, attitudes, and intentions.

The stepwise linear regression of HIV-positive disclosure behaviors score on all explanatory variables resulted in power distance being a significant predictor of HIV-positive disclosure behaviors at 10% significance level ($p = 0.090$). A 1-unit increase in power distance score is associated, on average, with a 0.43 units decrease in HIV-positive disclosure behaviors score (see Table 19). Variation in power distance explains 13.7% of variation in the dependent variable ($R^2 = 0.137$).

Table 19

Parameter Estimates of the Stepwise Regression of HIV-Positive Disclosure Behaviors Score on All Other Explanatory Variables

	Unstandardized Coefficients		Standardized Coefficients	<i>t</i>	Sig.
	β	Std. Error	β		
(Constant)	4.739	0.881		5.382	0
Power distance	-0.43	0.241	-0.371	-1.784	0.09

The stepwise linear regression of HIV-positive disclosure attitudes score on all explanatory variables resulted in a number of significant predictors, among which power distance is the most significant one ($p < 0.001$). Other things equal, a 1-unit increase in power distance score is associated, on average, with a 0.416 units decrease in HIV-positive disclosure behaviors score (see Table 20). Uncertainty avoidance ($p = 0.036$), masculinity ($p = 0.003$), and acculturation to host society's European American culture ($p = 0.089$) are associated with a significant increase in HIV-positive disclosure attitudes. Variation in the four factors mentioned above explains two thirds of the variation in the dependent variable ($R^2 = 0.667$).

Table 20

Parameter Estimates of the Stepwise Regression of HIV-Positive Disclosure Attitudes Score on All Other Explanatory Variables

	Unstandardized Coefficients		Standardized Coefficients	<i>t</i>	Sig.
	β	Std. Error	β		
(Constant)	1.882	.621		3.031	.007
Power distance	-.416	.080	-.921	-5.226	.000
Uncertainty avoidance	.192	.085	.334	2.256	.036
Masculinity	.324	.096	.632	3.369	.003
Acculturation to host society's European American culture	.175	.097	.284	1.793	.089

Finally, the stepwise linear regression of HIV-positive disclosure intentions score on all explanatory variables indicated negative impact of power distance ($p = 0.038$) and a positive impact of vertical collectivism ($p = 0.079$). This 2-factor model explains one third of the HIV-positive disclosure intentions' variance (see Table 21).

Table 21

Parameter Estimates of the Stepwise Regression of HIV-Positive Disclosure Intentions Score on All Other Explanatory Variables

	Unstandardized Coefficients		Standardized Coefficients	<i>t</i>	Sig.
	β	Std. Error	β		
(Constant)	3.207	0.735		4.362	0
Power distance	-0.248	0.112	-0.412	-2.225	0.038
Vertical collectivism	0.157	0.085	0.343	1.852	0.079

Qualitative

Recruitment and Response Rate

Participants for the qualitative study were recruited from the Los Angeles and Orange County areas in Southern California using an electronic or EDM campaign. The emails were sent to only LGBT and API organizations. The recruitment period lasted for two months. Eight participants completed the anonymous, confidential, in-depth semistructured interviews lasting between 20 minutes, 40 seconds and 62 minutes, 59 seconds. The average interviews lasted 39 minutes, 15 seconds. All participants were API MSM individuals who had experienced the phenomenon of HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners. There was a wide variety of API racial backgrounds in the sample with two of the men identifying as Chinese, two of the men identifying as other Asian (i.e., Indonesia and Pakistani), one as Filipino, one as Thai, one as Vietnamese, and one as two or more races (i.e., Filipino and Chinese).

Interviews took place at numerous locations including at participants' place of residence, at a public park, outside of a coffee shop, and inside the researcher's car. Interviews were conducted live in person and audiotaped using the Recorder app, a voice and call recorder for iOS, on an iPhone 7 Plus. Prior to the recording of the audiotaped interviews, I reviewed the main sections of the informed consent form, which included an introduction to the study, background information, procedures, sample questions, voluntary nature of the study, risks and benefits of being in a study, incentives for participating in the study, privacy, dissemination of survey results, and contacts and questions. Participants provided informed consent by verbally acknowledging that they had understood the

information and continued interest in participating in the study. All participants were asked the same nine questions (see Appendix F) that prompted them to share their lived experience of HIV-positive disclosure behaviors, attitudes, and intentions.

Qualitative Data Management

Qualitative interviews were audiotaped in an environment that allowed for reasonable privacy and quiet. Applying Colaizzi's strategy of descriptive phenomenological data analysis, I transcribed the interviews and listened to the audiotapes on the Recorder app to check for accuracy. Verbatim transcripts were first read for content, understanding, and accuracy, and then double-checked to the actual audiotaped recording of interviews. This task completed step 1 of Colaizzi's method of phenomenological data analysis.

The second step of Colaizzi's method of phenomenological data analysis was to extract significant statements that directly related to the HIV-positive disclosure behaviors, attitudes, and intentions phenomenon under investigation. The third and fourth steps involved meaning-making from the data by creating formulated meanings (step 3) and aggregating formulated meanings into themes (step 4). Appendix G provides a summary of significant statements and their associated formulated meanings for the qualitative study. As described previously QSR NVivo 11 was used to facilitate the data management process of organizing and managing the volume of interview transcripts. Although there were only eight participants in this qualitative study, each participant was asked a series of nine questions that produced a great volume of data to analyze. The interview responses were organized, coded, analyzed, and interpreted both by hand and by using QSR NVivo 11.

Appendix H includes the code book that provides the coding summary by node and presents the coding structure that emerged from the eight interviews.

During coding, the two major research questions were treated as the template for emergent content analysis of the transcripts. Themes that emerged from each interview question were coded to the research question and subthemes (or central ideas) were added to the coding structure. The final coding structure is in Appendix H: Qualitative Code Book – Coding Summary by Node.

Results of Qualitative Inquiry

Table 22 presents the development process that occurred in two phases:

- Phase 1 (step 4 of Colaizzi) was the initial coding of central ideas and codes with the emergence of categories.
- Phase 2 (step 5 of Colaizzi) was the deeper analysis to aggregate the categories into themes.

Table 22

Table of Qualitative Theme Development

Themes	Categories	Codes	Central Ideas
<u>Theme 1:</u> Disclosure attitudes and behaviors	<u>Category 1:</u> HIV-positive disclosure experience to a casual sexual partner	Finding the partner	<ul style="list-style-type: none"> • Attraction to person related to type of future relationship with the partner (i.e., casual versus long-term relationship) • Role of dating apps • Posted on social media • Role of social venue and gatherings • Use protection; undetectable • Disclose less if spontaneous • How/where met; role of shared friends
	<u>Category 2:</u> HIV-positive disclosure experience with sexual preference or position	Type of sexual encounters	<ul style="list-style-type: none"> • Varies by type of sex (i.e., anal versus oral) • Disclosure less critical since “undetectable” • Disclosure regardless; yet harder if anal sex compared to oral sex
	<u>Category 3:</u> Disclosure attitudes and dealing with HIV-positive	Time	<ul style="list-style-type: none"> • Role of time (i.e., pertaining to number of years dealing with HIV) • State of denial • Feeling of isolation and shock • Feeling of hopelessness and depression • Less sexual urge
		U.S. culture versus country of birth	<ul style="list-style-type: none"> • Acceptance of the situation • Personal education about HIV • Big cities’ diverse communities, better healthcare, and up-to-date resources. • Role of support groups • Better healthcare than home country

Table 22 Continued

Themes	Categories	Codes	Central Ideas
Theme 2: Influences on disclosure	<u>Category 1</u> : Level of education and socioeconomic class as influencing factors	Moderates disclosure (e.g., affects the likelihood and ease of disclosure)	<ul style="list-style-type: none"> • Higher education easier • Cultural progressive easier • Socioeconomic class relatively less influence
	<u>Category 2</u> : Identify with own and other Asian groups or with the White mainstream groups	Mediates disclosure (e.g., explains the relationship between disclosure behaviors and race)	<ul style="list-style-type: none"> • Asian openness to conversation regarding sexuality • Grew up in the United States but still practice their Asian roots
	<u>Category 3</u> : Influence of cultural background or values on HIV-positive disclosure experience	Natal versus adopted culture	<ul style="list-style-type: none"> • Strong influence; most from culturally conservative country and migrated to progressive city • Moral standpoint and how it affects the decision process • Birth families' strict beliefs and traditions
	<u>Category 4</u> : Other factors influencing HIV-positive disclosure to casual sexual partners	Acceptance Rejection	<ul style="list-style-type: none"> • The idea of acceptance based on shared experience • The idea of rejection based on ideology (i.e., progressive versus more conservative area of planet) or period of time with HIV knowledge and awareness • Attractiveness of partner

Overview of Qualitative Findings

- All interviewees disclosed their HIV-positive status to casual sexual partners. Six of the interviewees did so without question and the most frequent medium of disclosure was their social media profile.
- The other two interviewees responded honestly if asked, but did not volunteer the information.
 - Exceptions to immediate disclosure were: 1) if sex was spontaneous and oral or masturbation; or 2) if protection was used during anal sex.
 - Five interviewees felt disclosure was more difficult with anal sex, which seems to be a function of the depth of the relationship with the partner. The suggestion is that anal sex is harder to disclose because it is not typically a spontaneous event and occurs most often in a relationship or with someone with whom a relationship is desired.
- Spontaneous encounters led to nondisclosure while planned meetings led to disclosure of HIV-positive status. Spontaneous situations happened during nights out mostly under the influence of alcohol or drugs that lowered inhibitions. Planned meetings were arranged through online dating apps or through social gatherings. Presumably, participants were emotionally prepared to disclose where both parties agreed with each other's health status unless the participant was in a vulnerable state. The most often cited influence was location of encounter – online or bar (i.e., spontaneous, under the influence of alcohol) or elsewhere that was less conducive to spontaneous sex.

- All interviewees believed their status should be disclosed, and three felt that was easier to disclose now than when they were initially diagnosed with their HIV-positive status.
- Six interviewees stated that education level influenced ease of disclosure, with education level indicative of a greater understanding/awareness of the science of HIV.
- The reverse belief was held by some regarding socioeconomic class and geographic location, with disclosure more difficult with persons from lower socioeconomic class or more rural or less progressive cities.
- Beliefs involving less progressive and lower socioeconomic class links to the stated influences of cultural background on disclosure behavior. All interviewees were immigrants to the United States from a country more culturally conservative than the United States and from family economic circumstance less affluent than that realized their adopted country. For all interviewees, the topic of sex was a taboo and gay sex was considered unacceptable. Immigration to the United States gave the interviewees the freedom to accept and live openly as a gay man and access to support groups, associations, and society more welcoming of their sexual orientation.
 - The home country to United States pathway of the interviewees was reflected in the mix of responses to Q5 on ethnic identity. About half identified with and preferred to associate with others of Asian ancestry, while the other half preferred the White mainstream group.

Although the sample size was eight participants in this qualitative study, each participant was asked a series of nine questions that produced a great volume of data to analyze. According to Macia (2015), cluster analysis can be particularly helpful as an exploratory tool to support the identification of associations within qualitative data where numerous cases are studied or when there is a great volume of data that need to be analyzed. Additionally, cluster analysis can be applied to clarify the findings revealing such things as the motives of participants and the reasons behind findings, which can be served as a key component in mixed methods research with small and culturally distinct samples (Henry, Dymnicki, Mohatt, Allen, & Kelly, 2015). I used NVivo to produce the following cluster analysis (Figure 6).

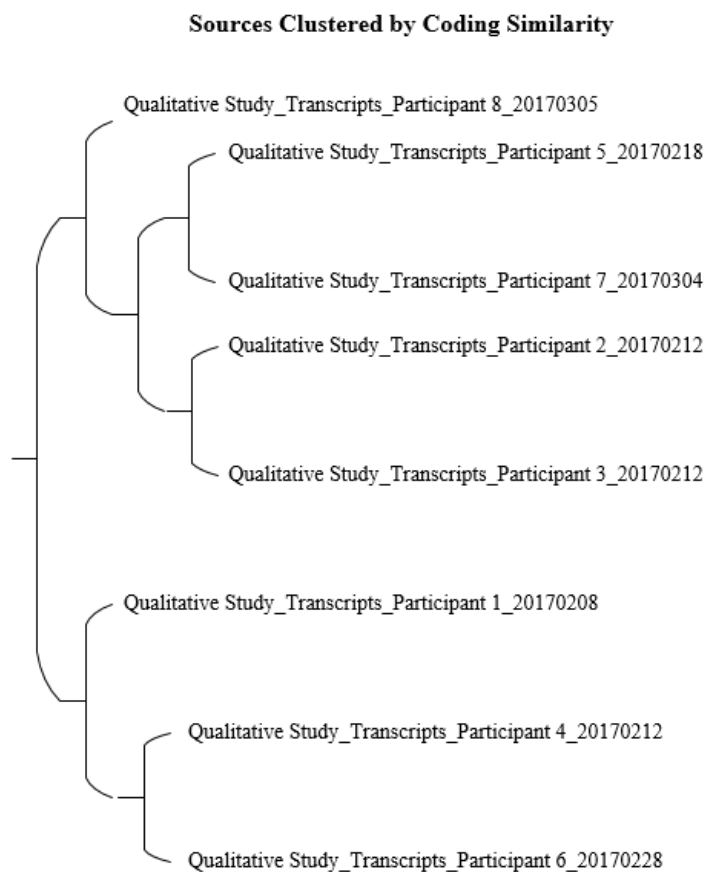


Figure 6. Sources clustered by coding similarity.

The above figure shows two main clusters. Responses from participants 2, 3, 5, and 7 were similar to those of participant 8, while responses from participants 4 and 6 were similar to those of participant 1. Cluster analysis helps to present the breadth and depth of data that qualitative inquiry produces into patterns, which underscore significant quotes, in a more manageable fashion when processing and interpreting the results of qualitative data (Macia, 2015).

Major Themes

Theme 1: Disclosure Attitudes and Behaviors

Nearly all of the eight participants felt that it was important to disclose their HIV-positive status even if their HIV-positive status was undetectable. Two participants felt that this was almost like a make-or-break-it factor, or an important step to move towards a relationship, or that they had to get this out of the way before they could move onto casual sex, or towards something more long term and worthwhile.

The majority of participants relied on their online profiles or modern technology (i.e., online gay dating app or the use of texts) to draw attention to their profile before they meet a potential casual sexual partner. Dating websites or apps such as Grindr and Adam4Adam have provided more options and have made it easier for participants to disclose their HIV-positive status. Technological advancement makes the potential vetting and filtering process easier for men with HIV-positive status. Moreover, technology helps participants to avoid face-to-face rejection and altercations, which can be painful and scar the individuals. However, two participants mentioned in their conversation that they preferred having face-to-face conversations about their HIV-positive status rather than explicitly stating their HIV-positive status in their online profile.

For myself, the pain or awkwardness of disclosing to somebody is assumed in terms of it being prominently visible in the profile that I have on these dating websites. So, unless it comes up as a subject in normal conversations there is that assumption that no further discussion about HIV status is needed. It's already there though.

Another important theme that emerged was that participants felt that they did not need to initiate the disclosure of HIV-positive status conversation as this information was already mentioned in their online profile. However, most of the participants felt that if a potential sexual partner were to ask them about their HIV-positive status, then it would be their responsibility to discuss the situation as openly and honestly as possible. Some of the participant even felt that this was their chance to educate the other partners presumably if they were HIV-negative, had misinformation, or demonstrated lack of knowledge on the subject. However, one participant did feel that it was the responsibility of the other partner to view his online profile indicating that he was HIV-positive. Again, if asked, then it would be his responsibility to answer truthfully. Figure 7 summarizes the three methods of HIV-positive disclosure including online gay dating apps, mobile messaging, and meetups.

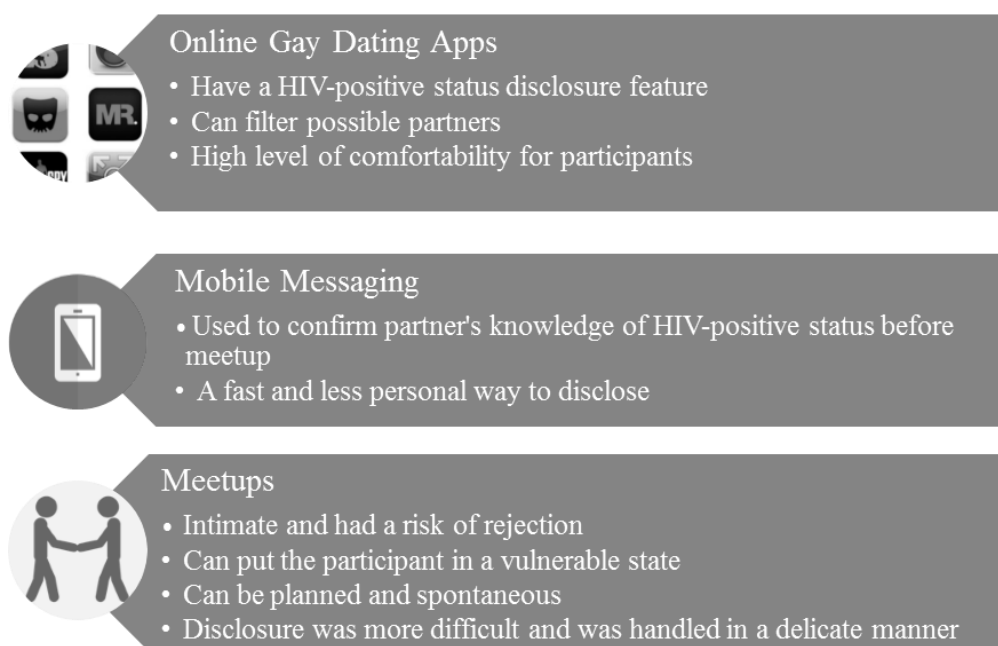


Figure 7. Methods of HIV-positive disclosure.

Another factor that weighed heavily into the participants' HIV-positive status disclosure was spontaneity. If the participants knew that the sexual encounter was a one-time occurrence, then they may not spend too much time wondering whether they should disclose their HIV-positive status.

There is less an inclination to discuss it because oral sex tends to be more or can become more spontaneous. Usually when you're just... speaking of spontaneity and when you're in the moment, you don't go into these types of conversation about status. You just like 'go for it'. So, I would say that the disclosure thing or the disclosure that I mentioned in the first question may not necessarily apply to casual, spontaneous oral sex. [Participant 1]

In terms of casual sexual encounters, participants felt that if they were on speaking terms or had a good communication link with the other person, then they would try to ensure that the other person was aware of their HIV-positive status. In addition, their good connection allowed their disclosure to go more smoothly. So even in case of a casual sexual encounter, there were different levels to their disclosing status. For example, if participants met a casual sexual partner in a bar or a club and things progressed quickly leading to sex, then they tend to forget to disclose their HIV-positive status.

Disclosure was more difficult when participants met their casual sexual partners in a bar or a club because of the face-to-face interaction and the fear of rejection. Disclosure becomes particularly more challenging when participants meet their sexual partners through

a friend or through their personal network because of the fear that the sexual partner would share this information with their friends.

The majority of participants ($n = 6$) felt that their HIV-positive disclosure experience was dependent on the type of sexual activity they were engaged in and the type of sexual encounter (i.e., casual one-off affair or had the potential to be something more lasting).

Participants did not feel the need to disclose their HIV-positive status when engaging in mutual masturbation. Overwhelmingly, participants felt that the risk of spreading the HIV virus was extremely low when they engage in mutual masturbation. Also, it was relatively easy to disclose when participants were just engaging in oral sex. Participants' rationale for not disclosing was because they are currently being treated with antiviral medications and that their viral load is undetectable. Participants also felt that the actual risk of transmitting the HIV virus was extremely low when engaging only in mutual masturbation or oral sex. However, when participants were engaging in anal sex, most felt that disclosure to their sexual partners was necessary and become more difficult as the chance of transmitting the HIV virus was greater, especially when condoms were not used. Therefore, disclosure was not warranted. Similarly, the risk of someone contracting HIV was also very low when participants are on treatment and their viral load is undetectable. However, the majority of participants felt that it was important to disclose their HIV-positive status when engaging in anal sexual intercourse. Two out of the eight participants felt that their disclosure was not determined by their sexual preference or position (i.e., insertive versus receptive intercourse).

You're also giving me another flavor that when you're giving oral sex as opposed to receiving it, then why would you need to share with someone about your HIV-positive. I mean... well, yes in the sense that it's been both... the times that I've been giving oral sex, I would say that probably half of the time I disclose and the other half of the time I don't disclose because... I... As long as I feel like I'm not giving them at risk, then... I don't necessarily feel that I need to disclose.

[Participant 5]

In regards to oral sex, I typically do not disclose my status (uhm). If it's someone who I have been talking for a while and then we engage in oral sex, and then ... (yeah) maybe ... but if it's anonymous casual oral sex, then I typically don't. In regards to (like) penetration, when I'm a top or a bottom, then I usually do. Uhm, in the past there has been instances where I did not [Laughing] ... when I use condoms so I do not disclose. [Participant 7]

Figure 8 below illustrates partner's level of risk for contracting HIV.

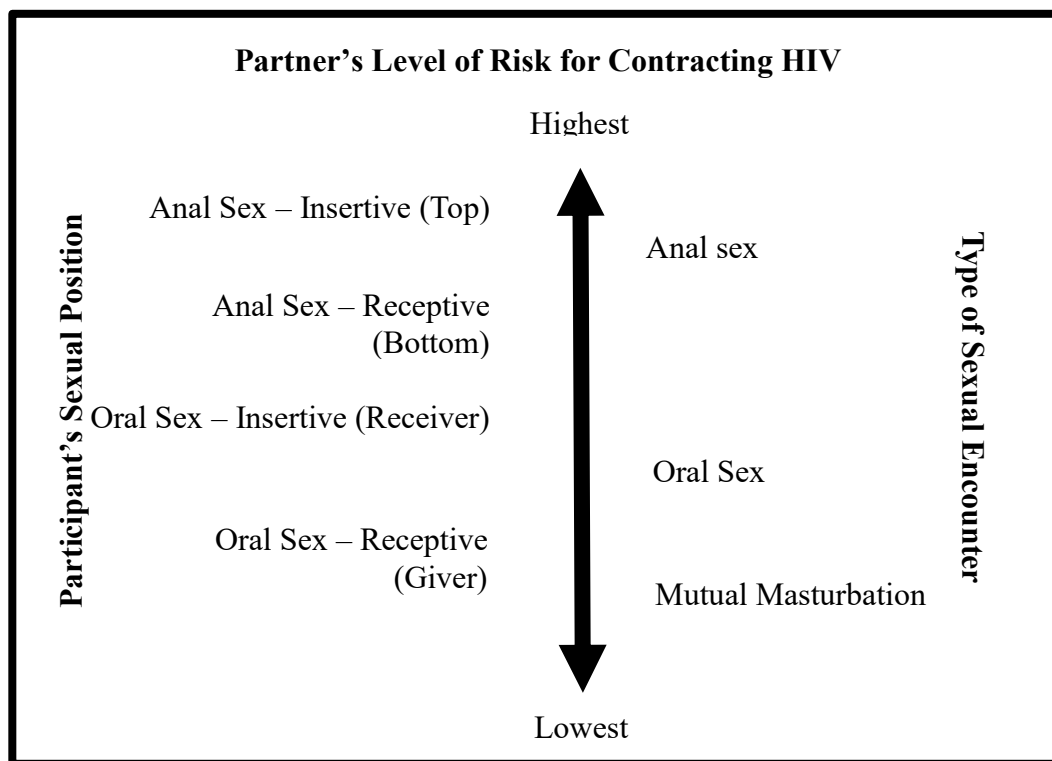


Figure 8. Partner's level of risk for contracting HIV.

Another important influencing factor was whether participants had a chance at turning a sexual encounter into a more lasting or long-term relationship. Regardless of position or type of sex, participants felt that the need to disclose their status as the encounter moved out of casual into a relationship with their sexual partner. If participants felt that there might be an intimate connection from the casual sexual encounter, then they were more inclined to disclose their HIV-positive status. On the other hand, if participants felt that the sexual encounter was only a one-night affair (i.e., casual), then they would be less inclined to disclose their HIV-positive status.

If there's a possibility for a relationship like... I feel like there's more at stake because I guess my hopes are up... maybe I'm a little bit more invested whereas

somebody who's casual, they would say 'no'... well OK, I can shrug that one off.

But, yeah, if it's somebody who I actually like... that I want to get to know better... interested in, then if there's rejection, then it's harder to deal with. So, that's why I say that it's a little more difficult in terms of that disclosure (uhm). I find it to be it's more pressure. Yeah. [Participant 5]

When participants were asked whether they felt that they should disclose their HIV-positive status to casual sexual partners when engaging in any sexual activities, the overwhelming response was yes. This attitude mirrored the responses to theme 1 above and was shaped by the various influences on disclosure discussed below in research question 2 findings. Generally, nearly all of the participants felt that they should disclose their status to casual sexual partners when engaging in mutual masturbation, oral sex, and anal sex. Participants felt that it was their responsibility to disclose citing that it was the right thing to do ethically and morally. A number of participants also felt that in addition to doing the right thing, they were also legally obligated to disclose their status.

Yes. I do feel that disclosure is important because... when I was negative... like... I would have wanted people to let me know regardless whether it was a casual thing or a non-casual sexual thing. Now... having been... on this side of things where I am positive, I understand that there are more... there are more considerations... and (uhm)... because sometimes (like, like) for something so casual where... and the other person is not at risk of getting it... one can make the argument that why do they need to know? I mean, before... and still today... it's sensitive information

about someone health status... uhm... so that person is being put in (uhm) a more vulnerable position, then (I guess) the other non-positive person is also in a vulnerable position as well. [Participant 5]

However, one participant had a different opinion. This participant felt that the responsibility of disclosure should not solely rest upon him because the sexual partner also had the responsibility to inquire about a person's HIV-positive status before engaging in any sexual behavior. While disclosure was necessary and important, most participants also felt that disclosure might not happen particularly when engaging in only mutual masturbation or oral sex. Most participants felt that the availability of online dating websites or apps has facilitated disclosure stating that technology is a great equalizer in terms of disclosure as it is fast, reliable, and democratic way of finding out about a sexual partner's HIV-positive status.

When participants were asked whether their HIV-positive status disclosure experience has changed over time, the answer was largely yes. Even though participants shared that disclosure has gotten easier over time, no one seemed to effectively articulate the reason why this was so. There has been a culmination of many factors that have made disclosure and living with HIV easier and more tolerable over the years after the initial diagnosis. As discussed previously, technology has made it easier for participants to disclose their HIV-positive status to casual sexual partners. Online gay dating websites and apps such as Grindr and Adam4Adam have provided options for participants to disclose anonymous without having to disclose in person. Potential casual sexual partners can now

view participants' online profiles that explicitly state their HIV-positive status. These potential casual sexual partners may choose to initiate or respond to online conversations via messaging or chat from those who have indicated that they are HIV-positive. The use of technology has made it easier and more convenient for participants to disclose their status.

Time as an important healer was also cited as one of the reasons that participants now feel more at ease about disclosure of their HIV-positive status. The majority of participants stated that when they were initially diagnosed with HIV or AIDS, they felt panic, horror, and were convinced that they were going to die soon after. Many initially chose not to disclose their status to family and friends. Yet, this changed for most with time. It is important to note that one participant did not feel that his disclosure experience has gotten easier over time. This participant shared that he had two unpleasant disclosure experiences in the past that continue to haunt him to this day. He felt that the stigma attached to having the HIV/AIDS diagnosis continues to persist and pervasive enough that has debilitated his ability to disclose his HIV-positive status to others despite the passing of time. Figure 9 illustrates participants' experiences with HIV for the first three years and four years and longer.

First 3 years	4 years & longer
<ul style="list-style-type: none"> • In denial of the situation • Feeling of isolation and shock • Loss of hope and depression • Diminished urge to engage in sexual activities 	<ul style="list-style-type: none"> • Acceptance of the situation • HIV education • Support group participation • Access to better healthcare

Figure 9. Participants' experiences with HIV and time since diagnosis.

A number of participants shared that their ability to disclose their HIV-positive status has been made easier over time mainly because they have left their home country and immigrated to the United States. Almost half of the participants interviewed stated that their HIV-positive status was not look upon favorably when they were living in their home countries. These Asian cultures did not accept their gay identity and HIV-positive status. These participants noticed a dramatic difference when they moved to the United States and found their new home to have a more open, understanding, and supportive society, which made the process of disclosure easier for them.

As participants obtained more information through support groups, took advantage of advanced medical treatment, and began to lead a normal life, they were able to disclose their status to others over time. Participants cited that acceptance of self and their current health situation helped to facilitate disclosure of their HIV-positive status when the need arises. The less people fight with themselves and drown themselves in negative thoughts and feelings, the more likely those participants are honest and open to others. In a sense, it is about being both pragmatic and kind to oneself. Figure 10 depicts the participants' opinions of living with HIV in their home country versus in the United States.

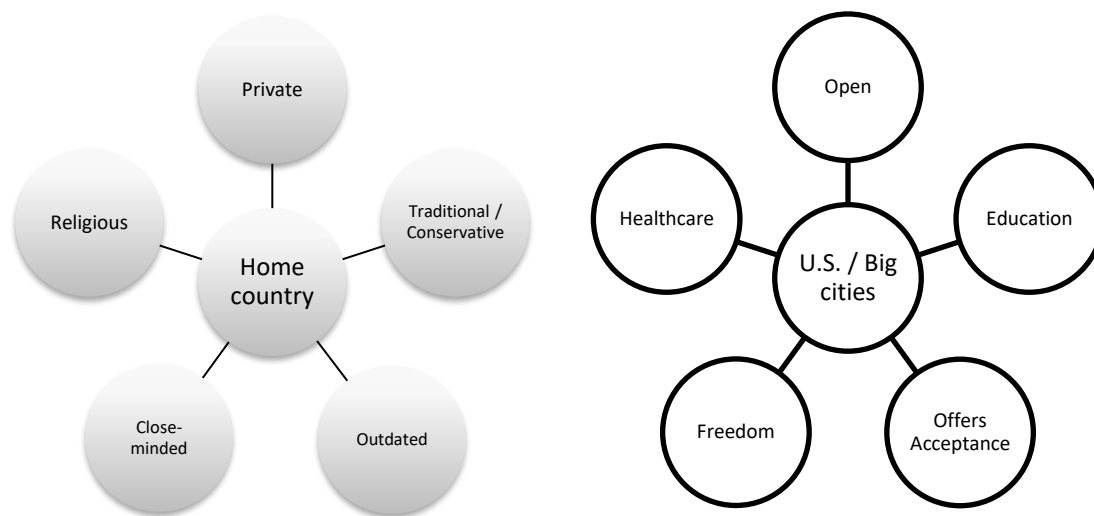


Figure 10. Participants' opinions of living with HIV in their home country and the United States.

Participants also acknowledged that they could live a long and reasonably normal life with advanced medical treatment and the availability of support groups. Disclosure of their HIV-positive status has gotten easier over time, especially with their viral load being undetectable and realizing that there is now a much lower risk of transmitting the virus to others. Since diagnosis, participants have taken an active role to learn more about HIV/AIDS, modes of transmission, treatment options, which all lead to less hysteria about the now chronic condition. Participants realized that they no longer should live in fear and be shunned, secluded, or excluded from the general population as previously thought.

Yeah, it does (you know) because every time I think about it (uhm) I feel like, oh my gosh, I shouldn't do that because that (disclose) fear has haunted you. I guess. It's haunting. OK (uhm) some people would not accept you in the community... even in the workplace environment (you know) if you disclose your status and they might

not (you know) hire you. And, here it's a fear... living with this fear that has been with me for decades and I just have to overcome it every day. It's another step, it's another layer I have to like overcome before like telling people (you know).

[Participant 7]

I'm from China (uhm) Chinese and... What's more, I'm from a very, very strict ... very traditional family. So, uhm, it's part of the reason why I chose to leave my hometown behind and come to this country alone. Uhm, I kinda like try to escape from the cultural environment... you know, my background. And, what's more (uhm)... when I was in Chinese... so... I feel like... my perspective... my point of view towards all those things are kind of different from the mainstream in China. So, I feel like (uhm) more free, less depressed in America. [Participant 6]

Theme 2: Influences on Disclosure

Participants were asked whether level of education and socioeconomic class might positively or negatively influence their willingness to disclose their HIV-positive status to casual sexual partners. While level of education and socioeconomic class were considered as important factors for disclosure, other factors were also brought into consideration. Five of the eight participants mentioned that they felt that level of education would play an important role in disclosing their HIV-positive status to their casual sexual partners. In general, education about HIV/AIDS and modes of transmission in particular made disclosure easier for the participants. Two participants emphasized the importance of education level of the casual sexual partner. In contrast, one participant who emigrated from

Thailand that more educated people might have more stigma of HIV/AIDS while less educated people might be more accepting of the diagnosis.

I would say that it is more likely to be discussed when there is a higher level of education or they're coming from a socioeconomic class that is a little bit more stable. I don't know if that's the right word. Uhm, but I feel like that they are more likely to disclose because there is more education in terms of like how things are transmitted, how it... what's risky, what's not risky... Uhm, so, when there isn't that level of education I feel like people (uhm)... they don't know how... or they're not aware of how things are transmitted and (uhm)... so maybe there is less likely to engage if there's more fear when there's less education. [Participant 2]

When participants were asked about how important they felt a person's socioeconomic background might influence their ability to disclose their HIV-positive status, the verdict was mixed. Three participants felt that socioeconomic background does play a role in influencing their decision to disclose. Two out of the three participants felt that people who came from higher or more stable socioeconomic backgrounds would be more willing to discuss and understand information about HIV-positive. One participants (from Thailand) felt that in Thailand the opposite would be the case, as people from lower socioeconomic backgrounds would be more likely to accept his HIV-positive diagnosis.

Finally, one of the participants felt that neither level of education nor socioeconomic class had any influence on disclosure of HIV-positive status. Instead, he felt that disclosure was more related to one's moral. That is, people should disclose their HIV-positive status

because it was morally right and that need not be dependent on level of education or socioeconomic class.

When participants were asked whether they closely identify with their own and other Asian groups in America or with the White mainstream groups, most responded that they identify with their own and other Asian groups. Participants felt more connected with their own ethnic groups than the White mainstream groups, especially when they get older. Two participants did share that they are more connected with the White mainstream groups rather than their own ethnic groups. Interestingly, those who more closely identify themselves with their own and other Asian groups felt that it was easier to communicate with their ethnic peers because of the ease of communication, stating that Asians tend to talk in more subtle and polite manners while their White mainstream groups tend to be more direct, to the point, and even at times were considered brash.

When participants were asked to describe how their cultural background or values might influence or affect their experiences relating to HIV-positive disclosure to casual sexual partners, the responses included a colorful mix. This highlighted the diverse range of people who were interviewed and the heterogeneous cultural background and values of the API group.

Three of the eight participants interviewed felt that they were raised in conservative and religious households back home. They felt that their upbringing warranted careful discussion of their gay identity, especially with their HIV-positive status. They also felt that there was a lack of information about HIV/AIDS and a lack of tolerance toward the gay community. These three participants were emigrated from China, Philippines, and Thailand.

Coincidentally, all three participants grew up in Christian and Roman Catholic families and described their families as strict and religious. All three faced a tough time in terms of coming out due to the way their culture or society views the LGBT community in their homeland country. Furthermore, they felt that there was misinformation about HIV/AIDS in their country and lack of proper medical treatment options available for those who are diagnosed with HIV.

When I first got diagnosed, I was raised Roman Catholic in the Philippines and things like that (you know). And growing up in the 1990s, during that times there was a lot of news (you know) regarding what's happening here in the United States and other countries. I was a kid when they had a travel ban in Africa all about AIDS and things like that. In my head, it was inculcated that if you have this disease, you're dead. And I got diagnosed when I was like 27. So, I was pretty old and should have been smarter than this (you know) but when I got diagnosed I really legitimately thought that I was going to die. [Participant 1]

OK, I was brought up in a pretty religious household... uhm... Protestant Christian background... and uhm... I would say that... uhm... because of that I feel that responsibility to be honest and open and that has... that has really... Pretty, I mean... it's kinda of like the core of who I am. It affects I should say and decisions come from that (but uhm). So, so I... That's where I feel I guess a responsibility to disclose and because I just... I would want that respect so that I would give that respect. [Participant 2]

The other five participants felt that their culture and family values did not really influence them or their experience with HIV-positive disclosure. These participants emigrated from China, Indonesia, Pakistan, and Vietnam. In fact, these five participants felt that their culture helped them to be open, honest, and hardworking, which helped facilitate the process of HIV-positive disclosure to their casual sexual partners. Two participants felt that being an Asian American or assimilating to White mainstream values helped to facilitate the process of disclosure. One of the participants felt that he was following the 12 steps of the Crystal Meth Anonymous (CMA) program and that has allowed him to be open and honest in order to avoid hurting others.

Participants were asked if there were any other factors that might influence their disclosure of their HIV-positive status to casual sexual partners. A number of notable factors emerged providing insight to the complexity of the disclosure phenomenon. Many described a more accepting attitude towards people who are HIV-positive. One participant stated that when he personally disclosed his HIV-positive status to gay men, they were generally accepting and were willing to have sexual intercourse. However, if the same information were provided to straight or bisexual men, then they would not really be willing to have a sexual relationship with him. The same participant also felt that if women were disclosed the same piece of information, then they would generally be more distressed. This participant identified himself as bisexual, which allowed him to compare experiences when disclosing to gay men and straight women.

So, my attitudes toward it is that there should be a more open conversation, definitely. I think there's definitely fear. Being on both sides of the fence, there's

fear of rejection, fear of disappointment. So, people tend to not discuss it openly.

[Participant 1]

“I’ve had friends who have encountered rejections because of their status.”

[Participant 2]

I had a negative experience [Laughing] where we hung out that day and then he came back to my place and then (uhm) he wanted to have sex and (uhm)... I had a lot of things running in my mind because I haven’t disclosed my status so it’s obviously... I usually don’t just say when I first meet someone and then... well, there’s something that I have to tell you and promise that you won’t get upset and then I told him that I was positive. Uhm, his reaction was really nice and that he said, thanks for telling me... however, he lost his erection [Laughing] so I kind of knew that [Laughing] that it was a negative experience in his mind... We continued to mess around but after that (like)... coming out to him was a very emotional process so I kind of lost interest in doing anything and so we never even saw each other after that... actually he blocked me on social media. [Participant 7]

Geographical area was another factor that may facilitate or hinder participants’ willingness to disclose their HIV-positive status. All of the participants stated that it was more difficult for them to disclose their status in their home countries (i.e., China, Philippines, Thailand, Indonesia, Pakistan, and Vietnam). In the United States, disclosure might be easier or harder depending on the geographical areas. For example, people living

in metropolitan cities tend to be more accepting of HIV-positive disclosure compared to rural areas. From experience, participants shared that disclosure was more difficult in rural or Southern states (e.g., Georgia, Tennessee, and Oklahoma) compared to the bicoastal cities such as Los Angeles and New York City.

Age was another factor influencing HIV-positive status disclosure. Older adult participants had been dealing with HIV for longer years. Casual sexual encounters did not happen as often, mainly because the priority shifts to looking for a long-term partner. When a partner was considered for a long-term relationship, disclosure was handled in a more delicate manner. Physical attraction also played a role. Participants became more conscious about their image. Disclosure becomes more difficult. One participant stated that people born in the 1990s and onwards were less likely to be afraid of HIV/AIDS and were less likely to attach stigma to it – probably because they were not around or aware of the hysteria surrounding the AIDS epidemic during its initial days of emergence in the media. Two participants also stated that older gay men tend not to frequent bars or clubs as much as younger gay men. Older gay men also tend to search for more meaningful and long-term relationships over casual sexual encounters. Therefore, participants who are older than their counterparts were more likely to disclose their HIV-positive status. Young adult participants, on the other hand, were in the experimentation stage. After being in isolation and recently learning more about HIV and support groups, they viewed their situation in a more hopeful light. They handled disclosure in a braver way compared to older adults: disclosing upfront in their online profile or before sex, paying less attention to fear of

rejection. Rejection was still a sensitive topic but it was handled carefully. Though young adult participants also seek for long-term relationships, it was not so much of a priority.

It used to be easier but now it's a lot harder. Makes sense? I feel like five years ago it was easier for me, here you go, this is my status, are you cool with that? What's your status? Because I didn't really care about my image that much ... but now the last time I went back on Grindr, for example, so yeah. I don't know. I kinda care about my image ... a lot more ... So it was so difficult to tell people." "I think it's more about me. Yeah. So. I think the older you are ... the older you are, you tend to have more fear [Laughing] I mean that's just me. [Participant 2]

Participants also shared other factors that might influence their decision to disclose their HIV-positive status. For example, one participant stated that if he thought his casual sexual partner was attractive, then he would be less likely to disclose in fear that this partner may not want to engage in a sexual encounter. Another participant also felt that he would be more likely to disclose his status if he felt physically or emotionally safe (i.e., sense of security) in anticipation of fear of rejection. Finally, one participant also stated with some humor that the size of his casual sexual partner's anatomy (i.e., penis size) might also play a factor in his willingness to disclose. That is, if his sexual partner's penis size was above average, then he would likely not want to disclose his HIV-positive disclosure status in fear of missing the opportunity to engage in this desirable casual sexual encounter.

Thematic Map

Step 6 of Colaizzi's method is intended to describe the "fundamental structure" of the "essence" of the lived experience through a higher level of representation of data (Shosha, 2012). This is accomplished through a thematic map (see Figure 11 below) depicted in a Venn diagram, which illustrates the interconnection between a person's emotional well-being, physical encounters, and social connections. These three main categories with their associated factors discussed above highlighted the complexities that participants experienced when disclosing their HIV-positive status to casual sexual partners. Groupings of similar topics were combined to summarize the various topics captured from the qualitative interviews into three distinct categories of emotional well-being, physical encounters, and social connection. Specifically, acceptance versus rejection, sexual experiences, moral standpoint, and age factors were grouped into the emotional well-being category. Methods of disclosure, types of sexual encounter, sexual positions, and partner's level of risk for contracting HIV were grouped into physical encounters category. Finally, levels of connection and casual versus long-term relationship were grouped into the social connections category.

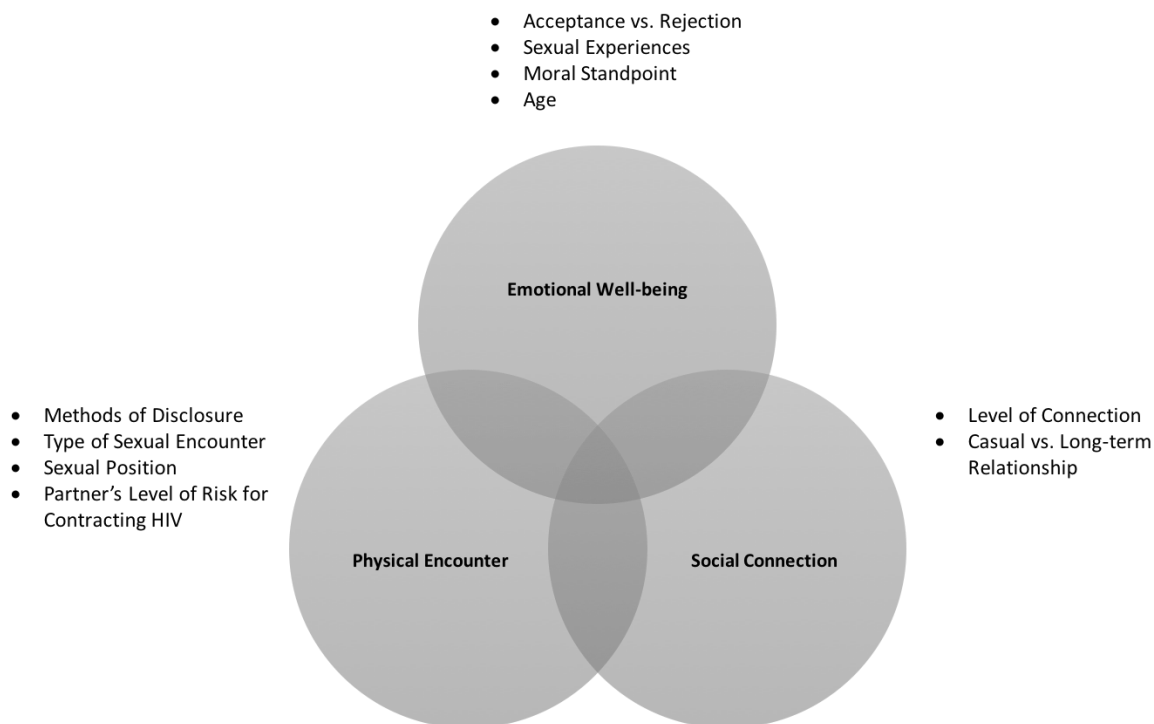


Figure 11. Thematic map of HIV-positive disclosure behaviors, attitudes, and intentions.

As discussed above, step 7 of Colaizzi's seven-step method of descriptive phenomenological data analysis was eliminated to preserve the anonymity and to protect the confidentiality of the research participants.

Triangulation Matrix

After separately analyzing all types of data, a joint integrative analysis of all data sources was conducted using the triangulation process. Triangulation is a powerful technique that facilitates validation of data through cross comparison of multiple sources. In particular, it refers to the application and combination of several research methodologies in the study of the same phenomenon (Erlandson, Harris, Skipper, & Allen, 1993; Lincoln & Guba, 1985). Using matrix analysis techniques (Miles, Huberman, & Saldaña, 2014), it was

possible to systematically compare the quantitative output and qualitative insights. The comparative matrix depicts the convergence of findings that support and add trustworthiness to the interpretations. Matrix coding as described in Miles, Huberman, and Saldaña (2014) was used to conduct triangulation.

Because the participants in the qualitative study were not a subset of the quantitative study, considerations must be taken when triangulating data. According to Flick (2007), “triangulation of both approaches stresses the mutual validation of results and not so much the mutual addition of knowledge potentials” (p. 3). Stated differently, the findings from quantitative and qualitative data will be different because of the nature of the data obtained from two different samples. However, findings from both approaches can be combined as “complementary” rather than “confirmatory” research strategies (Flick, 2007). Furthermore, Schwandt (2014) argued that the strategy of triangulation is often wedded to the assumption that data from different sources or methods should converge on or be aggregated to reveal the truth.

Summary of Quantitative Findings

Acculturation to host society’s European American culture and vertical collectivism are significantly positively associated with HIV-positive disclosure attitudes and intentions, while higher power distance, on the contrary, is associated with lower HIV-positive disclosure attitudes and intentions scores. Uncertainty avoidance and long-term orientation are significantly positively associated with HIV-positive disclosure attitudes only.

Integrating Quantitative and Qualitative Methods

For the follow-up qualitative portion of the study, the central research question was: *What factors influenced the HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners in API MSM?* Finally, the overarching research question for the mixed methods study was: *To what extent did the qualitative data help to explain, build, or connect upon initial quantitative results?* Integration of qualitative findings with the quantitative is shown in Table 23 (see pages 203-209) below. The bullet points in the left “Quantitative Finding” column is an excerpt of statements from the various instruments. In the left column, the translation of these statements is then extrapolated into the various qualitative themes. For example, the statement “Winning is everything” counts is in the vertical-individualism dimension from the Culture Orientation Scale. If the quantitative statement representing “winning” is translated into winning as a chance of a long-term relationship rather than just for a casual sexual encounter, then the corresponding two quotations are reflected in the “Qualitative Voice” right column.

Table 23

Triangulation Matrix

Quantitative Finding	Qualitative Voice
<p>Vertical Individualism significantly influences disclosure attitudes and behaviors:</p> <ul style="list-style-type: none"> • Winning is everything. • Competition is the law of nature. • When another person does better than I do, I get tense and aroused. • It is important to me that I do my job better than others. 	<p>Translating winning as a chance of a long-term relationship rather than just for a casual sexual encounter:</p> <p style="padding-left: 40px;">So, I feel like they have the right to know so my style is that I would tell them (uhm) right away. Well, if it's just a hookup – like a quick hookup – so, I don't think about that so much. Ahh, but if it's someone who we might have a shot at getting to know each other, so I would wait until after the third date, then I would say, 'hey, what's going on, I am HIV-positive' before engaging in sexual encounters. [Participant 2]</p> <p style="padding-left: 40px;">I do find that it is easier to disclose to somebody who is a casual sexual partner versus to somebody who has a possibility of a relationship. I find that to be hardest. [Participant 5]</p>

Table 23 Continued

Quantitative Finding	Qualitative Voice
<p>Power Distance significantly and inversely associated with disclosure attitudes and behaviors – the lower the power distance, the higher is disclosure:</p> <ul style="list-style-type: none"> • People in higher positions should make most decisions without consulting people in lower positions. • People in higher positions should not ask the opinions of people in lower positions too frequently. • People in higher positions should avoid social interaction with people in lower positions. • People in lower positions should not disagree with decisions by people in higher positions. • People in higher positions should not delegate important tasks to people in lower positions. 	<ol style="list-style-type: none"> 1. Missing or discrepant data found in the absence of mention about jobs/career, which are sources of status, power, and authority in United States. 2. Pattern of honesty and belief that potential partner (regardless of socioeconomic class) should be made aware of their HIV-positive status. <p>If I go to a bar, I meet somebody and we're going to go home, we're going to have sex, I'd probably disclose to him before we even have sex or even before we get home ... if the intent is to have sex. [Participant 4]</p> <p>Yes. I do feel that disclosure is important because ... when I was negative ... like ... I would have wanted people to let me know regardless whether it was a casual thing or a non-casual sexual thing. Now... having been ... on this side of things where I am positive, I understand that there are more ... there are more considerations ... and (uhm) ... because sometimes (like, like) ... for something so casual where ... and the other person is not at risk of getting it ... one can make the argument that why do they need to know? I mean, before ... and still today ... it's sensitive information about someone health status ... uhm ... so that person is being put in (uhm) a more vulnerable position, then (I guess) the other non-positive person is also in a vulnerable position as well. [Participant 5]</p> <p>"I choose to disclose it ... and let the other person know that he has his right to choose." [Participant 6]</p> <p>No. If you're just involving in mutual masturbation ... no, you don't need to disclose your status. Oral sex ... yeah... you should ... Uhm, I made the mistake of not telling that one guy ... thank God he didn't catch anything ... (uhm) ... Yeah, uhm, and if you're going all the way, most definitely. Uhm, you should absolutely ... absolutely because (you know) ... not only ... not only is it like ethically or morally wrong ... it's just (uhm) ... or legally or ... or it's also legally wrong because (uhm) ... (you know). If you do... if you decide to practice unprotected sex ... (uhm), then you should definitely (you know) ... let your partner know whether it's casual or (you know) long-term. [Participant 8]</p>

Table 23 Continued

Quantitative Finding	Qualitative Voice
<p>Uncertainty Avoidance significantly positively associated with HIV-positive disclosure attitudes:</p> <ul style="list-style-type: none"> • It is important to have instructions spelled out in detail so that I always know what I'm expected to do. • It is important to closely follow instructions and procedures. • Rules and regulations are important because they inform me of what is expected of me. • Standardized work procedures are helpful. • Instructions for operations are important. 	<p>1. Translating uncertainty avoidance as fears ...</p> <ul style="list-style-type: none"> • of rejection: <p>So, my attitudes toward it is that there should be a more open conversation, definitely. I think there's definitely fear. Being on both sides of the fence, there's fear of rejection, fear of disappointment. So people tend to not discuss it openly. So that, I understand. I feel that people should have a better way of being able to communicate and that's why I'm always for these social media apps because it helps you disclose without having to engage in that type of conversation. Uhh, it also allows you to have ... it gives you options and it gives you freedom (you know) for you to be able to say openly without having to bring it up in a more spontaneous encounter. [Participant 8]</p> • Of being sued or blamed: <p>I definitely do believe that we need to disclose because even though you're undetectable, there's still a little small chance of transmitting the disease. I've always been telling people ... telling my sexual partners about status because I really believe people should know. Ugh. Also, because I'm scared of I do like transmit to them, I'm scared of the legal lawsuit like that. [Participant 3]</p> <p>I would always tell them just to ... just to make sure they won't ask me about my status afterward and then I tell them that I'm HIV-positive and they would be too panicked and then like blame me and (you know) like do crazy things. So, just to be safe, I would tell them. [Participant 6]</p> <p>2. Translating uncertainty avoidance as importance of education:</p> <p>I feel like we should educate (you know) like people (you know) about HIV more and how it's transmitted and all of that so that they have a good understanding because you want to feel like accepted. [Participant 2]</p> <p>I would educate them ... I would tell them that so my current status is HIV-positive but undetectable. I'm taking the medication and everything's under control ... undetectable ... The virus copy is like lower than 20 something... Basically, (like) that's almost impossible to transmit it ... to pass it on to other people especially when I bottom. [Participant 6]</p>

Table 23 Continued

Quantitative Finding	Qualitative Voice
	<p data-bbox="724 348 1382 449">3. Everyone should disclose – a standard of disclosure should be adopted (except perhaps if masturbation only):</p> <p data-bbox="724 480 1403 695">I feel like everybody should (you know) tell (you know) their partners about it but ... I totally get it because I tried on my own and I had good experiences and that experiences ... so, it's not an easy situation ... makes you feel uncomfortable but I think everybody should. [Participant 2]</p> <p data-bbox="724 726 1406 1121">I think we all have the responsibility to disclose it because it is a disease and you don't want to just give it to somebody else. Uhm, you know ... I think that's just being responsible. Uhm, I think we all have the responsibility to disclose it. I think everybody should have responsibility to disclose it online, on their profile of their status (uhm) to start with (uhm) ... then if it didn't happen ... then ... uhm ... uhm ... what do you call that? Naturally when you go to the bar, then we all should disclose it in person if it's not through online. [Participant 4]</p> <p data-bbox="724 1152 1373 1293">I feel that they should disclose their status to all sexual partners but they don't have to in regards to mutual masturbation ... because it's just masturbation. [Participant 7]</p> <p data-bbox="724 1356 1406 1570">No. If you're just involving in mutual masturbation ... no, you don't need to disclose your status. Oral sex ... yeah... you should..., and if you're going all the way, most definitely. ... not only is it like ethically or morally wrong ... it's also legally wrong. [Participant 8]</p>

Table 23 Continued

Quantitative Finding	Qualitative Voice
<p>Long-term Orientation significantly positively associated with HIV-positive disclosure attitudes:</p> <ul style="list-style-type: none"> • Careful management of money (Thrift) • Going on resolutely in spite of opposition (Persistence) • Personal steadiness and stability • Long-term planning • Giving up today's fun for success in the future • Working hard for success in the future. 	<p>All are immigrants, which is key evidence.</p> <p><u>Participant 2:</u></p> <p>You know, when you disclose to someone, they would just like (you know), that's it, you're done with your gay scene, your gay life (you know). Uhm, yeah. And, I feel like that affect me a lot so that I have to overcome. Uhm, a lot (you know). But people are different. People are different (you know) like you said (you know) from my country and from America. So, at least people know more. They're more educated about this topic. So.</p> <p><u>Researcher:</u> "And which country is this?"</p> <p><u>Participant 2:</u> "Thailand."</p> <p><u>Researcher:</u> So, in Thailand, people are not as educated or shun you if you were to disclose your status and that carries through because you're still part of that Thai culture. Does it affect you in any way even though you are living the States now?</p> <p><u>Participant 2:</u> Yeah, it does (you know) because every time I think about it (uhm) I feel like, oh my gosh, I shouldn't do that because that fear has haunted you. I guess. It's haunting. OK (uhm) some people would not accept you in the community ... even in the workplace environment (you know) if you disclose your status and they might not (you know) hire you. And, here it's a fear ... living with this fear that has been with me for decades and I just have to overcome it every day. It's another step, it's another layer I have to like overcome before like telling people (you know).</p>

Table 23 Continued

Quantitative Finding	Qualitative Voice
<p>AAMAS-CO inversely associated with disclosure behavior (not significant) – the lower the identity to API culture, the higher the disclosure behaviors.</p>	<p>1. Context: All emigrated from a country where they were a persecuted minority to a U.S. city (i.e., Los Angeles) where less of a minority and less persecuted because of sexual orientation.</p> <p>I think my own previous experience of growing up in the Philippines has eroded and I've come to learn that this disclosure ... I should not be afraid of it ... afraid of disclosure ... for one thing ... it's not as much a big deal as it was for me (you know) and for other people who I have encountered. So, I think ... (you know) the Philippines is very conservative and I'm not too tight with that culture so therefore I'm (you know) I'm less conservative than your normal Filipino ... (you know) expected disclosure habits. [Participant 1]</p> <p>2. Ambivalence:</p> <p>That's a tough question. I don't identify with neither, which is really weird. I feel like (you know) I'm a well-rounded citizen so I identify with every group but if I have to choose in comparison, then I would identify with my people more because of cultures. I think (you know). [Participant 2]</p> <p>I would say growing up and up until maybe about 10 years or so ... I would say I identify with more White mainstream groups. And within the last 10 years, I definitely much more identify with my own ethnic background and other Asian groups. [Participant 5]</p> <p>Now that I'm growing older, I identify more with Asian groups in America. And (uhm), the fact that there are Asian Americans who are positive and those groups exist in California has helped me to bond and accept myself as an Asian American male who is positive, which is different than another mainstream whether it would be White, Latino, or African American who may be positive. [Participant 7]</p>

Table 23 Continued

Quantitative Finding	Qualitative Voice
<p>Time: A negative association between disclosure behavior and the length of time that has passed since testing positive for HIV</p>	<p>I'm sure attitudes have shifted and it has been an easier conversation. There has been partners who I have encountered where they asked me ... and almost in the heat of the moment they asked me and I told them the truth and they said, 'fine, I'm on PrEP so let's do it'. They say things like that. Those conversations don't or won't happen like 10 years ago. Right, if you think about it. Right? So, uhmm, there's definitely been improvements. There's definitely still stigma there ... I'm sure ... I've had friends who have encountered rejections because of their status. So, uhmm, we have work to do but it's gotten better. [Participant 1]</p> <p>I kept it for like eight years until I moved to L.A. (you know) ... I think we have ... We're so lucky that we have like so many good doctors, so many good healthcare (you know) in L.A. So, that kinda opened up my doors so, so. And, then, yeah, yeah. I feel like it gets easier and easier (you know) over time. [Participant 2]</p> <p>I think I'm getting to come to a point where I'm more comfortable with it ... where I don't actually care if anybody knows ... who knows ... but I'm not at that point yet. [Participant 5]</p>

The data revealed a host of influences that promoted or hindered disclosure of HIV-positive status (see Table 23). Another way to augment and connect the results of the quantitative study and the findings from the qualitative study is by integrating the results of the quantitative and qualitative methods. Baron and Kenny (1986) distinguished between the properties of moderator and mediator variables in a way that helps to clarify the different ways in which conceptual variables may account for differences in people's

behavior. According to Baron and Kenny (1986), a moderator may increase the strength of a relationship (i.e., promote), decrease the strength of a relationship (i.e., hinder), or change the direction of a relationship. A mediator explains how or why a particular relationship occurs (Baron & Kenny, 1986). This background context forms the substrate upon which the two fundamental structures rest.

Depicted in Table 24, the expression of disclosure attitudes and behaviors is grounded in the individual, sociocultural, and economic context, which forms the conditions that created the quantitative long-term orientation results. Considering that all interviewees were immigrants with undetectable HIV-positive status, these conditions indicate a level of economic mobility and capacity that enabled travel to live in another country and access to healthcare with advanced medical treatment to effectively manage the progression and expression of HIV. Additionally, the cultural mores and family values (faith, morals) of home were not abandoned with migration to a more progressive, open society.

Table 24

Triangulation of Quantitative and Qualitative Findings

HIV-Positive Disclosure		
Fundamental Structures	Moderators	Mediators
Personal	<ul style="list-style-type: none"> • Higher education level • Age • Vertical Individualism • Uncertainty Avoidance 	<ul style="list-style-type: none"> • Ethnic identity / AAMAS-CO • Natal versus adopted culture • Shift from casual to relationship • Power distance
Progress	Time <ul style="list-style-type: none"> • Acceptance • Healthcare with advanced medical treatment 	Technology <ul style="list-style-type: none"> • Social media • Apps

Individual, Sociocultural, and Economic Context / Long-Term Orientation

The two structures of personal and progress (see Table 24) consist of characteristics that act as moderators (hinder or promote disclosure) or mediators (factors that explain the relationship between structure and disclosure) to disclosure. Personal differs from the individual substrate in these actions and that the characteristics are mutable and change with circumstance. For the personal structure, higher education level, age (i.e., being younger), vertical individualism, and uncertainty avoidance were found to promote HIV-positive disclosure. For the progress structure, time since diagnosed with HIV/AIDS helps facilitate acceptance towards HIV/AIDS and access to healthcare with advanced medical treatment, which were also promoters of HIV-positive disclosure. While ethnic identity, natal versus adopted culture, shift from casual sex to long-term relationship, and power distance were

found to be mediators of the personal structure. Finally, technology including social media and apps were mediators of HIV-positive disclosure of the progress structure. Applying the properties of moderator and mediator variables help to augment and connect the results of the quantitative and qualitative studies and allow for a deeper, richer, and better understanding and explanation of those results than either approach alone.

Summary and Transition

This chapter began with a review of the research questions for the quantitative phase of the study, the central research question for the qualitative phase of the study, and the overarching research question for this two-phase, mixed methods sequential explanatory study. The results of the quantitative study were presented in the first half of chapter 4, which includes the recruitment and response rate, data collation, descriptive statistics, statistical assumptions, quantitative instrumentation measure scores, tests for assumptions, and hypothesis testing results. The results of the qualitative study were presented in the second half of chapter 4, which includes the recruitment and response, qualitative data management, results of qualitative inquiry, and triangulation matrix.

Twenty-four participants completed the online survey of the quantitative study. Despite the small sample in this study, there was representation from the nine API racial groups as defined by the United States Census Bureau (2011). There were no missing data as all 24 participants completed all of the questions in the online survey regarding their demographic information and responses from the four surveys (i.e., Culture Orientation Scale, Individual Cultural Values Scale, Asian American Multidimensional Acculturation Scale, and HIV-Positive Disclosure Scale). The descriptive statistics for the sample group

were compared with the statistics from the U.S. Census Bureau (2016a). The educational attainment and income information for the 24 API MSM were consistent with the latest U.S. Census Bureau (2016a) data.

Statistic assumptions and summary statistics for all scale variables and z-standardized variables involved in the analysis were presented. The descriptive statistics and Cronbach's alpha for all quantitative instruments were provided. A discussion of testing for normality assumptions followed and included a rationale for the use of a normal probability plot over a histogram. Specifically, the P-P plot was used over the Q-Q plot because the former was better at finding deviations from normality in the center of the distribution, while the latter was better at finding deviations in the tails (Grace-Martin, 2016).

Linear multiple regression analyses were conducted for the three research questions in the quantitative phase of the study. None of the regressions produced significant findings at the requested significance level (i.e., $p < 0.5$). However, some effects were significantly below, or close to, the ten percent level (i.e., $p < .10$). There were interesting correlations across variables despite the extremely small sample size of 24 participants. Arguably, these correlations are even more important than the linear multiple regressions because they facilitate explanations about the patterns between scales. Because of the small sample size, a stepwise regression analysis was conducted for exploratory purposes to assess which factors are predictive of HIV-positive disclosure, behaviors, attitudes, and intentions.

For the second half of chapter 4, the results of the qualitative study were presented beginning with a discussion of the recruitment and response rate. Eight API MSM participants completed the anonymous, confidential, in-depth semistructured interviews

lasting on average 39 minutes, 15 seconds for each interview. A detailed discussion of the Colaizzi's method of phenomenological data analysis then followed. The results of qualitative inquiry including the qualitative Code Book, coding structure, coding report, and cluster analysis were presented providing an indication of the commonality (and uniqueness) of subcategories and the volume of content recorded. A thematic map was provided to illustrate the interconnection between a person's emotional well-being, physical encounters, and social connections. These three main relationships with their associated themes highlighted the complexities that participants experienced when disclosing their HIV-positive status to casual sexual partners. Finally, a triangulation matrix was provided to aid in the integration of the quantitative and qualitative results. The comparative matrix depicted the convergence of findings that support and add trustworthiness to the interpretations.

Chapter 5 will provide detailed discussion of the result findings for this two-phase, mixed methods sequential explanatory study, limitations of the study, implications for social change, and recommendations for future research and action. Finally, the chapter will end with a summary and conclusions from the research project.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

This was a two-phase, mixed methods, sequential explanatory study. The first quantitative phase of the study included data collection and analysis to examine the influence of cultural factors, level of acculturation, length of time since diagnosis, age, level of education, and income relating to HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners in a sample group of 24 API MSM. In the second qualitative phase, I used open-ended, semistructured interview questions to probe significant quantitative results by exploring aspects of the HIV-positive disclosure behaviors, attitudes, and intentions with eight participants. The reason for combining both quantitative and qualitative data was to first obtain statistical, quantitative results from a sample and then follow up with qualitative research in the second phase with eight individuals to help better understand and explain those results in more depth.

People who are diagnosed with HIV/AIDS have the responsibility and burden of disclosing their HIV-positive serostatus to others (Lehman et al., 2014). Disclosure is a complex and emotionally charged burden for those who are infected with HIV (Iwelunmor et al., 2014; O'Connell et al., 2014; Tshabalala, 2014). To date, there is no known recent published study in which the racial and ethnic differences related to HIV-positive serostatus to casual sexual partners focusing on the API MSM population has been examined. Despite the need, there have not been any studies published since 2002 in which API MSM in the United States were exclusively targeted to examine the influence of cultural values, level of

acculturation, and other contributing factors on HIV-positive disclosure to casual sexual partners.

This chapter includes a summary of the study results, interpretation of the quantitative and qualitative findings, discussion of the findings, limitations of the study, implications for social change, and recommendations for future research and action.

Interpretation of the Findings

In this discussion, I will address significant as well as nonsignificant findings in light of the small sample size of 24 API MSM involved in the quantitative phase of the study in tandem with the aims of the study. I will offer interpretations of data based on the statistical and qualitative analyses that were conducted for the respective quantitative and qualitative phases of the study.

Discussion of Quantitative Data

The main objective of the quantitative phase of this study was to articulate relationships between cultural values, level of acculturation, length of time since diagnosis, age, level of education, and income that are associated with HIV-positive disclosure behaviors, attitudes, and intentions in API MSM. I selected the independent variables of cultural values, level of acculturation, length of time since diagnosis, age, level of education, and income because findings from previous studies have been mixed or inconclusive findings as discussed in the review of the literature. Moreover, it is not known whether these variables are relevant to the targeted population of API MSM.

For the quantitative hypothesis testing, I conducted linear multiple regression analyses to answer the three research questions. None of the analyses produced significant

findings at the determined significance level. As stated previously, the *a priori* significance level was set at $p < .05$. However, it was appropriate to provide regression analyses where the p value was $< .10$ as they may be of interest to future researchers suggesting that these significant associations might have been robust enough if the sample size was larger.

For RQ1, based on the results of the regression analysis, it is possible that the length of time that has passed since testing positive for HIV and annual income may be associated with HIV-positive disclosure behaviors if the sample size had been larger. Specifically, the length of time since diagnosis was negatively associated with HIV-positive disclosure behaviors when the significance level was set at $p < .10$. On the other hand, income was positively associated with HIV-positive disclosure behaviors when the significance level was set at $p < .10$. Although not significant, a notably strong effect was estimated for the average score of the AAMAS-CO variable to HIV-positive disclosure behaviors. These findings warrant further exploration using a larger sample size. For RQ2, the results of the regression analysis indicate that, with a larger sample size, vertical individualism and power distance were associated with HIV-positive disclosure attitudes. For RQ3, no significant effects were reported. However, the results of the regression analysis showed that the same two variables of vertical individualism and power distance were close to being significant with effects of similar magnitude and direction. This finding may increase the level of interest regarding further exploration of the potential impact these variables may have on both HIV-positive disclosure attitudes and intentions if a larger sample size was involved. Interestingly, the two variables of vertical individualism and power distance were associated with HIV-positive attitudes and interventions but not HIV-positive disclosure behaviors.

Further research is needed to explore whether HIV-positive disclosure attitudes and intentions may be more similar in constructs but not for actual HIV-positive disclosure behaviors.

As stated previously, there were interesting correlations across variables despite the extremely small sample size of 24 participants. Arguably, these correlations are even more important than the linear multiple regression analyses because they facilitate explanations about the patterns between scales when the correlation coefficients significance level was set at 10%. Acculturation to the host society's European American culture and vertical collectivism were significantly positively associated with HIV-positive disclosure attitudes and intentions, while higher power distance, on the contrary, was associated with lower HIV-positive disclosure attitudes and intentions scores. Uncertainty avoidance and long-term orientation was significantly positively associated with HIV-positive disclosure attitudes only.

Additionally, I conducted a stepwise regression for exploratory purposes to assess which factors were predictive of HIV-positive disclosure behaviors, attitudes, and intentions. Stepwise linear regression of HIV-positive disclosure behaviors score on all explanatory variables resulted in power distance being a strong predictor of HIV-positive disclosure behaviors when the 10% significance level ($p = 0.090$) was used for exploratory purpose. The stepwise linear regression of HIV-positive disclosure attitudes score on all explanatory variables resulted in a number of significant predictors, among which power distance was the most significant ($p < 0.001$). Uncertainty avoidance ($p = 0.036$), masculinity ($p = 0.003$), and acculturation to host society's European American culture ($p =$

0.089) were associated with a significant increase in HIV-positive disclosure attitudes.

Finally, the stepwise linear regression of HIV-positive disclosure intentions score on all explanatory variables indicated negative impact of power distance ($p = 0.038$) and a positive impact of vertical collectivism ($p = 0.079$).

It is appropriate to analyze and interpret the above quantitative findings in the context of Hostede's and Triandis's cultural values framework. Based on the results of the regression analysis, the power distance dimension of Hostede's cultural values framework emerged as an important finding. Power distance is a term that describes how people belonging to a specific culture view superior and subordinate relationships. Consistent with Hofstede's cultural dimensions theory, the API MSM sample in this study demonstrated a high power distance, which has an inverse effects on HIV-positive disclosure attitudes and intentions but not for HIV-positive behavior. Collectivist cultures tend to score high on the power distance dimension demonstrating relationships that are paternalistic, autocratic, dependent, hierarchical, and inequitable (Hostede, 2011). The power distance score was found to be the most significant predictor of HIV-positive disclosure attitudes when stepwise regression analysis was conducted.

When applying Triandis's cultural theory to the individual level, the variable of vertical individualism was close to being significant for HIV-positive disclosure attitudes and intentions but not for HIV-positive disclosure behavior. Vertical individualism is a cultural pattern where inequality is expected and individuals strive to be different or distinct through competition, achievement, and power (Triandis, 2001; Triandis & Gelfand, 1998; Triandis & Gelfand, 2012). For this sample of 24 API MSM, the findings suggest that these

participants view themselves as fully autonomous but also recognize that inequality will exist among individuals. The individual cultural dimension of vertical collectivism was also positively associated with HIV-positive disclosure intentions when stepwise regression analysis was conducted. Consistent with Triandis's cultural theory, vertical individualism is more common in the United States while vertical collectivism is more common in countries like China or India (Triandis, 2004). Interestingly, the results of the stepwise regression analysis also suggested an association between acculturation to the host society's European American culture to HIV-positive disclosure attitudes.

The findings from this study extend the knowledge of what is known about HIV-positive disclosure for a specific API MSM population. As discussed in the review of the literature, there are numerous factors that may influence HIV-positive serostatus disclosure including relationship types, sociocultural, cultural, and racial/ethnic variables, level of acculturation, length of time since HIV diagnosis, age, level of education, and income. The reported rates of disclosure to sex partners ranged from 50% to 95% (Niccolai et al., 1999). Disclosure of HIV-positive serostatus to nonexclusive partnerships, less committed, occasional partnerships, and one-time encounters continues to be problematic compared to marriage, more committed, and/or primary same-sex relationships (Duru et al., 2006; Sullivan, 2005; Sullivan, 2009). Stated differently, the rates of disclosure decrease as relationship commitment decreases (Sullivan, 2009). MSM are also less likely to disclose their HIV status to their sexual partners compared to HIV-positive heterosexual men (Lin et al., 2015; Sullivan, 2005). The findings from this study are important and augment what is already known and not known about API MSM.

The findings from this study are consistent with previous studies highlighting the importance of cultural differences. Similar to the research that was conducted by Yoshioka and Schustack (2001), the collectivism cultural dimension might affect HIV-positive disclosure experiences in an API MSM population. In their study, Yoshioka and Schustack (2001) described how Asian cultural values of harmony and avoidance of conflict might have affected HIV-positive disclosure experiences for a small population of 16 HIV-positive Asian men recruited from an AIDS organization in northeastern United States while the findings in this study suggested that vertical individualism and power distance were associated with HIV-positive disclosure attitudes. Similarly, Nemoto et al. (2003) and Körner (2007) have found that cultural background, factors, values, and differences may have influenced disclosure decisions for API MSM (Körner, 2007; Lin et al., 2015; Nemoto et al., 2003). The findings from this study also extend the knowledge of what is already known about the influence of level of acculturation and HIV-positive disclosure. That is, this study expanded on what is known about HIV-positive Latino gay men. Zea et al. (2004) found that level of acculturation was related to disclosure to fathers and marginally related to disclosure to mothers, but not related to disclosure to closest friends. Although not significant, acculturation to host society's European American culture and vertical collectivism are significantly positively associated with HIV-positive disclosure attitudes and intentions for this sample of API MSM.

The findings relating to length of time since HIV diagnosis remain unclear. As discussed previously, two earlier studies from the 1990s suggest that disclosure to family and friends was positively correlated with length of time since HIV-seropositive diagnosis

(Hayes et al., 1993; Mason et al., 1995). However, other researchers (Mansergh, Marks, & Simoni, 1995; Stein et al., 1998) reported that the association between length of time since HIV diagnosis did not exist for disclosure to intimate partners. Zea et al. (2004) found that time since diagnosis was positively correlated only to disclosure to friends but negatively correlated with disclosure to mothers and fathers in a sample of 155 HIV-positive Latino gay men. Kang and Rapkin (2008) reported that there was no correlation between the length of time since HIV diagnosis and acceptance of illness among API MSM, heterosexual API males, and heterosexual API females. Finally, Sullivan (2005) reported after reviewing the findings from 13 previous studies that there was a typical pattern of lower levels of self-disclosure after individuals test positive followed by more disclosure over time as individuals come to terms with their illness. The findings from this study indicate a strong negative association between disclosure and the length of time that has passed since testing positive for HIV. That is, each five-year period since testing positively correlated to a nearly 2-point drop in the respondent's average Likert score for HIV-positive disclosure behaviors. Consistent with previous research, the relationship between disease chronology and HIV-positive disclosure rates to sexual partners among MSM remains unclear.

The findings from this study also disconfirm previous studies for other contributing variables such as age, level of education, and income. Age did not significantly influence HIV-positive disclosure behaviors, attitudes, or intentions. This finding contrasts the results from Serovich and Mosack's study (2003) where they reported that men who were likely to disclose their serostatus to casual sexual partners were, on average, younger in age. However, in a later study, Serovich et al. (2007) found that age of the participant at the time

of disclosure did not significantly influence HIV-positive disclosure rates of HIV-positive men to family members and friends over a 15-year time span. Specific to young men who have sex with men, Cook, Valera, and Wilson (2015) reported that more than half (52.4%) of these men reported disclosing to their current sexual or romantic partner. For MSM age 50 years and older, Brown et al. (2015) reported that this older population actually scored lower in HIV-positive disclosure behavior compared to MSM among 18 to 34 years old. From these results, further research is needed to assess whether age of the participants has any influence with HIV-positive disclosure behaviors, attitudes, and intentions for the targeted API MSM population.

Similar to the factor of age, the findings from this study did not indicate whether level of education influenced positively or negatively to HIV-positive disclosure behaviors, attitudes, and intentions. This finding contradicts what Serovich and Mosack (2003) has reported previously. In their study, they reported that men with higher education were more likely to disclose their serostatus to casual sexual partners. Similarly, Kang and Rapkin (2008) also reported that APIs who self-identified as MSM and who completed more years of education were more inclined to disclose their serostatus for purposes of receiving support from others compared to APIs who were self-identified as heterosexual. The findings from this study are more aligned with a more recent study conducted by Yamazaki et al. (2015) where they reported that education level was not associated with HIV-positive disclosure to friends and family. The sample used in this study, however, included 402 youths (aged 12-24 years) living with HIV compared to the sample of 24 API MSM in this study.

Finally, the findings from previous studies have suggested that level of income may influence the rate of HIV-positive serostatus disclosure. Crepaz and Marks (2003) did report that increased income was correlated with safer sex practices but it was unclear whether these practices translated to HIV-positive disclosure behaviors, attitudes, and intentions. Previous studies (Crepaz & Marks, 2003; Marks & Crepaz, 2001; Zea et al., 2003; Zea et al., 2004) that reported the influence of level of income to HIV-positive disclosure did not specifically target the API MSM population. In another study, Sullivan (2009) reported that income influenced men's disclosure with those having lower income disclosing more frequently than men with higher income. This finding is in strict contrast to the findings from this study as income was found to be positively associated with disclosure among API MSM.

This discussion illustrates that the phenomenon of HIV-positive serostatus disclosure is a complex and multifaceted process. Depending on the various contributing variables, the findings from this study extend the current knowledge while other findings confirm or disconfirm the understanding of HIV-positive disclosure behaviors, attitudes, and intentions for a specific population of API MSM.

Discussion of Qualitative Data

For the follow-up qualitative portion of the study, the central research question was: What factors influenced the HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners in API MSM? All eight participants disclosed their HIV-positive status to casual sexual partners in most circumstances. The most frequent medium of disclosure was their social media profile. Spontaneous encounters led to nondisclosure

while planned meetings led to disclosure of HIV-positive status. Of the eight participants interviewed, most felt that education level might have influenced ease of disclosure. Conversely, disclosure was more difficult with persons from lower socioeconomic class or more rural or less progressive cities. HIV-positive disclosure was dependent on the type of sexual activity they were engaged in and the type of sexual encounter. That is, participants did not feel the need to disclose their HIV-positive status when engaging in mutual masturbation as they felt that the risk of spreading the HIV virus was extremely low. However, the majority of participants felt that it was important and necessary to disclose their HIV-positive status when engaging in anal sexual intercourse because of the inherent risk of transmitting the HIV virus was greater, especially when condoms were not used.

Relating to disclosure attitudes, participants felt that they should disclose their HIV-positive status to casual sexual partners when engaging in any sexual activities. Participants felt that it was their responsibility to disclose, citing that it was the right thing to do ethically and morally. A number of participants also felt that they were also legally obligated to disclose their status. Even though participants shared that disclosure has gotten easier over time, no one seemed to effectively articulate the reason why this was so. The use of technology has made it easier and more convenient for participants to disclose their status. Time as an important healer was also cited as one of the reasons that participants now feel more at ease about disclosure of their HIV-positive status. Several participants shared that their ability to disclose their HIV-positive status has been made easier over time mainly because they have left their home country and immigrated to the United States where there is more acceptance.

When participants were asked whether they closely identify with their own and other Asian groups in America or with the White mainstream groups, most responded that they identified with their own and other Asian groups. Participants felt more connected with their own ethnic groups than the White mainstream groups, especially when they get older. When participants were asked to describe how their cultural background or values might influence or affect their experiences relating to HIV-positive disclosure to casual sexual partners, the responses included a mix of opinions. This highlighted the diverse range of people who were interviewed and the heterogeneous cultural background and values of the API group. Five of the eight participants felt that their culture and family values did not really influence them or their experience with HIV-positive disclosure. These five participants felt that their culture helped them to be open, honest, and hardworking, which helped facilitate the process of HIV-positive disclosure to their casual sexual partners. Two participants felt that being an Asian American or assimilating to White mainstream values helped to facilitate the process of disclosure.

Some notable factors emerged providing insight to the complexity of the disclosure phenomenon. Several participants described a more accepting attitude towards people who are HIV-positive, particularly in the last decade. Geographical area was another factor that may facilitate or hinder participants' willingness to disclose their HIV-positive status. For those participants who had moved from rural or suburban areas to Los Angeles or Orange County, they all expressed that people in metropolitan cities tended to be more accepting of HIV-positive disclosure compared to those in rural areas. From experience, participants shared that disclosure was more difficult in rural or southern states compared to the

bicoastal cities such as Los Angeles and New York City. Age was another factor influencing HIV-positive status disclosure. Of those interviewed, participants who were older than their counterparts were more likely to disclose their HIV-positive status. Physical attraction also played a role. For example, one participant stated that if he thought his casual sexual partner was attractive, then he would be less likely to disclose in fear that this partner may not want to engage in a sexual encounter. Some participants felt that feeling physically or emotionally safe facilitated HIV-positive disclosure as this mitigates the anticipated fear of rejection. Conversely, one participant shared that he would not disclose his HIV-positive status if the casual sexual partner was found to be desirable (i.e., having an above average penis size) in fear of the potential missed opportunity to engage in a desirable casual sexual encounter.

Limitations of the Study

This research study represents the first focused, mixed methods, sequential, explanatory study in which the influence of cultural factors, level of acculturation, social determinants of health, and other confounding variables (e.g., age, education, education, level of income, and length of time since diagnoses) as it relates to HIV-positive disclosure behaviors, attitudes, and intentions in API MSM were examined. To promote support for the development of methodologically sound and rigorous HIV-positive disclosure research in the future for this hard-to-reach population of API MSM, it is important to highlight conceptual and methodological limitations focusing on aspects of design and analysis.

Design

Sample

For the quantitative phase of the study, 24 API MSM participants completed the anonymous online SurveyMonkey survey over the course of 10 months of data collection using a purposeful convenience sampling method coupled with snowball sampling procedure. As discussed previously, only nine participants elected to complete the survey after two months of data collection. The original target population was API MSM who were members of Fridae. Because of the declining trend in the response rate, I offered a \$5 Starbucks gift card incentive starting in the fourth month. Despite this incentive and coupled with a more aggressive recruitment campaign of reaching out to other API organizations across the United States, the total sample size did not yield the originally planned sample size of 98 participants. Moreover, it is unknown whether there is any difference between participants who completed the online survey prior to the incentive and those who completed the survey after the incentive was offered. Consequently, results cannot be generalized because of the limitations with recruitment procedures. It was unknown whether the participants who participated in the study prior to when the incentive was offered was different from those who participated in the study when the incentive was not offered. Surprisingly, the small sample size of 24 participants did yield a representation from the nine API racial groups as defined by the United States Census Bureau (2011) and other independent variables (i.e., level of acculturation, length of time since HIV diagnosis, age, level of education, and income). Addressing the identified recruitment challenges of

reaching the hard-to-reach API MSM population will enhance the research results presented here.

Procedure

The study design was conceptualized to provide the opportunity for explanation or exploration of the results. Specifically, the mixed methods design was used to augment, connect, and integrate the quantitative and qualitative results, allowing for a deeper, richer, and better understanding and explanation of those results than either approach alone. As discussed previously, the participants from this two-phased, mixed methods study did not come from the same sampling pool. Therefore, findings from both approaches should only be combined as complementary rather than confirmatory research strategies. To address any concerns around the triangulation of data, participants should ideally be drawn from the same sample pool for the two phases of a mixed methods study. The participants from the qualitative phase were also confined to those living in Southern California in Los Angeles and Orange County. Therefore, the results cannot be generalized as it was unknown whether these participants may be different than those in other parts of the country. Moreover, I am of Asian ethnicity. It is uncertain whether results from the qualitative study would have been different if the interviewer was from another racial ethnicity that is different than the API MSM research participants. Although this may be considered a strength of the study, future researchers may want to explore whether there are differences in interview response and participation using interviewers who share similar or different racial or ethnic identity with the participants. Addressing the identified procedural challenges will enhance the results presented here.

Analysis

Instrumentation

For the quantitative phase of the study, participants were asked to complete 112 questions. These questions included demographics information and questions from the four instruments (i.e., Culture Orientation Scale, Individual Cultural Values Scale, Asian American Multidimensional Acculturation Scale, and HIV-Positive Disclosure Scale). All participants were asked to the same 112 questions in the same sequence. It is not surprising that some participants may have experienced survey taking fatigue completing the long online survey. Because of the sensitivity of the research topic of HIV-positive disclosure, participants may also experience survey response fatigue. Stated differently, survey taking response is related to the length of the survey while survey response fatigue relates to the topic of the survey. Both of these types of survey taking fatigue and survey response fatigue can have negative impacts on the response rates and the quality of the data (Porter, Whitcomb, & Weitzer, 2004). Response fatigue can also cause measurement error and misclassification problems particularly for questions that are asked later in a long survey (Egleston, Miller, & Meropol, 2011). The effects of both survey taking fatigue and survey response fatigue may be moderated by addressing the length of the survey and the order of the survey questions.

Results

Results from this study should be reviewed with caution regard to generalizability of findings, as they are based on a small sample size. In fact, the sample size of 24 was much smaller than the needed 98 participants to establish a power of .80 based on an alpha level

(α) of .05 and a medium effect size. In addition to the inherent limitations of not being able to infer causation from a correlational study, there are also other intrapersonal, situational, contextual, and cultural variables that may also played a role to influence the phenomenon of HIV-positive disclosure over time. Moreover, the data from both the quantitative and qualitative phases of the study were self-reported and having a high propensity to be flawed with errors in recall and possibly tainted with biases such as social desirability and acquiescence bias. Further research is needed with a larger sample for which contextual factors are better controlled, to validate significant findings associated with HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners among API MSM.

Implications for Positive Social Change

Despite the limitations of the study, this study is unique because it addresses an under-researched population of API MSM that is considered to be both a racial/ethnic minority and a sexual minority. HIV disclosure remains a key factor in reducing the spread of the virus to others, especially between casual sexual partners. Individuals, practitioners, and policymakers are in need of more evidence-based scientific data to implement key components of effective HIV-positive disclosure health behavior strategies. The findings from this study highlight the importance of developing successful strategies to promote healthy behavior for the targeted API MSM populations.

The findings from this study may help API MSM individuals to understand the influence of culture, level of acculturation, length of time since diagnosis, age, level of education, and income on HIV-positive disclosure behaviors, attitudes, and intentions. Awareness of these influences help API MSM individuals to modify communication and

behavior patterns to act responsibly and to promote HIV-positive disclosure in risky sexual behaviors when engaging in casual sexual encounters. Having awareness of the cultural tendencies that may be specific to API will empower individuals to seek support and counseling, set goals, and recognize unhealthy risky sexual behaviors. When working with clients, therapists and healthcare providers can promote a healthy dialogue while at the same time recognize the importance of cultural dimensions that may promote or hinder HIV-positive disclosure behaviors, attitudes, and intentions. Counselors and therapists should take an active role to identify and suggest available social support groups and other community resources tailored to API MSM when working with their clients.

The field of health education and health promotion relies on our acknowledgement and understanding of interventions at multiple levels including cultural dimensions. Stated differently, holistic care to effect health behavior needs to incorporate culturally competent care in addition to social, economic, and political forces on health (Glanz, Rimer, & Viswanath, 2015). Marks (2009) also advocated for culturally tailored messages to minimize poor outcomes due to misunderstandings or miscommunications. The findings from this study elucidate the need for practitioners (i.e., healthcare providers, counselors, therapists, and other healthcare professionals) to be multiculturally competent. By incorporating culturally sensitive counseling, intervention strategies, and ongoing support to promote API MSM preventive health behavior, healthcare practitioners can improve the patient-provider or client-provider communication process (Marks, 2009). This study is important because it addresses the gap or lack of research in the current literature to examine the influence of cultural factors, level of acculturation, social determinants of

health, and other confounding variables (e.g., age, education, level of education, and length of time since diagnosis) as it relates to HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners for the culturally diverse, marginalized, and minority populations of API MSM. Policymakers will be able to incorporate the findings from this study to proactively develop or modify existing HIV preventive health education and health promotion programs to negotiate safer sex behaviors (e.g., condom usage, HIV-positive self-disclosure) that would promote competent quality care tailored to the needs of the high risk population of API MSM who engage in casual sexual encounters when working with this diverse racial and ethnic group in the LGBT community. Policymakers should incorporate evidence-based research and program evaluation, outcomes, and effectiveness when considering cutting funding resources for HIV-prevention health education and promotion programs for a segment of the population such as API MSM. The findings from this two-phase, mixed methods study have profound implications for positive social change because it affords the scientific community with a richer and deeper understanding of the cultural dimensions of the API MSM populations and facilitate the elimination of the health disparities and inequities for this minority population.

Recommendations for Future Research and Action

The findings of this research study shed light into the need for more cultural research for marginalized and minority populations. The API population has experienced the fastest rate of growth compared to other major race groups (U.S. Department of Commerce, 1996) and API MSM are by far the largest at-risk group to contract the virus in the United States. There needs to be more research targeting this population. Future research

needs to deploy more methodologically rigorous experimental designs with a larger sample size in which factors influencing HIV-positive disclosure behaviors, attitudes, and intentions are specifically measured. Although this was a two-phase mixed methods study, the sample pool of the quantitative phase was different from the qualitative phase. It would be desirable to obtain a subset from the same sample for the qualitative phase to allow for triangulation of data.

As discussed previously, the length of the online quantitative survey should be addressed to mitigate the effects of survey taking fatigue and survey response fatigue. To adequately assess the effects of HIV-positive behavior, researchers should also consider using a longitudinal survey and administer the survey several times to the same participants over a period of time. This is particularly important as the findings suggest a negative association between disclosure behavior and the length of time that has passed since testing positive for HIV. That is, there was nearly a 2-point drop in the respondent's average Likert score on the HIV-positive disclosure scale with each five-year period since testing positive.

For the qualitative phase of the study, it might be helpful to assess whether there would be a difference in the participants' response if the interviews were conducted by someone who shares the same racial and ethnic group as opposed to an interviewer who is from a different racial and ethnic background. Although there are advantages of conducting live interviews as they afford the interviewer to assess for nonverbal gestures and nuances, it would be equally advantageous to also offer anonymous telephone interviews. The latter approach would allow researchers to assess for the effects of social desirability bias. Researchers should also follow up with participants' casual sexual partners to confirm the

veracity of participants' HIV-positive disclosure as opposed to relying to self-reported data. Additionally, it might be interesting to interview both the participant and the participant's casual sexual partner at the same to assess for any potential interpersonal and extrapersonal communication.

Because API MSM are a heterogeneous group, it would be wise to conduct studies using a sample size that is representative of the API populations in the United States for the quantitative study. Samples should include HIV-positive API MSM who reside in urban, metropolitan areas and suburban, rural locales in numerous states within the United States. There is also value in learning more about the API subgroups including those who are afflicted with other chronic medical and mental health conditions and those who suffered from chemical dependence and substance abuse. The results of this study suggest a correlation between acculturation to the host society's European American culture and HIV-positive disclosure attitudes and intentions. The extent of acculturation should be assessed more thoroughly. The aforementioned methodologically rigorous experimental design with a larger sample size should also be deployed in different Asian countries to assess for differences and similarities between how API MSM who reside in the United States versus in their homeland country.

Conclusion

HIV-positive, API MSM experience triple minority stigma including HIV, sexual orientation, and minority ethnicity, which increases the already burdened and multifaceted challenge of disclosing serostatus to casual sexual partners. Disclosure is a complex and emotionally charged burden for those who are infected with HIV (Iwelunmor et al., 2014;

O'Connell et al., 2014; Tshabalala, 2014). MSM are faced with the challenge and responsibility of disclosing their HIV-positive serostatus to others including casual sexual partners (Knox, Reddy, Kaighobadi, Nel, & Sandfort, 2012; Tang, Bensman, & Hatfield, 2013). In addition to the growing population of API in the United States, there are many contributory factors why APIs are particularly affected by HIV. Nearly one in four (22%) API persons living with HIV does not know that they have it and therefore are unable to obtain the needed care, such as taking advantage of highly active antiretroviral therapy (HAART) to extend their lives and reduce the risk of transmission to others (CDC, 2015a; Koh, 2014). Cultural factors including language barriers, fear of discrimination, stigma of homosexuality and HIV, immigration issues, and fear of bringing shame to their families may affect the risk of HIV infection as some APIs avoid seeking testing, counseling, or treatment (CDC, 2015a). There is also limited research about API health and HIV infection resulting in few targeted prevention programs and behavioral interventions in this population (CDC, 2015a). English language fluency is also a barrier to many API, as 76.5% of Asian Americans reported speaking a language other than English at home (U.S. Census Bureau, 2011).

Future research studies using a more methodologically rigorous experimental design with a larger sample size should examine the veracity of the associations between length of time since diagnosis, income, vertical individualism, power distance, and other contributing factors that may influence HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners for API MSM. Despite the limitations of the study, this study is

unique because it addresses an under-researched population of API MSM that is considered to be both a racial/ethnic minority and a sexual minority.

The research findings shed light on the dynamics of HIV-positive disclosure behaviors, attitudes, and intentions to casual sexual partners for API MSM. Despite recent advances in highly active antiretroviral therapy (HAART) and the declining annual rates of HIV infections and diagnoses in the U.S, HIV remains a chronic condition without a cure. Gay and bisexual men are the population most affected by HIV and remain a persistent problem in the United States. The API population in the United States grew around 11% between 2010 and 2014 (CDC, 2017). During this same period, the number of API receiving an HIV diagnosis increased by 36%, particularly among Asian gay and bisexual men (CDC, 2017). Factors that particularly affect Asians include undiagnosed HIV, cultural factors, limited research, and data limitations. Specifically, Asians may avoid seeking testing, counseling, or treatment because of language barriers or fear of discrimination, the stigma of homosexuality, or fear of bringing shame to their families (CDC, 2017). Moreover, there is limited research about Asian health and HIV infection, which results in few targeted prevention programs and behavioral interventions in this population (CDC, 2017). All of these factors present prevention challenges for the API population.

HIV disclosure remains a key factor in reducing the spread of the virus to others, especially between casual sexual partners. The findings from this study highlight the importance of developing successful strategies to promote healthy behavior for the targeted API MSM populations. There are profound implications for positive social change because it affords the scientific community with a richer and deeper understanding of the cultural

dimensions of the API MSM populations and facilitate the elimination of the health disparities and inequities for this minority population. This study contributes to the current body of knowledge on cultural research and provides empirical evidence of the characteristics that are associated with HIV-positive serostatus disclosure behaviors, attitudes, and intentions to casual sexual partners of API MSM.

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Appendix A: Questionnaire – Demographics

1. What is your race?
 - a. Asian Indian
 - b. Cambodian
 - c. Chinese
 - d. Filipino
 - e. Japanese
 - f. Korean
 - g. Native Hawaiian and Other Pacific Islander – Hawaiian, Guamanian or Chamorro, Samoan, or other Pacific Islanders
 - h. Thai
 - i. Vietnamese
 - j. Other Asian – Hmong, Indonesian, Laotian, Malaysian, Pakistani, etc.
 - k. Other Pacific Islander – Fijan, Tongan, etc.
 - l. Two or more races
2. What is your current age?
 - a. 18-30 years old
 - b. 31-40 years old
 - c. 41-50 years old
 - d. 51-60 years old
 - e. 61 years old and above
3. How long ago since you have been diagnosed with HIV/AIDS?

- a. 6 months – 1 year
 - b. 2 years – 5 years
 - c. 6 years – 10 years
 - d. 11 years – 15 years
 - e. 16 years – 20 years
 - f. More than (>) 21 years
4. What is the highest degree or level of education you have completed?
- a. Some high school, no diploma
 - b. High school graduate, diploma, or equivalent (e.g., GED)
 - c. Some college credit, no degree
 - d. Trade / technical / vocational training
 - e. Associate's degree
 - f. Bachelor's degree
 - g. Master's degree
 - h. Doctoral degree
5. What is your current annual income?
- a. \$0 to \$19,999
 - b. \$20,000 to \$39,999
 - c. \$40,000 to \$59,999
 - d. \$60,000 to \$79,999
 - e. \$80,000 to \$99,999
 - f. \$100,000 or higher

Appendix B: Questionnaire – Culture Orientation Scale

This questionnaire is anonymous, and there are no right or wrong answers.

We want to know if you strongly agree or disagree with some statements. If you strongly agree, enter a 9 in the blank space; if you strongly disagree, enter a 1 in that space; if you are unsure or think that the question does not apply to you, enter a 5 next to the statement.

In short, use this key:

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

1. I'd rather depend on myself than others. (H-I)
2. Winning is everything. (V-I)
3. If a coworker gets a prize, I would feel proud. (H-C)
4. Family members should stick together, no matter what sacrifices are required. (V-C)
5. Competition is the law of nature. (V-I)
6. Parents and children must stay together as much as possible. (V-C)
7. The well-being of my coworkers is important to me. (H-C)
8. I often do "my own thing." (H-I)
9. It is my duty to take care of my family, even when one have to sacrifice what I want.
(V-C)
10. To me, pleasure is spending time with others. (H-C)
11. When another person does better than I do, I get tense and aroused. (V-I)
12. I feel good when I cooperate with others. (H-C)
13. My personal identity, independent of others, is very important to me. (H-I)

14. I rely on myself most of the time; I rarely rely on others. (H-I)

15. It is important to me that I respect the decisions made by my groups. (V-C)

16. It is important to me that I do my job better than others. (V-I)

Note:

H-C: Horizontal collectivism

H-I: Horizontal individualism

V-C: Vertical collectivism

V-I: Vertical individualism

The cultural dimensions of H-C, H-I, V-C, and V-I are not known to the participants. That is, the notation of H-C, H-I, V-C, and V-I will not be included after each statement for the participants. This information is provided to the researcher only.

Scoring:

Each dimension's items are summed up separately to create a H-C, H-I, V-C, and V-I score.

Reference:

Triandis, H. C., & Gelfand, M. J. (1998). Converging measurement of horizontal and vertical individualism and collectivism. *Journal of Personality and Social Psychology, 74*, 118-128. <http://dx.doi.org/10.1037/0022-3514.74.1.118>

Appendix C: Questionnaire – Individual Cultural Values Scale (CVSCALE)

Please indicate the extent to which you agree or disagree with each statement. There are no right or wrong answers – just give us your honest opinion.

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Somewhat Disagree</i>	<i>Neither Agree nor Disagree</i>	<i>Somewhat Agree</i>	<i>Agree</i>	<i>Strongly Agree</i>
1	2	3	4	5	6	7

- PO1. People in higher positions should make most decisions without consulting people in lower positions.
- PO2. People in higher positions should not ask the opinions of people in lower positions too frequently.
- PO3. People in higher positions should avoid social interaction with people in lower positions.
- PO4. People in lower positions should not disagree with decisions by people in higher positions.
- PO5. People in higher positions should not delegate important tasks to people in lower positions.
- UN1. It is important to have instructions spelled out in detail so that I always know what I'm expected to do.
- UN2. It is important to closely follow instructions and procedures.
- UN3. Rules and regulations are important because they inform me of what is expected of me.

UN4. Standardized work procedures are helpful.

UN5. Instructions for operations are important.

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Somewhat Disagree</i>	<i>Neither Agree nor Disagree</i>	<i>Somewhat Agree</i>	<i>Agree</i>	<i>Strongly Agree</i>
1	2	3	4	5	6	7

CO1. Individuals should sacrifice self-interest for the group (either at school or the work place).

CO2. Individuals should stick with the group even through difficulties.

CO3. Group welfare is more important than individual rewards.

CO4. Group success is more important than individual success.

CO5. Individuals should only pursue their goals after considering the welfare of the group.

CO6. Group loyalty should be encouraged even if individual goals suffer.

MA1. It is more important for men to have a professional career than it is for women.

MA2. Men usually solve problems with logical analysis; women usually solve problems with intuition.

MA3. Solving difficult problems usually requires an active, forcible approach, which is typical of men.

MA4. There are some jobs that a man can always do better than a woman.

Please indicate the extent to which you believe to be important or unimportant with each statement. There are no right or wrong answers – just give us your honest opinion.

<i>Extremely Unimportant to me</i>	<i>Unimportant to me</i>	<i>Somewhat Unimportant to me</i>	<i>Neither Important nor Unimportant</i>	<i>Somewhat Important to me</i>	<i>Important to me</i>	<i>Extremely Important to me</i>
1	2	3	4	5	6	7

LT1. Careful management of money (Thrift)

LT2. Going on resolutely in spite of opposition (Persistence)

LT3. Personal steadiness and stability

LT4. Long-term planning

LT5. Giving up today's fun for success in the future

LT6. Working hard for success in the future

Note:

PO = Power distance

UN = Uncertainty avoidance

CO = Collectivism

MA = Masculinity

LT = Long-term orientation

Reference:

Yoo, B., Donthu, N., & Lenartowicz, T. (2011). Measuring Hofstede's five dimensions of cultural values at the individual level: Development and validation of CVSCALE.

Journal of International Consumer Marketing, 23, 193-210.

doi:10.1080/08961530.200.578059

Appendix D: Questionnaire – Asian American Multidimensional Acculturation Scale

(AAMAS)

Instructions:

Use the scale below to answer the following questions. Please select the number that best represents your view on each item. Please note that reference to “Asian” hereafter refers to Asians in America and not Asia.

	Not very well	Somewhat				Very well
	1	2	3	4	5	6
1. How well do you <u>speak</u> the language of:						
a. your own Asian culture of origin?	1	2	3	4	5	6
b. other Asian groups in America?	1	2	3	4	5	6
c. English?	1	2	3	4	5	6
2. How well do you <u>understand</u> the language of:						
a. your own Asian culture of origin?	1	2	3	4	5	6
b. other Asian groups in America?	1	2	3	4	5	6
c. English?	1	2	3	4	5	6
3. How well do you <u>read and write</u> in the language of:						
a. your own Asian culture of origin?	1	2	3	4	5	6
b. other Asian groups in America?	1	2	3	4	5	6

- | | | | | | | |
|-------------|---|---|---|---|---|---|
| c. English? | 1 | 2 | 3 | 4 | 5 | 6 |
|-------------|---|---|---|---|---|---|
- 4. How often do you listen to music or look at movies and magazines from:**
- | | | | | | | |
|--------------------------------------|---|---|---|---|---|---|
| a. your own Asian culture of origin? | 1 | 2 | 3 | 4 | 5 | 6 |
| b. other Asian groups in America? | 1 | 2 | 3 | 4 | 5 | 6 |
| c. the White mainstream groups? | 1 | 2 | 3 | 4 | 5 | 6 |
- 5. How much do you like the food of:**
- | | | | | | | |
|--------------------------------------|---|---|---|---|---|---|
| a. your own Asian culture of origin? | 1 | 2 | 3 | 4 | 5 | 6 |
| b. other Asian groups in America? | 1 | 2 | 3 | 4 | 5 | 6 |
| c. the White mainstream groups? | 1 | 2 | 3 | 4 | 5 | 6 |
- 6. How often do you eat the food of:**
- | | | | | | | |
|--------------------------------------|---|---|---|---|---|---|
| a. your own Asian culture of origin? | 1 | 2 | 3 | 4 | 5 | 6 |
| b. other Asian groups in America? | 1 | 2 | 3 | 4 | 5 | 6 |
| c. the White mainstream groups? | 1 | 2 | 3 | 4 | 5 | 6 |
- 7. How knowledgeable are you about the history of:**
- | | | | | | | |
|--------------------------------------|---|---|---|---|---|---|
| a. your own Asian culture of origin? | 1 | 2 | 3 | 4 | 5 | 6 |
| b. other Asian groups in America? | 1 | 2 | 3 | 4 | 5 | 6 |
| c. the White mainstream groups? | 1 | 2 | 3 | 4 | 5 | 6 |
- 8. How knowledgeable are you about the culture and traditions of:**

- | | | | | | | |
|--------------------------------------|---|---|---|---|---|---|
| a. your own Asian culture of origin? | 1 | 2 | 3 | 4 | 5 | 6 |
| b. other Asian groups in America? | 1 | 2 | 3 | 4 | 5 | 6 |
| c. the White mainstream groups? | 1 | 2 | 3 | 4 | 5 | 6 |

9. How much do you practice the

traditions and keep the holidays of:

- | | | | | | | |
|--------------------------------------|---|---|---|---|---|---|
| a. your own Asian culture of origin? | 1 | 2 | 3 | 4 | 5 | 6 |
| b. other Asian American cultures? | 1 | 2 | 3 | 4 | 5 | 6 |
| c. the White mainstream culture? | 1 | 2 | 3 | 4 | 5 | 6 |

10. How much do you identify with:

- | | | | | | | |
|--------------------------------------|---|---|---|---|---|---|
| a. your own Asian culture of origin? | 1 | 2 | 3 | 4 | 5 | 6 |
| b. other Asian groups in America? | 1 | 2 | 3 | 4 | 5 | 6 |
| c. the White mainstream groups? | 1 | 2 | 3 | 4 | 5 | 6 |

11. How much do you feel you have in

common with people from:

- | | | | | | | |
|--------------------------------------|---|---|---|---|---|---|
| a. your own Asian culture of origin? | 1 | 2 | 3 | 4 | 5 | 6 |
| b. other Asian groups in America? | 1 | 2 | 3 | 4 | 5 | 6 |
| c. the White mainstream groups? | 1 | 2 | 3 | 4 | 5 | 6 |

12. How much do you interact and associate

with people from:

- | | | | | | | |
|--------------------------------------|---|---|---|---|---|---|
| a. your own Asian culture of origin? | 1 | 2 | 3 | 4 | 5 | 6 |
| b. other Asian groups in America? | 1 | 2 | 3 | 4 | 5 | 6 |

c. the White mainstream groups? 1 2 3 4 5 6

**13. How much would you like to interact
and associate with people from:**

a. your own Asian culture of origin? 1 2 3 4 5 6

b. Other Asian groups in America? 1 2 3 4 5 6

c. the White mainstream groups? 1 2 3 4 5 6

14. How proud are you to be part of:

a. your own Asian culture of origin? 1 2 3 4 5 6

b. other Asian groups in America? 1 2 3 4 5 6

c. the White mainstream groups? 1 2 3 4 5 6

***15. How negative do you feel about people
from:**

a. your own Asian culture of origin? 1 2 3 4 5 6

b. other Asian groups in America? 1 2 3 4 5 6

c. the White mainstream groups? 1 2 3 4 5 6

*This item must be reverse-coded before scoring.

AAMAS Description

AAMAS is an orthogonal measure that assesses acculturation to three different cultural dimensions: Culture of Origin (AAMAS-CO), Asian American culture (AAMAS-AA), and European American culture (AAMAS-EA). The pan-ethnic Asian American (AAMAS-AA) acculturation dimension is unique to the AAMAS. If this dimension is not of interest to the researcher and there is a compelling need for a shorter measure, it can be left out by eliminating option “b” under each item. However, in order to maintain orthogonality, at least two cultural dimensions must be assessed at the same time.

Three Cultural Dimension Scales:

<u>Name of Scale</u>	<u>What it measures</u>
Culture of Origin (AAMAS-CO)	Acculturation to one’s own Asian culture of origin
Asian Americans (AAMAS-AA)	Pan-ethnic Asian American culture
European Americans (AAMAS-EA)	Host society’s European American culture

Four Acculturation Domain Subscales

Within each of the cultural dimension scales above are 4 subscales assessing specific domains of acculturation:

<u>Name of Scale</u>	<u>No. of Items</u>	
Language	4	Items 1-4
Food Consumption	2	Items 5-6
Cultural Knowledge	3	Items 7-9
Cultural Identity	6	Items 10-15

Reliability Data for Cultural Dimension Scales

<u>Internal Consistency</u>	<u>Range</u>	<u>Test-Retest: 2 week interval</u>
AAMAS-CO	.87 to .91	.89
AAMAS-AA	.78 to .83	.75
AAMAS-EA	.76 to .81	.78

Reliability Data for Acculturation Domain Subscales

Internal Consistency in 2 Studies

	<i>AAMAS-CO</i>		<i>AAMAS-AA</i>		<i>AAMAS-EA</i>	
Language	.84	.76	.85	.85	.82	.87
Food Consumption	.71	.65	.79	.68	.71	.68
Cultural Knowledge	.77	.89	.77	.66	.71	.67
Cultural Identity	.79	.79	.70	.72	.78	.74

Instructions for Scoring the AAMAS

1. Item #15 needs to be reverse scored:
 - a. To reverse the score:
 - i. 1 should be changed to 6
 - ii. 2 should be changed to 5
 - iii. 3 should be changed to 4
 - iv. 4 should be changed to 3
 - v. 5 should be changed to 2
 - vi. 6 should be changed to 1
2. Calculate the total score for each scale:

- a. AAMAS-CO add together all the responses to “a” (your own Asian ethnic group) for all 15 items
 - b. AAMAS-AA add together all of the responses to “b” (other Asian groups) for all 15 items
 - c. AAMAS-EA add together all of the responses to “c” (the White mainstream groups) for all 15 items
3. Divide the total score for each cultural dimension by 15 to obtain the scale score.

Reference:

Chung, R. H. G, Kim, B. S., & Abreu, J. M. (2004). Asian American multidimensional acculturation scale: development, factor analysis, reliability, and validity. *Cultural Diversity and Ethnic Minority Psychology, 10*(1), 66-80, Table 2 (pp. 73-74).
doi:10.1037/1099-9809.10.1.66

Appendix E: Questionnaire – HIV-Positive Disclosure Scale

Instructions:

We would like to ask you some additional questions about your disclosure to sexual partners over the last 30 days. These questions are focused on disclosure with different types of partners and in different situations. If any of the situations described don't apply to you, you may choose "not applicable" as your response.

Module DBS

DBS_	I have disclosed my	[]	[]	[]	[]	[]	...of my sexual partners	[]
001	HIV status to...	All	Most	About half	A few	None	to whom I <u>gave oral sex</u> <u>with</u> a condom	N/A
DBS_	I have disclosed my	[]	[]	[]	[]	[]	...of my sexual partners	[]
002	HIV status to...	All	Most	About half	A few	None	to whom I <u>gave oral sex</u> <u>without</u> a condom	N/A
DBS_	I have disclosed my	[]	[]	[]	[]	[]	...of my sexual partners	[]
003	HIV status to...	All	Most	About half	A few	None	from whom I <u>received</u> <u>oral sex</u> with a condom	N/A
DBS_	I have disclosed my	[]	[]	[]	[]	[]	...of my sexual partners	[]
004	HIV status to...	All	Most	About half	A few	None	from whom I <u>received</u> <u>oral sex without</u> a condom	N/A
DBS_	I have disclosed my	[]	[]	[]	[]	[]	...of my sexual partners	[]
005	HIV status to...	All	Most	About half	A few	None	with whom I had	N/A

							<u>insertive anal sex (I was the top) with a condom</u>	
DBS_	I have disclosed my	[]	[]	[]	[]	[]	...of my sexual partners	[]
006	HIV status to...	All	Most	About half	A few	None	with whom I had <u>insertive anal sex (I was the top) without a condom</u>	N/A
DBS_	I have disclosed my	[]	[]	[]	[]	[]	...of my sexual partners	[]
007	HIV status to...	All	Most	About half	A few	None	with whom I had <u>receptive anal sex (I was the bottom) with a condom</u>	N/A
DBS_	I have disclosed my	[]	[]	[]	[]	[]	...of my sexual partners	[]
008	HIV status to...	All	Most	About half	A few	None	with whom I had <u>receptive anal sex (I was the bottom) without a condom</u>	N/A
DBS_	I have disclosed my	[]	[]	[]	[]	[]	...of my sexual partners	[]
009	HIV status to...	All	Most	About half	A few	None	with whom I engaged in any <u>other sexual behavior</u> (e.g., petting, dry humping, mutual masturbation)	N/A
DBS_	I have disclosed my	[]	[]	[]	[]	[]	...of my sexual partners	[]
010	HIV status to...	All	Most	About half	A few	None	that I <u>just met</u>	N/A

DBS_	I have disclosed my	[]	[]	[]	[]	[]	...of my <u>casual sexual</u>	[]
011	HIV status to...	All	Most	About	A few	None	partners	N/A
				half				
DBS_	I have disclosed my	[]	[]	[]	[]	[]	...of my sexual partners	[]
012	HIV status to...	All	Most	About	A few	None	who I believed were	N/A
				half			<u>HIV-negative</u>	
DBS_	I have disclosed my	[]	[]	[]	[]	[]	...of my sexual partners	[]
013	HIV status to...	All	Most	About	A few	None	who I believed were	N/A
				half			<u>HIV-positive</u>	
DBS_	I have disclosed my	[]	[]	[]	[]	[]	...of my sexual partners	[]
014	HIV status to...	All	Most	About	A few	None	who have specifically	N/A
				half			asked about my HIV	
							status	

Instructions:

We would like to ask you some questions about your attitudes about disclosure. Please select the response that best describes how strongly you agree or disagree with each item.

Module DAS

People with HIV should disclose their status to sexual partners to whom they...

DAS_	...give oral sex <u>with</u> a	[]	[]	[]	[]
001	condom	Strongly	Agree	Disagree	Strongly disagree
		agree			

DAS_	...give oral sex <u>without</u> a	[]	[]	[]	[]
002	condom	Strongly	Agree	Disagree	Strongly disagree
		agree			

People with HIV should disclose their HIV status to their sexual partners from whom they...

DAS_	...receive oral sex <u>with</u> a	[]	[]	[]	[]
003	condom	Strongly agree	Agree	Disagree	Strongly disagree
DAS_	...receive oral sex <u>without</u> a	[]	[]	[]	[]
004	condom	Strongly agree	Agree	Disagree	Strongly disagree

People with HIV should disclose their HIV status to their sexual partners with whom they...

DAS_	...have insertive anal (they are	[]	[]	[]	[]
005	the top) <u>with</u> a condom	Strongly	Agree	Disagree	Strongly disagree
		agree			
DAS_	...have insertive anal sex (they	[]	[]	[]	[]
006	are the top) <u>without</u> a condom	Strongly	Agree	Disagree	Strongly disagree
		agree			

People with HIV should disclose their HIV status to their sexual partners with whom they...

DAS_	...have receptive anal sex (they	[]	[]	[]	[]
007	are the bottom) <u>with</u> a condom	Strongly	Agree	Disagree	Strongly disagree
		agree			

DAS_	...have receptive anal sex (they	[]	[]	[]	[]
008	are the bottom) <u>without</u> a	Strongly	Agree	Disagree	Strongly disagree
	condom	agree			

People with HIV should disclose their HIV status to their sexual partners with whom they...

DAS_	...engage in any other sexual	[]	[]	[]	[]
009	behavior	Strongly agree	Agree	Disagree	Strongly disagree

People with HIV should disclose their HIV status to...

DAS_	...sexual partners they just met	[]	[]	[]	[]
010		Strongly agree	Agree	Disagree	Strongly disagree
DAS_	...casual sexual partners	[]	[]	[]	[]
011		Strongly agree	Agree	Disagree	Strongly disagree

People with HIV should disclose their HIV status to their sexual partners whom they think are...

DAS_ 012	...HIV-negative	[]	[]	[]	[]
		Strongly agree	Agree	Disagree	Strongly disagree
DAS_ 013	...HIV-positive	[]	[]	[]	[]
		Strongly agree	Agree	Disagree	Strongly disagree

People with HIV should disclose their HIV status to sexual partners...

DAS_	...only when the sexual partner	[]	[]	[]	[]
014	specifically asks	Strongly agree	Agree	Disagree	Strongly disagree

Instructions:

We would like to ask you some questions about your plans to disclose to your sexual partners in the future. If some items describe situations that you feel don't apply to you, you may respond with a "not applicable" response. However, even if a situation is unusual to you, you may also be able to choose a response that best describes the plans you would make should that situation arise.

Module DIS

DIS_	I plan to tell my future sexual partners to	[]	[]	[]	[]	[]
001	whom I <u>give oral sex with</u> a condom about my HIV status	Strongly agree	Agree	Disagree	Strongly disagree	N/A
DIS_	I plan to tell my future sexual partners to	[]	[]	[]	[]	[]
002	whom I <u>give oral sex without</u> a condom about my HIV status	Strongly agree	Agree	Disagree	Strongly disagree	N/A
DIS_	I plan to tell my future sexual partners from	[]	[]	[]	[]	[]
003	whom I <u>receive oral sex with</u> a condom about my HIV status	Strongly agree	Agree	Disagree	Strongly disagree	N/A
DIS_	I plan to tell my future sexual partners from	[]	[]	[]	[]	[]
004	whom I <u>receive oral sex without</u> a condom about my HIV status	Strongly agree	Agree	Disagree	Strongly disagree	N/A
DIS_	I plan to tell my future sexual partners with	[]	[]	[]	[]	[]
005	whom I have <u>insertive anal sex (I am the top) with</u> a condom about my HIV status	Strongly agree	Agree	Disagree	Strongly disagree	N/A

DIS_006	I plan to tell my future sexual partners with whom I have <u>insertive anal sex (I am the top) without</u> a condom about my HIV status	[]	[]	[]	[]	[]
		Strongly agree	Agree	Disagree	Strongly disagree	N/A
DIS_007	I plan to tell my future sexual partners with whom I have <u>receptive anal sex (I am the bottom) with</u> a condom about my HIV status	[]	[]	[]	[]	[]
		Strongly agree	Agree	Disagree	Strongly disagree	N/A
DIS_008	I plan to tell my future sexual partners with whom I have <u>receptive anal sex (I am the bottom) without</u> a condom about my HIV status	[]	[]	[]	[]	[]
		Strongly agree	Agree	Disagree	Strongly disagree	N/A
DIS_009	I plan to tell my future sexual partners with whom I engage in other sexual behaviors (e.g., petting, mutual masturbation) about my HIV status	[]	[]	[]	[]	[]
		Strongly agree	Agree	Disagree	Strongly disagree	N/A
DIS_010	I plan to tell my future <u>sexual partners that I just met</u> about my HIV status	[]	[]	[]	[]	[]
		Strongly agree	Agree	Disagree	Strongly disagree	N/A
DIS_011	I plan to tell my future <u>casual sexual</u> partners about my HIV status	[]	[]	[]	[]	[]
		Strongly agree	Agree	Disagree	Strongly disagree	N/A
DIS_012	I plan to tell my future sexual partners who I believe are HIV- <u>negative</u> about my HIV status	[]	[]	[]	[]	[]
		Strongly agree	Agree	Disagree	Strongly disagree	N/A
DIS_013	I plan to tell my future sexual partners who I believe are HIV- <u>positive</u> about my HIV status	[]	[]	[]	[]	[]
		Strongly agree	Agree	Disagree	Strongly disagree	N/A

DIS_	I plan to tell my future sexual partners about	[]	[]	[]	[]	301
014	my HIV status <u>only if they specifically ask</u>	Strongly	Agree	Disagree	Strongly	N/A
		agree			disagree	

Appendix F: Qualitative Study Interview Guide

- 1) Can you tell me about a specific situation where you disclosed to a casual sexual partner that you were HIV-positive?
- 2) How was your HIV-positive disclosure experience to casual sexual partners the same or different relating to receiving oral sex, with whom you were the top, and with whom you were the bottom?
- 3) Do you feel it is easier or harder for you to disclose your HIV-positive status to casual sexual partners when engaging in oral sex, in anal sex, or other sexual behaviors such as mutual masturbation? Please explain.
- 4) Do you feel that people with HIV should disclose their status to casual sexual partners when engaging in oral sex, in anal sex, or other sexual behaviors such as mutual masturbation? Please explain.
- 5) Do you more closely identify with your own and other Asian groups in America or with the White mainstream groups?
- 6) Describe how your cultural background or values might influence or affect your experiences relating to HIV-positive disclosure to casual sexual partners.
- 7) Has the way you discuss your HIV status with casual sexual partners changed over time?
- 8) Do you feel that level of education or socioeconomic class may positively or negatively influence people's willingness to disclose their HIV-positive status to casual sexual partners?

- 9) What typically influences or affects your experiences relating to HIV-positive disclosure to casual sexual partners?

Appendix G: Qualitative Study Significant Statements and Formulated Meanings –

Colaizzi's Step 2 and Step 3

Significant Statements	Formulated Meanings
<p><i>"I avoid the whole discussion by being open with it in my profile. A lot of hookup apps or websites out there provide options where you not only disclose your position, sexuality, or what you're looking for but also allows you to disclose your HIV status."</i> Participant 1</p>	<p>The participant uses the online dating app profile to disclose his HIV status. This helps him avoid discussions.</p>
<p><i>"For myself, the pain or awkwardness of disclosing to somebody is assumed in terms of it being prominently visible in the profile that I have on these dating websites. So, unless it comes up as a subject in normal conversations there is that assumption that no further discussion about HIV status is needed. It's already there though."</i> Participant 1</p>	<p>The participant uses the online dating app profile to disclose his HIV status. This helps him avoid awkward discussions and no further discussion is needed.</p>
<p><i>"Ahh, but if it's someone who we might have a shot at getting to know each other, so I would wait until after the third date, then I would say, 'hey, what's going on, I am HIV-positive' before engaging in sexual encounters."</i> Participant 2</p>	<p>If a partner is considered for a long-term relationship, disclosure is handled delicately and it takes time. Sexual encounters also happen after the disclosure.</p>
<p><i>"But I think nowadays since I turned... well, about three years ago ... something has happened to me that I said, 'OK, why don't we just like be straightforward to each other (you know). They have the right to know, I have the right to tell and it would eliminate (you know) a lot of drama and complications. So, I don't need that in my life. So, I decided that I'm going to do this (you know). It's fair and square (you know). Yeah. I've been doing that ever since."</i> Participant 2</p>	<p>Past experiences influenced the participant's way of disclosing to avoid unpleasant outcomes.</p>

<p><i>"disclosure ... I don't find it to be very easy ... Uhm, you would think that as time goes on, it would get easier. It hasn't for me. Uhm, I do find that it is easier to disclose to somebody who is a casual sexual partner versus to somebody who has a possibility of a relationship. It's easier for me because I find that ... well, there's more riding on the ... if there's a possibility for a relationship like ... I feel like there's more at stake because I guess my hopes are up ... maybe I'm a little bit more invested whereas somebody who's casual, they would say 'no' ... well OK, I can shrug that one off. But, yeah, if it's somebody who I actually like ... that I want to get to know better ... interested in, then if there's rejection, then it's harder to deal with. So, that's why I say that it's a little more difficult in terms of that disclosure (uhm). I find it to be its more pressure. Yeah."</i> Participant 5</p>	<p>Disclosure is a difficult task. However, it is easier to disclose to a total stranger than with possible long-term partner. There are other factors to be consider and more at stake when a partner is for a long-term relationship.</p>
<p><i>"I choose to disclose it ... and let the other person know that he has his right to choose ... and I would educate them ... I would tell them that so my current status is HIV-positive but undetectable. I'm taking the medication and everything's under control ... undetectable ... The virus copy is like lower than 20 something... Basically, (like) that's almost impossible to transmit it ... to pass it on to other people especially when I bottom."</i> Participant 6</p>	<p>The participant chooses to disclose to educate his partners, telling the different kinds of HIV cases and the level of risk based on sexual position. This allows the partner to make an informed decision.</p>
<p><i>"I actually told him before he came over and then he was fine with it as long as we use condoms. Yeah, that was it. I think telling him before made it more comfortable (uhm) instead of waiting until he got there and then we ended up not using condoms."</i> Participant 7</p>	<p>Disclosure was done before sex where the partner did an informed decision. This made the encounter a good experience.</p>

<p><i>"I had a negative experience [Laughing] where we hung out that day and then he came back to my place and then (uhm) he wanted to have sex and (uhm) ... I had a lot of things running in my mind because I haven't disclosed my status so it's obviously ... I usually don't just say when I first meet someone and then ... well, there's something that I have to tell you and promise that you won't get upset and then I told him that I was positive. Uhm, his reaction was really nice and that he said, thanks for telling me ... however, he lost his erection [Laughing] so I kind of knew that [Laughing] that it was a negative experience in his mind ... We continued to mess around but after that (like) ... coming out to him was a very emotional process so I kind of lost interest in doing anything and so we never even saw each other after that ... actually he blocked me on social media." Participant 7</i></p>	<p>Disclosure was done before sex, however, the partner lost his interest and avoided the participant after. This became an emotional and bad experience.</p>
<p><i>"most of the people I meet are usually HIV-positive themselves ... Uhm, if they're not ... (uhm), then I do tell them. Uhm, I was seeing a gentleman who was (uhm) ... was not positive (uhm) ... and I wanted something serious with him. We had sex a few times and I was (uhm) ... it was protected. Uhm, we made sure we used protection every time (uhm) and (uhm) ... after I told him ... We've been together for about six months after I told him, I ... (uhm) ... it just ended up abruptly." Participant 8</i></p>	<p>The participant chooses to engage more with partners with the same health status. When a disclosure with a non-infected partner who considered for a long-term relationship was done after many months of protected sex, the relationship ended abruptly. This has become a bad experience.</p>
<p><i>"He identified himself as bisexual ... I do too. I've had female partners (uhm) ... in fact, someone I was seeing when I first found out about (uhm) being positive ... when the news was broken to me, it ended the relationship that I had with my girlfriend at the time and (uhm) ... That also ended abruptly and (uhm) ... she (uhm) ... we haven't talked since. I did ... We were having protected sex (uhm). Uhm, yeah, the stigma is still alive... (you know) ... PrEP is doing the best it can (uhm). There is hope out there but a lot of people just from what they've heard or seen on TV, they really have like negative (uhm) ... a negative view on ... on positive people." Participant 8</i></p>	<p>The stigma of HIV has ended relationships of the participant. There is a wide negative view about HIV.</p>

<p><i>"It's usually before ... before we even meet really. Uhm, there's way to filter (uhm) people that want to engage in sex ... casual sex ... on apps like Grindr and that sort of things (uhm) ... (uhm) Adam4Adam, what have you ... but (uhm). Yeah, it's usually through text (uhm) because that's how we usually communicate with those apps and then we ... (you know) ... if given the green light, then we proceed to ... (you know) ... to have sex." Participant 8</i></p>	<p>Online dating apps have a feature to filter possible partners. Mobile messaging is also another method to disclose one's HIV status.</p>
<p><i>"there is less an inclination to discuss it because oral sex tends to be more or can become more spontaneous. Usually when you're just ... speaking of spontaneity and when you're in the moment, you don't go into these types of conversation about status. You just like 'go for it'. Like we go to a club, that would be different (you know)... if I go to a club and I would meet a guy and (you know) things just got (like) heated and you ended up doing something like oral sex. Probably in that case, I would not disclose my status But I think if (you know) I want to get to know someone, that's a different story (like), I would tell. Whether it's like (you know) oral sex or more, so I would definitely tell. Yeah. It's hard to tell when (you know) when you hook up with someone ... you don't have the right moment to tell ... I guess ... everything just happens so quickly and so fast and you feel like 'oh my gosh. Yeah, you don't have time to do that (you know). So, you just have to be careful (you know). That's how I remind myself." Participant 1</i></p>	<p>Spontaneous situations often lead to nondisclosure. Disclosure needs a certain kind of moment which is not possible in a spontaneous situation. The participant ends up being careful during the sexual encounter.</p>

<p><i>"Well, let's say oral sex, in particular (uhm), I feel like it's different in oral (you know) oral sex because (uhm) well, every time sex happens, it usually happens spontaneously. Uhm, I don't usually plan unless I just go on Grindr or something like, which I don't do anymore [laughing]. I don't usually tell to people because nothing is going to happen. It's so weird (uhm). When you're HIV-positive (you know) ... there is a difference between HIV-positive and HIV undetectable. People just argue about it (you know). You can talk about it all day (you know). Ah, so, I now undetectable so I don't have to tell people about my status if we're not going to go... or if we're not going to do it all the way. You know what I mean? If we're not going to have like sex ... like (you know) ... we're going to like oral sex so ... I don't think that's important because ... Yeah. So, typically if it's more of a casual sexual partner, it's been more of oral sex than anal sex."</i> Participant 2</p>	<p>Oral sex mostly happens during spontaneous encounters. Since oral sex is considered to have a low risk of transmitting HIV, disclosure is less probable. Oral sex is also typically done with casual partners and anal sex are for long-term partners.</p>
<p><i>"And in terms of the oral sex ... (uhm) ... I think I found that ... I don't know if it's just situational or it has to do with the fact that I just preferred to give oral sex ... that's usually like what it ends up happening. So, I'm usually the one who are performing oral sex ... but I think that's just I enjoy doing that ... so ... I don't know if it has necessarily played into ... that they were planning on doing it when they found out that I was HIV-positive that they decided not to."</i> Participant 5</p>	<p>The participant is a doer during oral sex and mostly enjoy doing it.</p>
<p><i>"You're also giving me another flavor that when you're giving oral sex as opposed to receiving it, then why would you need to share with someone about your HIV-positive." I mean ... well, yes in the sense that it's been both ... the times that I've been giving oral sex, I would say that probably half of the time I disclose and the other half of the time I don't disclose because ... I ... As long as I feel like I'm not giving them at risk, then ... I don't necessarily feel that I need to disclose."</i> Participant 5</p>	<p>The participant has a conflicting moral standpoint when it comes to disclosure especially when the act is done through oral sex where the level of risk is low.</p>

<p><i>"Uhm, well ... ahhh, this is really interesting because I haven't had actually that much anal sex since (uhm) finding out that I've been positive. Uhm, so, the times that I have ... So, I go through like phases. So, right now, I wouldn't say that I'm versatile ... like I'd go through these phases that I feel like I'm more top than bottom. And, (uhm), I guess it really depends on where I'm at ... in that place and who I meet (like) ... if they're predominantly a top or predominantly a bottom ... uhm ... Uhm, you know, I would have to say that as a top, I disclose because even though there's protection ... Uhm, I want them to go into these situations with their eyes open ... like they know ... like they have all the information available to them ... and they can decide if they would like to proceed or not."</i></p> <p>Participant 5</p>	<p>The participant rarely engages to anal sex after contracting HIV. His sexual positions vary when he engages to anal sex either the top or bottom position; and it requires disclosure to give the partner an informed decision.</p>
<p><i>"As a bottom ... again, still with protection ... I haven't always disclosed because they're the top and they're using a condom and I'm a bottom and I'm undetectable ... I mean, the risk is so negligible that (like) ... I don't know ... I haven't always ... Yeah, [Laughing] ... I feel bad for saying that but ... in my head it seems rational [Laughing]."</i> Participant 5</p>	<p>The level of risk of transmitting HIV decides the probability of disclosing.</p>
<p><i>"In regards to oral sex, I typically do not disclose my status (uhm). If it's someone who I have been talking for a while and then we engage in oral sex, and then (yeah) maybe... but if it's anonymous casual oral sex, then I typically don't. In regards to (like) penetration, when I'm a top or a bottom, then I usually do. Uhm, in the past there has been instances where I did not [Laughing] ... when I use condoms so I do not disclose."</i> Participant 7</p>	<p>The participant discloses to his partner depending on the type of sexual encounter.</p>
<p><i>"I mostly identify as a bottom. I've had experiences where I played the top role (uhm)... I (uhm)... yeah, normally I'm the bottom."</i> Participant 8</p>	<p>The participant usually take the bottom position during anal sex encounters.</p>

<p><i>"before it gets to anything ... like I said it's ... I make sure that (you know) ... and I ... I'm mostly ... I not very ... I don't like go out to bars or that sort of things. I could see that ... where the night could lead to that ... you know? It's just ... oral sex or whatever but ... Being a bottom you kind of have to plan things out ... it's not like hey, I'm going to meet someone ... it comes with the territory [Laughing]. Uhm, uhm, to answer your question, do I just meet people for oral sex? Uhm, not ... not really. If I do, I would definitely (uhm) disclose the fact that I have ... you know something and I would appreciate if they did too."</i></p> <p>Participant 8</p>	<p>The probability of disclosure depends on the sexual position and level of risk.</p>
<p><i>"It's easier for me to disclose my status online because apps made that possible so I don't have to talk about it. There is still a similar difficulty of discussing status during more spontaneous acts or when you're face-to-face with somebody unless ... unless it's more of like a date or a long-term thing. If it's a long-term thing ... are we talking about long-term here? We don't know so, so. So, let's differentiate. If it's more of a long-term thing, then you would definitely bring it up. (You know) it's something you got to discuss. It's just got to be out there."</i> Participant 1</p>	<p>Disclosing through online dating apps makes it possible for the participant to avoid discussion. The difficulty to disclose also depends on the situation, spontaneous or one-on-one meetups, or if the partner is for a casual or long-term relationship.</p>
<p><i>In terms of casual [sexual partners], then not much discussion happens, especially when it's spontaneous. Ummm, a lot of that conversation – for me at least – goes online (you know) if they ask, which I have no problem answering. And I think ... and I don't know if that's one of your questions ... the undetectability comes with it. I'm confident that I'm not going to pass on the virus because I take care of myself. So, there's that."</i> Participant 1</p>	<p>Disclosure does not happen with spontaneous encounters. Though discussions also happen during online introductions.</p>
<p><i>"I feel like it's actually easier if you are just doing oral sex. Uhm, yeah. It actually a lot easier (uhm), because people get it (you know) ... like you're not technically contagious. Uh, so, I'm OK. They usually (uhm). Unless someone says, 'I'm on PrEP, then we can talk about it'. Like (you know) that makes it a lot easier but when you come to like (you know) in the clubs (you know), it would be a whole different, new game."</i> Participant 2</p>	<p>The level of risk of transmitting HIV decides the probability of disclosing. Oral sex has a low risk of transmitting HIV.</p>

<p><i>"I definitely feel more of a responsibility to disclose when having anal sex. That's probably the number one where I feel the most responsibility in disclosing. Uhm, and then less so with oral sex and then even less so ... in fact, I probably ... well, I don't know if I were to disclose where I have been in a situation where I was engaging in mutual masturbation ...uhm... I would say that it goes in that ranking ... uhm, in terms where I most likely to disclose where I least likely to disclose." Participant 5</i></p>	<p>The participant feel more obligated to disclose during anal sex than oral sex. He also does not engage in mutual masturbation.</p>
<p><i>"Definitely much more difficult in terms of like meeting through friends because now there are social circles involved and I would likely see them again and they know people who I know ... So, I'm less likely to get into a sexual situation with them or ... I would phrase it this way, I am much more cautious in getting into those situations with them because, A., I would want to disclose but then I have to start weighing in like Well, let's say this doesn't work out, how likely are they to start talking about that to our mutual friends ... Am I OK with the mutual friends knowing ... I mean it opens up all these others (like) doors." Participant 7</i></p>	<p>The participant is more cautious in disclosing if there is a common friend involved.</p>
<p><i>I think it's easier to disclose your status when it's just oral sex because there's no risk involved. Uhm, when the partner wants penetration – anal sex – then it's harder (you know) because you've moved past first and second base already (uhm). Uhm, and then there is more risk involved with anal sex." Participant 8</i></p>	<p>The level of risk of transmitting HIV decides the probability of disclosing. Oral sex has a low risk of transmitting HIV while anal sex has the highest risk.</p>
<p><i>"Yeah. I think (uhm) ... it's harder for (uhm) ... it's harder for people to disclose during ... anal .. I think (uhm)... Yeah. Absolutely. If someone (uhm) ... I guess they weigh out the risks involved and when you're just ... when you're at a ... when you're just masturbating then ... there's very risk involved. So, uhm,.. Yeah, it's uhm, ... but like I said ... because I'm a bottom (uhm) ... because I'm a bottom ... that's usually and I'm usually out for something specific, then (uhm) ... then I know I have to be upfront. Uhm, while it's mutual masturbation, then ... which I almost never have ... that doesn't even turn me on to be honest with you. Tops need to be more concerned because their chances of spreading are a lot higher ... you know... Bottoms are the most at risk and (uhm)" Participant 8</i></p>	<p>Bottom position during anal sex is considered to have lower risk of transmitting HIV. Top position has the highest risk.</p>

<p><i>"So, my attitudes toward it is that there should be a more open conversation, definitely. I think there's definitely fear. Being on both sides of the fence, there's fear of rejection, fear of disappointment. So, people tend to not discuss it openly."</i> Participant 1</p>	<p>People with HIV mostly do not disclose because of fear of rejection and fear of disappointment.</p>
<p><i>"I feel that people should have a better way of being able to communicate and that's why I'm always for these social media apps because it helps you disclose without having to engage in that type of conversation. Uh, it also allows you to have ... it gives you options and it gives you freedom (you know) for you to be able to say openly without having to bring it up in a more spontaneous encounter."</i> Participant 1</p>	<p>Online dating apps gives the freedom to disclose without engaging in any type of conversation. It saves the participant from disclosing during spontaneous encounters.</p>
<p><i>"I've had where (you know) ... when you go online and they come to your door and it's like pizza, you consume it right away. So, there is no disclosure happening there."</i> Participant 1</p>	<p>Spontaneous encounters leave no time for disclosure.</p>
<p><i>"I've had friends who have encountered rejections because of their status."</i> Participant 1</p>	<p>Other people's experience of rejection also affects the participant.</p>
<p><i>"I feel like everybody should (you know) tell (you know) their partners about it but ... I totally get it because I tried on my own and I had good experiences and that experiences ... so, it's not an easy situation ... makes you feel uncomfortable but I think everybody should ... and at the same time, I feel like we should educate (you know) like people (you know) about HIV more and how it's transmitted and all of that so that they have a good understanding because you want to feel like accepted. Uh huh."</i> Participant 2</p>	<p>The participant feels that is it an obligation to disclose to partners whether they had bad or good experiences. This could be a way to educate people.</p>

<p><i>"Yes. I do feel that disclosure is important because ... when I was negative ... like ... I would have wanted people to let me know regardless whether it was a casual thing or a non-casual sexual thing. Now... having been ... on this side of things where I am positive, I understand that there are more ... there are more considerations ... and (uhm) ... because sometimes (like, like) ... for something so casual where ... and the other person is not at risk of getting it ... one can make the argument that why do they need to know? I mean, before ... and still today ... it's sensitive information about someone health status ... uhm ... so that person is being put in (uhm) a more vulnerable position, then (I guess) the other non-positive person is also in a vulnerable position as well."</i> Participant 2</p>	<p>The participant feels that disclosing is necessary but there are considerations because it is private and personal. Level of risk could affect the probability to disclose.</p>
<p><i>"I feel that they should disclose their status to all sexual partners but they don't have to in regards to mutual masturbation ... because it's just masturbation. You're not having any bodily fluid exchanged (uhm). In regards to oral sex, I don't believe that you have to disclose your status (uhm) because there has not been any documented cases where oral transmission of HIV was involved. So, in anal sex ... yeah ... you should disclose."</i> Participant</p>	<p>Depending on the level risk of transmitting HIV, the probability of disclosing varies. Masturbation and oral sex have a low risk because there is no fluid exchange; while anal sex has the highest risk.</p>
<p><i>Well, when you're giving, it's less risk involved translates to having to disclose or not then it's up to you ... but ... If you're the receiver, then... Well, if you're the positive person and you're receiving the blowjob, then (uhm) the other person has a higher risk than if they were the person receiving the blowjob from you."</i> Participant 7</p>	<p>The doer position in oral sex has a low risk of transmitting HIV but the receiver position in oral sex has a higher risk.</p>
<p><i>"When it comes to masturbation, I don't think tha(uhm) ... I don't think they should be inclined to (uhm) ... uhm... what is it called ... to disclose their status ... That ... Because the risk ... the risk is so low that I don't think that they should ... and the people receiving it ... whatever ... the people involved know that (uhm) that they... what do you call it ... their chances of getting anything are very little."</i> Participant 8</p>	<p>Masturbation has the lowest risk of transmitting HIV that it's no longer necessary to disclose one's HIV status.</p>

<p><i>I am a Filipino. I lived there for over 20 years and moved here seven or eight years ago and I know for a fact that a lot of my Filipino friends tend to go into these small Filipino cells that they have where they have their TFC and talk about politics and (you know) and eat all those fun foods that Filipino have." Participant 1</i></p>	<p>The participants grew up in the US but continued to practice his culture.</p>
<p><i>"OK, I was brought up in a pretty religious household ...uhm ... Protestant Christian background ... and uhm ... I would say that ... uhm... because of that I feel that responsibility to be honest and open and that has ... that has really Pretty, I mean ... it's kinda of like the core of who I am. It affects I should say and decisions come from that (but uhm). So,... so I That's where I feel I guess a responsibility to disclose and because I just ... I would want that respect so that I would give that respect." Participant 1</i></p>	<p>The participants religious background taught him to be open and honest. This affects his decisions when it comes to disclosure.</p>
<p><i>"When I first got diagnosed, I was raised Roman Catholic in the Philippines and things like that (you know). And growing up in the 1990s, during that times there was a lot of news (you know) regarding what's happening here in the United States and other countries. I was a kid when they had a travel ban in Africa all about AIDS and things like that. In my head, it was inculcated that if you have this disease, you're dead. And I got diagnosed when I was like 27. So, I was pretty old and should have been smarter than this (you know) but when I got diagnosed I really legitimately thought that I was going to die. Literally, I have like six months to live and gone ... but literally ... that's what I saw the pictures that ... I heard the news that's what (you know) my ... I'm making that up that my teachers told me (you know) ... that's what I heard when I was growing up. And, (you know) it ... I had to like re-indoctrinate myself or relearn what was really going on and how the disease is managed and progressed. So, in terms of how that reflects as my own disclosure habits (you know), I come to initially ... I thought that now I'm like marked." Participant 1</i></p>	<p>Childhood perception of early death and seriousness of the virus affected the participant's perception of HIV after contraction.</p>

<p><i>"It's a tough exercise but moving forward and knowing and learning about undetectability, I think my own previous experience of growing up in the Philippines has eroded and I've come to learn that this disclosure ... I should not be afraid of it .. afraid of disclosure ... for one thing ... it's not as much a big deal as it was for me (you know) and for other people who I have encountered. So, I think ... (you know) the Philippines is very conservative and I'm not too tight with that culture so therefore I'm (you know) I'm less conservative than your normal Filipino ... (you know) expected disclosure habits."</i> Participant 1</p>	<p>HIV education helps with disclosure. This outweighs cultural upbringing.</p>
<p><i>"I think that there's (uhmm) ... there's things that changed and things that don't change (you know) with people and ... For me, for moving here taught me to be less afraid of myself. Growing up gay in the Philippines (you know) really didn't only give me a really, really terrible idea of what HIV is but it also really gave me a terrible idea of what it's like being gay is (you know) and I grew up being afraid or angry or upset about being who I am. And in turn, I'm like that to my partners and the people who I meet in the LGBT community ... I'm paranoid of having HIV (you know). So, there's that kind of (you know) ... there's a lot of caution that I had ... (uhm) to the point of sometimes being unapproachable or paranoid or however that comes across to other people."</i> Participant 2</p>	<p>Childhood perception of early death and seriousness of the virus affected the participant's perception of HIV after contraction as well as building relationship or engaging to sex.</p>
<p><i>When I moved here I started looking for... that I could be gay... to the other side of the spectrum I could do whatever the fuck I want (you know). So, that has led me to better understand (you know) that it's OK to talk about it. It also led me to understand that sometimes you just want to have sex for the sake of having sex and just do it (you know) throw 'caution to the wind' and (you know) it's free me in a sense (you know). So, even though I was raised in a certain way back in the Philippines, being able to embrace myself and move away from the negativity that I had growing up as a kid, as a gay man in the Philippines, I was able to like reinvent myself here essentially (you know) and not be too tied down to what I used to previously believe."</i> Participant 2</p>	<p>Participant felt freedom after the change in environment and beliefs.</p>

<p><i>"When I did my homework and I was surrounded by a really good support group (you know) I have a few friends that are HIV-positive and met several people in groups in L.A. and it's ... Those resources have helped me understand the disease and myself."</i> Participant 2</p>	<p>HIV education and positive support system helped in dealing with HIV.</p>
<p><i>I feel like where I came from (uhm) ... people would never do that because you'd be rejected ... like right away. You'd be put to shame and (you know) uhm, like very badly like (uhm). It's because I think they do that out of their ignorance (you know). Like I said earlier, we should educate them more. The place where I came from (uhm) they don't understand the difference between HIV and AIDS. So, it's kinda hard just to like tell people (you know) because people talk."</i> Participant 2</p>	<p>Rejection and shame are prevalent in environment when people lacks education about HIV.</p>
<p><i>"You know, when you disclose to someone, they would just like (you know), that's it, you're done with your gay scene, your gay life (you know). Uhm, yeah. And, I feel like that affect me a lot so that I have to overcome."</i> Participant 2</p>	<p>Other people's perception of HIV also affected his outlook on HIV.</p>
<p><i>"But people are different. People are different (you know) like you said (you know) from my country and from America. So, at least people know more. They're more educated about this topic. So."</i> Participant 2</p>	<p>People in the US are perceived to be more educated about HIV.</p>
<p><i>"Yeah, it does (you know) because every time I think about it (uhm) I feel like, oh my gosh, I shouldn't do that because that fear has haunted you. I guess. It's haunting. OK (uhm) some people would not accept you in the community ... even in the workplace environment (you know) if you disclose your status and they might not (you know) hire you. And, here it's a fear ... living with this fear that has been with me for decades and I just have to overcome it every day. It's another step, it's another layer I have to like overcome before like telling people (you know)."</i> Participant 2</p>	<p>People with HIV carries its stigma in the community, workplace, and with their family which creates fear and shame.</p>

<p><i>"I would have to say ... if ... I think Asians in general are private ... generally more private ... and don't talk so many things so openly whether sexuality in general ... and even more so HIV because there's stigma attached. Uhm, and so ... (uhm) ... I being ... It's definitely So, those two things are at odds with each other ... because one part of me is like well I want to be very private, the other part of me, well, you have a responsibility ... and so, uhm, The responsibility generally with ... There are times that I haven't disclosed when there has been negligible risk to them. If there's any kind of risk, then I feel (like, uhm), I need to disclose." Participant 5</i></p>	<p>Asians are perceived as private and less open to discussion about sexuality. Cultural upbringing and social responsibility affects disclosure.</p>
<p><i>"The other thing too is that I have actually talked to my parents they do know and they didn't want me disclosing to other relatives. They just want me to keep it very private. And, while I understand where they're coming from ... it has held me back... and it's It has not allowed me to process and like to be able to ... like fully accept it and really be OK with it because ... I feel like I have to hide it for their sake. And I'm working on them with that ... because, you know what ... this is now affecting me in a negative way and I need you guys to patch up and like get on board with me and it's a non-issue." Participant 5</i></p>	<p>Family acceptance is crucial for the participant to fully accept the HIV situation.</p>
<p><i>"I'm from China (uhm) Chinese and ... What's more, I'm from a very, very strict ... very traditional family. So, uhm, it's part of the reason why I chose to leave my hometown behind and come to this country alone. Uhm, I kinda like try to escape from the cultural environment ... you know, my background. And, what's more (uhm) ... when I was in Chinese ... so... I feel like ... my perspective ... my point of view towards all those things are kind of different from the mainstream in China. So, I feel like (uhm) more free, less depressed in America." Participant 6</i></p>	<p>A strict and traditional family hinders the participant to gain a more positive perspective of the situation. An environment that is more accepting can give freedom and lessen the depression.</p>

<p><i>Because when I was in China I know more knowledge about this virus, this disease, everything than most other people. And ... I actually got infected when I was in China and that's also (uhm) the biggest reason I want ... one of the biggest reason I (uhm) chose to come to America to get access to better treatment and (you know) to have a better quality of life because back in China the ... like the discrimination... They are very, very out of time... how do I say this? The treatment is very, very out of time ... medication sources are very limited and side effects.... I suffered a lot of side effects Like the depression from certain kind of medication. I try to suicide in China because of depression and but I had no other choice ... I have to take the medication... that was the best (uhm) combination that I could get when I was in China. Things were different when I came to America, I got more choices and now suffer from nothing based on the side effects of the medication. Everything ... at least I don't feel anything [Laughing] from that ... so, I got my back life ... I got my life back (uhm) ... and I stand back on the ground again [Laughing] and so, I'm pretty ... happy and I appreciate."</i></p> <p>Participant 6</p>	<p>Participant left his home country because of its outdated HIV information, limited treatment as well as prevalent discrimination.</p>
<p><i>"I think being Asian American ... yes, sometimes it's hard to discuss about sex, sexual preference even in an LGBT community ... but since I live in L.A. ... it's a very open society so ... I feel for me personally, it's not as hard as if I were to live elsewhere."</i></p> <p>Participant 7</p>	<p>Though the participant's cultural background prevents him from discussing about sex, a community that is open to discussion encourages disclosure.</p>
<p><i>"My family is Buddhist ... Uhm, I feel that my religion plays a little part of it. I try to live life in a good way and I try not to harm other people. So, whenever I have casual sex, I do feel awful when I don't disclose my status to a partner. I feel horrible."</i></p> <p>Participant 7</p>	<p>Respect for religion encourages disclosure because of feeling guilt.</p>
<p><i>"So, what happens here ... I believe it was six months after ... six months after I was diagnosed I eventually learned that (you know) I just got to get out there again. And just (you know) why not? And, at that point I had to make a choice ... I had to make a choice whether (you know) you want to pretend that everything is normal or you want to go out there and (you know) that's when I made a choice that I got to disclose right up front."</i></p> <p>Participant 1</p>	<p>One's outlook in life affects disclosure and how a person deals with HIV.</p>

<p><i>"Well, for the first five years, it was so difficult. I only told like (uhm) three people that I trust. They were my best friends. My parents didn't even know until like 2010 so like (uhm) basically eight years later I ... I told them eight years later. It was so difficult because I thought I was going to die for sure. For sure, there was no way that I was ... there was no hope for me (you know) for the future and like I said in Thailand, that's the end of it. You have HIV, you're going to die (you know) lonely and (you know) that's the background that I was coming from. So, I didn't want to tell anybody (you know). People wouldn't sit at the same table as you or eat with you or drink with you. It was just so weird. They think that they might catch it ... and they even made fun of it. It's almost like a joke ... humor. Like, you just cough (you know) you just cough like ... OK, you get the flu or something ... like what is going on with you? I mean, did you just get infected? (You know). But they actually used the term, AIDS. They used that a lot (you know). So, uhm, that was tough. The first five years was tough. I was crying and wanting to die and then (you know) uhm ... I kept it for like eight years until I moved to L.A."</i></p> <p>Participant 2</p>	<p>There are feelings of isolation, depression, and confusion.</p>
<p><i>"We're so lucky that we have like so many good doctors, so many good healthcare (you know) in L.A. So, that kinda opened up my doors so, so. And, then, yeah, yeah. I feel like it gets easier and easier (you know) over time ... but it depends on your experience. I mostly ... most people accepted..."</i></p> <p>Participant 2</p>	<p>Access to proper healthcare and acceptance made life with HIV easier.</p>
<p><i>"There was one time, this one time that I was rejected (you know) That was like... that kind of scar me for life. I mean, he knows a lot because he's a doctor. Alright, he's a doctor so he knows ... he knows how to protect ... he knows what's going on. I think he used that as an excuse (because he met someone, I believe. So, OK, this is like too much. Too much pressure, so it worries me blah, blah, blah. It was fine when I told him (you know). He understood everything perfectly but after like two months things changed and so I believe that it was not me, it was him using that as an excuse. Used it to find his way out. Uhm, after that experience, it got a little harder again (you know) uhm ... so..."</i></p> <p>Participant 2</p>	<p>Experience of rejection is a hindrance to disclosure. It affects a person's emotional well-being</p>

<p><i>"So, I actually am now very picky (you know) uhm with whom I tell actually. I don't really tell like everybody (you know) ... at the same time, I don't want to meet people like I used to anymore. I'm not online or like OK that's shouldn't be a problem. Beforehand, it was easy ... like I was online (you know) on a hookup app ... I just tell everybody, right. Hey, this is my status, are you OK with that? (You know) it was so easy. Yeah, I think I felt like three years of that (you know) that freedom. So, it's a huge relief and ... I think I loved that and I think the doctor actually (you know) pulled me back a little."</i> Participant 2</p>	<p>Experience of rejection makes a person become disengage with people and less trusting.</p>
<p><i>"For some reason I just didn't want to believe it. Ugh, I think when I was ... my gosh ... I think when I was 17 when I found out. Yeah, I just kind of ... I just ignored it for like five, seven, or eight years. 1995. I got really, really, really sick. I was so sick. Yeah."</i> Participant 2</p>	<p>There is feeling of in denial.</p>
<p><i>"I almost wanted to say that I did not have any kind of sexual relationship for about almost a year ... I was very ... and ... I'm sure that psychologically ... it was affecting my drive but I would say (like) ... it just ... it wasn't a struggle ... like I didn't have any urges ... like I had no urge ... like I just didn't... like there was no drive so I ... which is fine with because I ... I don't know ... it just did a number on me (like) ... mentally that I just... I was kind of in shellshock and like I didn't ... so I just didn't engage ... so almost a year. So, there was no disclosure because I wasn't having any sex."</i> Participant 5</p>	<p>"The urge to engage with sexual activities lessen and there's a feeling of shock.</p>

"So, uhm, I actually got diagnosed (uhm) with HIV probably back in 2012 like two days before Christmas and (uhm) ... At the beginning, I was so desperate, I was so afraid and Although I had all those knowledge ... (uhm) before I was diagnosed but at that time, I just feel like completely hopeless and helpless. And then (uhm), I even thought that maybe in a couple of years I would die or something [Laughing] ... because I know there's treatment but ... but in the same time I know in China, the situation wasn't optimistic because everything was out of time.... And, I thought about (uhm) like maybe I'm going to die in two years... maybe I'll be really, really sick ... maybe I'll suffer a lot ... maybe I couldn't achieve my life dreams. Uhm, so, that was a pretty depressing time ... but soon I tried to go online and study more about this ... but then (uhm) because I speak a little English ... a little English so I ... What I did was that .. I went on those websites like based in America or European ... those European websites instead of websites in China because (uhm) that information are also out of time and those people ... they don't know much about this disease and they ... they just say a lot of wrong information, spread a lot of wrong information and make people feel like desperate. So, I pay a lot of attention to the frontier of the studies and research and those kinds of things. I tried to ... I tried to find hope and then ... and also [Laughing]. So, during this process, I decided to (uhm) to get out of China ... to, to, to get better treatment (you know) ... to get better chances so that's why I'm here today." Participant 5

There are feelings of hopelessness and helplessness. The environment also affects the person's outlook of the situation.

<p><i>"actually before I left China I barely had since ... I mean since I got the diagnosis because that's base on my ... base on my Christianity (uhm) and being Asian. I don't want to ... (uhm) I don't want to pass the virus to anybody else and so I kind of like limited myself even if I had the physical needs ... I ... of course I got horny sometimes but I just ... I didn't want to do anything in China when I was in China. Even when I learned that as long as I was receiving the treatment ... the treatment was effective in my system and (uhm) undetectable ... remain undetectable. So, that actually pretty safe to have sex with others ... But, well, on the other hand I ... I don't like condoms so ... [Laughing]. I don't ... I know that the risk is really, really, really small ... real, real small, I just don't want anybody innocent to take the risk. And then when I came to America and I actually changed a lot..." Participant 6</i></p>	<p>Religious and cultural upbringing affected the urge to engage in any sexual act to prevent the spread of the virus.</p>
<p><i>"it's ... the change also happened along with .. I know myself better (uhm) .. better knowledge about this disease and I saw a lot of examples ... positive examples around me. I ... I go those supporting groups ... Uhm, I saw other people ... a lot of people they just ... a lot of people also go for their dreams and their goals in life (uhm) ... they live a very positive life (you know) ... That pretty changed me ... changed me ... My whole point of view." Participant 6</i></p>	<p>HIV education and positive support system can change a person's point of view.</p>
<p><i>"when I first came here my first encounter was with that guy ... we fall in love with each other but because I was ... I was really afraid of ... So I didn't disclose it until (uhm) I feel like I need to (uhm) ... I need to see this relationship like serious ... So, I disclosed it to him (uhm) very, very carefully but still (uhm) ... he was in shock .. he was (you know) ... So, after that I changed like more ... after that I just prefer to tell people even before we met each other. So, to avoid this situation from happening again." Participant 6</i></p>	<p>Personal bad experience encourages to disclose upfront to prevent unpleasant situations.</p>
<p><i>"as for now I don't... I don't intentionally (uhm) hide it. So, I can pretty ... because ... Well, this is a big city and who knows about me? I'm just a FOTB. I'm new here. Nobody knows about me. Whatever. I just tell people." Participant 6</i></p>	<p>The idea of not having any personal ties to anybody encourages disclosure.</p>

<p><i>"it has definitely changed since I was first diagnosed in my early 20s and now I'm in my late 30s. As maturity ... (uhm) as maturity happens (you know) ... the way you disclose to your partners also changes ... so... At first, I was not disclosing because I was frozen (you know) ... I didn't know what to say or what to do and (uhm) it was hard to find support ... And then over the years I went to counseling and developed ways to (uhm) cope with it. I gather friends who knew about my status and through those relationships; I knew that it was OK to live with it. And then I was able to disclose to more people ... first to friends and then to sexual partners."</i> Participant 7</p>	<p>First few years are difficult because of lack of support and education about HIV. As a person develop a support system and find people with the same experiences, disclosure becomes easier. Friends are always the first point of disclosure, second is sexual partners.</p>
<p><i>"Uhm, at first it was happening while they were in bed with me and then later it happened ... now I try to disclose before they meet me so that we don't get disappointed. Uhm, although I haven't had many bad (uhm) rejections or (uhm) responses to my disclosure of my status but ... People usually (uhm) take it better when I tell them before we have sex."</i> Participant 7</p>	<p>Partners are more receptive when disclosure is done before the sexual act.</p>
<p><i>"If I know someone who doesn't have ... like I said ... it has come a lot easier to find someone in the same boat with HIV when you have Adam4Adam, Grindr, and what have you. You know, there are ways to filter your results (uhm) and so that's (you know) ... that has made it easier for people like me ... but (uhm) a lot of those people ... they're not what I'm looking for So, when I try to go outside of that world it's ... Yeah, 'til this day I'm ... I still find it really, really difficult."</i> Participant 8</p>	<p>Participants find partners also with HIV; it is less difficult to disclose.</p>
<p><i>"One factor that I do know is that I'm in L.A. (you know). I'm in Los Angeles and the more that you're closer to West Hollywood or Downtown L.A., it's easier to have that conversation. You see more profiles. You see more people congregate and be OK to discuss their status. So, in New York. I was visiting ... I visited New York – it's the same thing. Recently I visited Oklahoma – not the same thing (you know)."</i> Participant 1</p>	<p>People in big cities are more open to conversation regarding HIV than people in small towns.</p>

<p><i>"It's plausible just because you're more educated, you get more information but then again I have a master's degree and I was crying and freaking myself out. I had a master's degree! I had a master's degree in psychology and here I was telling this doctor in the park over at Olympic crying myself that I was going to die (you know). I think about it now and it's absurd, it's silly, it's funny but I was seriously misinformed at 27 with a master's degree." Participant 1</i></p>	<p>Knowledge about HIV is more crucial than the level of education when it comes to disclosure.</p>
<p><i>"I would say that it is more likely to be discussed when there is a higher level of education or they're coming from a socioeconomic class that is a little bit more stable. I don't know if that's the right word. Uhm, but I feel like that they are more likely to disclose because there is more education in terms of like how things are transmitted, how it ... what's risky, what's not risky... Uhm, so, when there isn't that level of education I feel like people (uhm) ... they don't know how ... or they're not aware of how things are transmitted and (uhm) ... so maybe there is less likely to engage if there's more fear when there's less education." Participant 1</i></p>	<p>The level of education affects how people resonate with discussion about HIV. This encourages disclosure.</p>
<p><i>"For the general education level ... but usually this is the case that ... the better, the higher education you get and that the better understanding you will have about (uhm) HIV ... about this ... Again, you will be more (uhm) worry-free to disclose your status even when the situation happens and the other people may be confused ... may worry, may be hesitant and they You yourself are very well educated and then you can educate other people. Even if it ended up (like) the other people decide to not have anything with you ... but still it's a good thing to educate other people and it's a positive thing to (uhm) ... to (uhm) weaken the discrimination I think." Participant 6</i></p>	<p>The level of education affects how people resonate with discussion about HIV. This encourages disclosure. Yet does not guarantee acceptance.</p>

<p><i>"Definitely I feel that if you're educated on the disease itself (uhm) you will be more likely (uhm) understand its transmission and you would be more likely to disclose to other sexual partners. In regards to socioeconomic class, (uhm) I guess it depends like ... if you're in the middle or upper class, I don't see a huge difference because you're living comfortably anyway. I could see if you like not making money, then maybe you are more financially dependent on people (uhm) ... that in itself may change ... I think that only level of education (uhm) matters in regards to disclosing their status sexual partners. So obviously, the more education, the more likely ... and hopefully. "</i> Participant 7</p>	<p>Disclosure is encouraged when there is a certain level of understanding about HIV that cancels out any misconceptions about the virus.</p>
<p><i>"It only plays a factor when it's affecting like your living situation or your basis needs like water and food and things like that ... but if you have money to pay for those things, then I don't think it affects your ability to disclose your status to sexual partners."</i> Participant 7</p>	<p>Socioeconomic class affects the lifestyle of the carrier but not the participation in disclosure.</p>
<p><i>"Oh, since uhm ... the other thing is that I belong to certain organizations where I know people are HIV-positive, there's almost this silent assumption that other people in that group is also HIV-positive. So, there is no discussion."</i> Participant 1</p>	<p>Disclosure is less probable to happen when the partner is met in a place where everybody is assumed to have HIV.</p>
<p><i>"Drug use maybe a factor and I think that's ... uhm ... that's something that there's been a lot of studies regarding this ... but drug use leads to lower inhibition, which leads to less talky talky. (You know) when there's drug use involved regardless your drug of choice, there's definitely less discussion about disclosure. Uhm, unless you're really talking to somebody (uhm, you know) who's really nice."</i> Participant 1</p>	<p>There is a lower probability of disclosure when drugs are involved. It is perceived to lower inhibitions; thus, people are less likely to talk.</p>
<p><i>"I think if you are educated ... I feel like you are informed. Right. I feel like it's easier. You just talk openly about it (you know) I feel like everyone should just at least (you know) like study or read some articles about it and know the truth instead of like being so judgmental. You know of course (you know) people ... there are many fish in the sea but people are people. Human beings are fragile so you just have to be careful (you know). Because in a gay men world, people are so dismissive (you know) like, 'next' (you know). Yeah."</i> Participant 1</p>	<p>HIV education is perceived to help people become more open to discussion and less judgmental.</p>

<p><i>"It used to be easier but now it's a lot harder. Makes sense? I feel like five years ago it was easier for me, here you go, this is my status, are you cool with that? What's your status? Because I didn't really care about my image that much ... but now the last time I went back on Grindr, for example, so yeah. I don't know. I kinda care about my image ... a lot more ... So it was so difficult to tell people."</i></p> <p><i>"I think it's more about me. Yeah. So. I think the older you are ... the older you are, you tend to have more fear [Laughing] I mean that's just me."</i> Participant 2</p>	<p>Adult participants become more conscious about their image, affecting the way they find partners and disclose to partners.</p>
<p><i>"That's so funny because like I'm hitting like 30, 40, ... this is the end of the gay world. I might not find anybody. Right? At the same time, you say fuck it, I don't even care, just tell people because it's the right thing to do and then you start to have like insecurities. Right? Insecurities, oh, oh my gosh... I might die lonely (you know) uhm. So, it's such a weird dynamic. It would change from time to time I believe. I think when you get older, you get wiser too so it's that kind ... You have to make that kind of decision (you know) very quickly for yourself. Like, who do I want to have as a partner or a hookup partner? You know, it's kinda different so you. I don't know. Some people just like I don't care (you know) they just don't give a fuck. Yeah, so, but ... I think for me ... right now, I'm just looking for someone long-term."</i> Participant 2</p>	<p>As the participant grows older, the priority shifts to finding long-term partners.</p>
<p><i>"If I'm interested in the person, I am more likely to disclose but I also find it harder to disclose. Uhm, because there's more riding on it and I feel like (uhm) OK, I'm going to be let down. Uhm, ... I could be let down. Uhm, then, in terms of (uhm) ... in terms of if they know a friend of mind, we met through friends, or we share some friends (uhm), then again, very likely that I will tell them but also less likely that I'm going to get involved with them in that situation because do I want ... Then other questions, how ... the rewards versus risks ... like am I comfortable with my mutual friends knowing or how gossipy are they, or it just like talk about (like)." Participant 5</i></p>	<p>When a partner is considered for a long-term relationship, there are factors to consider and more at stake.</p>

<p><i>"The first question goes more into like ... well, do I want to even open that door and have sex with them because then I feel the responsibility to tell them and then my friends ... uhm, our mutual friends would know... blah, blah, blah. So, I will look at that situation a little more ... I would analyze that a little bit more. How badly do I want to hook up with this person?" Participant 7</i></p>	<p>There is a less probability of engaging to sex or disclosure when a partner is met through friends. There is a fear that the partner would tell the common friend the participant's HIV status.</p>
<p><i>"Well, I would say any support group but it does help. I think the more (uhm) the more you share in common whether sex ... or gender I should say ... well (you know) age, (uhm) ... ethnicity. I think that the more you share in common that I think it does help (uhm) because I don't know. You just kinda find people that kinda can get it or in the same situation as you. So, it's like ... Oh, OK, you can learn a lot from them and they can learn a lot from you. Your experiences. Their experiences." Participant 7</i></p>	<p>Support groups are crucial to coping with HIV.</p>
<p><i>"Well [Laughing] ... recently from my experience I met a guy online and he never asked me ... but just because he never asked me before we ... we had sex... Before we had sex ... wait a minute (uhm) ... I think I need to tell you that I'm HIV-positive ... undetectable ... and then he said, "Oh, I guess so. I'm the same status and welcome to the club." [Laughing] So, well, that's pretty funny ... (uhm, uhm) ... I think that that's a positive thing .. it kinda pulled us closer." Participant 7</i></p>	<p>When the partner also has HIV, disclosure becomes easy and the discussion is more on the deeper level.</p>
<p><i>"It depends on the way you see someone that you would disclose your status obviously. If I meet someone online ... sometimes it's a lot easier to disclose because I don't know the person ... it's just a text message away ... I just have to message him ... so that's it. If I meet someone at the bar, it's harder. Now you see this person in person. You met them, you talk to them and then it's like ... you want to go home with me or not? But then you're probably drunk so your decision would be impaired to disclose or not." Participant 7</i></p>	<p>Physical presence also affects disclosure. It is easy to disclose through mobile messaging because it is less personal. Disclosing in person is more intimate.</p>

<p><i>"If it's through friends, it's probably not going to be disclosed the first time you meet someone ... at least not for me ... because they're your friend's friends. And your friend doesn't know about your status, then you might not disclose to that person who might go back and tell your friends or make everyone else uncomfortable. When it's face-to-face, it's definitely harder when you meet someone through friends because when you disclose, then that person might share to your friends, which you might not want your friends to know."</i> Participant 7</p>	<p>There is less probability of disclosing to a partner with a common friend, who does not know the participant's status. This might lead to unpleasant situation if the partner shares the participant's HIV status with the common friend.</p>
<p><i>"I'm not originally from L.A. but ever since like moving to L.A. (like) I feel more comfortable with myself ... not because I'm more comfortable financially but I feel that the support group that they have here and meetings that they have here ... and even the educational seminars and the events that they have here has helped ... helped me understand more about the diagnosis. Uhm, even though I am in the medical profession, I still didn't know as much about HIV until I actually went to the seminars and that I feel that the education and the support helped me coming out and understanding ... and accepting the diagnosis. And (uhm), the fact that there are Asian Americans who are positive and those groups exist in California has helped me to bond and accept myself as an Asian American male who is positive, which is different than another mainstream whether it would be White, Latino, or African American who may be positive. So, having those subcultures to connect with and those educations and I feel that people understand here more ... and accept it ... it has helped me."</i> Participant 7</p>	<p>Big cities have better healthcare, more educational materials about HIV, and various support groups and communities. People are also more understanding and accepting.</p>

"I'm originally from Tennessee ... so it's really conservative for me to like find a support group for my status, it was really hard because there was nothing to be found ... And most people in those support groups were homeless people, so I found it really hard to connect with anyone. So, without that connection, I did not return and that doesn't help. So, those federally funded programs are more for the lower income ... almost homeless people. I didn't fit into that category. And then I lived in Texas [Laughing] ... I tried to find an Asian American support group there and I couldn't find anything either. And that was hard because (uhm) ... even though it's a big area that it was not big enough to have an Asian American support group. So, I didn't have it until I come to California. So, that's made a big difference." Participant 7

Small towns have limited HIV support. Most programs are directed to homeless people.

Coding Summary By Node

HIV-Positive Disclosure Behaviors, Attitudes, and Intentions Interviews (N=8)

3/7/2017

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
Node				
Nodes\\Q1 Disclose HIV status to casual sex partner\\IF asked will give honest answer				
Document				
Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)				
No		0.0283	2	
				1
				<p>You placed the responsibility almost on the person to make sure that they read your profile sort of speak and that they should be aware of your status.”</p> <p>Participant 1: “Correct.”</p> <p>Researcher: “And if they have any questions about your HIV-positive status, then they would ask you about that?”</p> <p>Participant 1: “Absolutely.”</p>
				2
				<p>So, do you tend to take the initiative to disclose first or are you referring back to the profile in the dating app and let that person has to...”</p> <p>Participant 1: “No. If they ask and that we’re about to have sex ... If they ask, then I would just answer. If they bring it up.”</p> <p>Researcher: “If they bring it up but you would not ... just to clarify... typically, you would not be the person to initiate that</p>
Internals\\Qualitative Study_Transcripts_Participant 4_20170212				
No		0.0127	1	
				1
				<p>Uhm, but if it didn’t get to that point, I (uhm) normally just met (and uhm) and my old behavior [Laughing], I usually wait until I’m asked about my status. If I’m asked about my status, then I’d disclose it. And, uhm, if I’m not asked, then I usually don’t tell voluntarily but ... uhm. That’s the old me (you know).</p>

3/7/2017 1:24 PM

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
Nodes\\Q1 Disclose HIV status to casual sex partner\\Included in profile on website or app				

Document**Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)**

No	0.0334	2
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1

This is where it gets a little bit blurry. Usually, I avoid the whole discussion by being open with it in my profile. A lot of hookup apps or websites out there provide options where you not only disclose your position, sexuality, or what you're looking for, but it [also] allows you to disclose your HIV status whether you are positive, negative, on PrEP, or undetectable. And, it seems like most websites categorize into those four distinct categories. For myself, the pain or awkwardness of disclosing to somebody is assumed in terms of it being prominently visible in the profile that I have on these dating websites. So, unless it comes up as a subject in normal conversations there is that assumption that no further discussion about HIV status is needed. It's already

2

It's easier for me to disclose my status online because apps made that possible so I don't have to talk about it

Internals\\Qualitative Study_Transcripts_Participant 2_20170212

No	0.0355	2
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1

Beforehand, it was easy ... like I was online (you know) on a hookup app ... I just tell everybody, right. Hey, this is my status, are you OK with that? (You know) it was so easy. Yeah, I think I felt like three years of that (you know) that freedom. So, it's a huge relief and ... I think I loved that

2

And you mentioned about the dating apps or the hookup apps, has that made it easier or more difficult to disclose your status?" Participant 2: "It used to be easier but now it's a lot harder. Makes sense? I feel like five years ago it was easier for me, here you go, this is my status, are you cool with that? What's your status? Because I didn't really care about my image that much ... but now the last time I went back on Grindr, for example, so yeah. I don't know. I kinda care about my image ... a lot more ... So it

Internals\\Qualitative Study_Transcripts_Participant 3_20170212

No	0.0518	1
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1

It does affect ... Like in a club or in public, I haven't met a person to disclose before and I think it would be harder for me but it has never happened. You're meeting face-to-face rather than ... but on the computer it's definitely easier to disclose (uhm)."

Researcher: "So have you disclosed through hookup apps?"

Participant 3: "Yeah, like Grindr. Like, I wouldn't put like I'm HIV-positive on my profile mainly because I don't want like people who I know like co-workers that I'm positive ... but when we do start chatting, then I would disclose and it's not really. I'm kinda like open to disclose now about it."

Internals\\Qualitative Study_Transcripts_Participant 4_20170212

No	0.0422	2
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1

Well, most of the time when ... uhm ... I look for sex partners for casual sex ... or whatever ... it's done through online or through the app. And, most of the time, I disclose it there ... uhm ... through online or the app.

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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2

How about online? You mentioned that online helps to facilitate the process of disclosing because in profiles you can just say you are HIV-positive Do you feel that makes it easier or the same?"

Participant 4: "It's easier because if they don't want message me, then I would just assumed he was not attracted to me or that he has a problem with me being positive. If they message me, then they know and (you know) that I'm positive. And, a lot of times they still ask even though I elicit as positive. I don't know if they just don't read or [Laughing] or if they just want ..."

Researcher: "And if they ask, you would say ..."

Participant 4: "Yes. Yes. I used to say undetectable because I think it's important to know the difference between negative, positive, (you know), positive undetectable. So, yeah. And full blown AIDS."

Internals\\Qualitative Study_Transcripts_Participant 6_20170228

No	0.0235	1
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1

When you said that sometimes you might disclose before you meet them, does that mean online or through the telephone?"

Participant 6: "Online. Online."

Researcher: "So they would inquire about your status because of the profile online?"

Participant 6: "Yes, I actually put my profile there as poz undetectable and even though still some people will ask me (uhm) ... Are you clean or you neg? Please read my profile. As for clean my reason as for my labs results show that all those ... other STIs are negative but I do have HIV situation but my status is positive but undetectable"

Internals\\Qualitative Study_Transcripts_Participant 8_20170305

No	0.0124	1
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1

Where I were to get involved with someone like after the night has ended, then I find it more difficult (uhm) because ... then it goes back to (you know) ... uhm, verbally disclosing whereas you go ... this application whatever ... you got your profile stating it... yeah, so...it's very little (uhm) ... little to be said ... but (uhm)."

Researcher: "Did you explicitly state in your profile?"

Participant 8: "I don't have profile. I don't have ... I used to have a poz profile ... I took that down too ... I don't ..."

Nodes\\Q1 Disclose HIV status to casual sex partner\\Included in profile on website or app \\If not posted prefers face-to-face

Document

Internals\\Qualitative Study_Transcripts_Participant 5_20170218

No	0.0122	2
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1

And just as a follow-on to that question, when you disclose to your casual sexual partners, is it done through online, was it done face-to-face...?"

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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2

I don't disclose over the app but (uhm) .. but when we meet and they don't feel like it .. (ehhh) ... they don't feel like it, then that's fine or walk away from that.

Nodes\\Q1 Disclose HIV status to casual sex partner\\NO - but Protected

Document

Internals\\Qualitative Study_Transcripts_Participant 8_20170305

No	0.0143	2
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1

I was seeing a gentleman who was (uhm) ... was not positive (uhm) ... and I wanted something serious with him. We had sex a few times and I was (uhm) ... it was protected. Uhm, we made sure we used protection every time (uhm) and (uhm)

2

I think I've had protected sex maybe like once or twice ...uhm, but that was casual sex and uhm I didn't (uhm) ... I didn't disclose ... I ..."

Researcher: "This was a female or male?"

Participant 8: "Female. Yeah. Yeah, I didn't disclose ... but I mean I ... I didn't disclose. No. No. To answer your question. Yeah."

Nodes\\Q1 Disclose HIV status to casual sex partner\\Not if spontaneous

Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

No	0.0178	1
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1

So let's talk about casual sexual partners. Umm. In terms of casual [sexual partners], then not much discussion happens, especially when it's spontaneous. Ummm, a lot of that conversation – for me at least – goes online (you know) if they ask, which I have no problem answering. And I think ... and I don't know if that's one of your questions ... the undetectability comes with it. I'm confident that I'm not going to pass on the virus because I take care of myself. So, there's that."

Internals\\Qualitative Study_Transcripts_Participant 2_20170212

No	0.0110	1
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1

I usually do tell people right away to kinda eliminate any complications. So, I feel like they have the right to know so my style is that I would tell them (uhm) right away. Well, if it's just a hookup – like a quick hookup – so, I don't think about that so much

Reports\\Coding Summary By Node Report

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Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Internals\\Qualitative Study_Transcripts_Participant 7_20170304

No	0.0065	1
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1

I try ... sometimes I don't ... especially if it's a casual sexual partner that doesn't involve penetration. Yeah.”

Nodes\\Q1 Disclose HIV status to casual sex partner\\Yes

Document

Internals\\Qualitative Study_Transcripts_Participant 2_20170212

No	0.0462	2
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1

Well, hmm, I usually do tell people right away to kinda eliminate any complications. So, I feel like they have the right to know so my style is that I would tell them (uhm) right away. Well, if it's just a hookup – like a quick hookup – so, I don't think about that so much. Ahh, but if it's someone who we might have a shot at getting to know each other, so I would wait until after the third date, then I would say, 'hey, what's going on, I am HIV-positive' before engaging in sexual encounters.

2

you ended up doing something like oral sex. Probably in that case, I would not disclose my status But I think if (you know) I want to get to know someone, that's a different story (like), I would tell. Whether it's like (you know) oral sex or more, so I would definitely tell. Yeah. It's hard to tell when (you know) when you hook up with someone ... you don't have the right moment to tell ... I guess ... everything just happens so quickly and so fast and you feel like 'oh my gosh. Yeah, you don't have time to do that (you know). So, you just have to be careful (you know). That's how I remind myself."

Internals\\Qualitative Study_Transcripts_Participant 3_20170212

No	0.0344	1
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Mmm. I usually disclose upfront to a sexual partner before we even have intercourse and it's very ... To me, it's very like (uhm) make or break where usually they would be very nice about it or they would just say they're not interested."
 Researcher: "So, it could go either way. Sometimes it's a positive or negative experience?"
 Participant 3: "Usually about 90% of the time, it doesn't bother them anymore."

Internals\\Qualitative Study_Transcripts_Participant 4_20170212

No	0.0079	1
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if I go to a bar, I meet somebody and we're going to go home, we're going to have sex, I'd probably disclose to him before we even have sex or even before we get home ... if the intent is to have sex

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Internals\\Qualitative Study_Transcripts_Participant 5_20170218

No	0.0134	1
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I don't find it to be very easy ... Uhm, you would think that as time goes on, it would get easier. It hasn't for me. Uhm, I do find that it is easier to disclose to somebody who is a casual sexual partner versus to somebody who has a possibility of a relationship. I find that to be hardest. But in terms of like casual sexual partners ... uhm ... it actually went fine. They had minimal questions but they were OK with that ... with my status and we still got together physically."

Internals\\Qualitative Study_Transcripts_Participant 6_20170228

No	0.0174	1
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1

choose to disclose it ... and let the other person know that he has his right to choose ... and I would educate them ... I would tell them that so my current status is HIV-positive but undetectable. I'm taking the medication and everything's under control ... undetectable ... The virus copy is like lower than 20 something... Basically, (like) that's almost impossible to transmit it ... to pass it on to other people especially when I bottom.

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

No	0.0088	1
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1

"In regards to disclosure to a casual sexual partner, I actually told him before he came over and then he was fine with it as long as we use condoms.

Internals\\Qualitative Study_Transcripts_Participant 8_20170305

No	0.0038	1
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1

casual sexual partner... Uhm, most of my ... most of the people I meet are usually HIV-positive themselves ... Uhm, if they're not ... (uhm), then I do tell them

Nodes\\Q2 Disclosure vary by sex role or type

Document

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

No	0.0208	2
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1

In regards to oral sex, I typically do not disclose my status (uhm). If it's someone who I have been talking for a while and then we engage in oral sex, and then (yeah) maybe ... but if it's anonymous casual oral sex, then I typically don't.

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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2

Uhm, in the past there has been instances where I did not [Laughing] ... when I use condoms so I do not disclose.

Internals\\Qualitative Study_Transcripts_Participant 8_20170305

No	0.0160	3
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1

Well, yeah. Mostly when I'm looking for sex ... the majority of the time is ... is we're going like ... like I know what I want. Do you know what I mean? So, if I'm not going to engage in anything that isn't going to be satisfying to me ... so... if I'm looking for anal sex, then of course I'm straightforward about it and (uhm)

2

Uhm, uhm, to answer your question, do I just meet people for oral sex? Uhm, not ... not really. If I do, I would definitely (uhm) disclose the fact that I have ... you know something and I would appreciate if they did too.

3

Yeah, I think tops .. tops actually have it ... should be more active with letting people know .. Uhm...

Nodes\\Q2 Disclosure vary by sex role or type\\No will disclose

Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

No	0.0397	2
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1

So, the question is does my disclosure changes depending on my sexual positions or sexual preference. And the question is 'no'. I don't think that there has been a disclosure issue. I do know that is a wider belief or understanding that (you know) if you're a top that (you know) it's easier or that it's less likely that you're going to contract HIV or something like that (you know). So there is less reason to disclose but I'm sorry to speak for everybody else, that's not been my experience. From my experience, there is no significant difference in terms of disclosure between the two.

2

So let's talk about casual sexual partners. Umm. In terms of casual [sexual partners], then not much discussion happens, especially when it's spontaneous. Ummm, a lot of that conversation – for me at least – goes online (you know) if they ask, which I have no problem answering. And I think ... and I don't know if that's one of your questions ... the undetectability comes with it. I'm confident that I'm not going to pass on the virus because I take care of myself. So, there's that.

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Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Internals\\Qualitative Study_Transcripts_Participant 3_20170212

No		0.0310	1	
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1

I think it's the same because to them I think it's very ... it's very difficult for me as a bottom to give oral sex. So they think it's not very much risk. So, it's pretty much the same if I were negative."

Researcher: "So, it's not anything different whether it's oral sex or whether you're engaging in sexual intercourse?"

Participant 3: "No, there is no difference."

Internals\\Qualitative Study_Transcripts_Participant 4_20170212

No		0.0406	1	
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1

I want to say the same because I truthfully and honestly don't like condoms. [Laughing] So, if it disclosed before we meet (uhm), I would probably not going to meet with him if he prefers to use condoms. To me, it's more like a preference to use condoms or not to use condoms. And, I prefer not to use condoms."

Researcher: "Right, so if you're just having oral sex ... uhm ... it doesn't matter ..."

Participant 4: "Yeah. Masturbation, jerking off ... It would be all without condoms. It's all the same."

Researcher: "You would be able to disclose in those situations or no?"

Participant 4: "I'm sorry. The question is ... Uhm, I would probably feel a little different (uhm) however ... I mean that said, I would probably disclose my status ... the new me regardless of what type of sexual activities that I would be doing."

Researcher: "OK. So it doesn't matter which sexual experience or encounter it is, you would now disclose, whether oral sex or mutual masturbation or anal intercourse?"

Participant 4: "Yeah"

Internals\\Qualitative Study_Transcripts_Participant 5_20170218

No	0.0038	1
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1

so like specifically anal sex, I feel like that's something that I always let people know or that's when I'm most likely to tell people.

Internals\\Qualitative Study_Transcripts_Participant 6_20170228

No	0.0013	1
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1

most of the time ... it's the same.

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Internals\\Qualitative Study_Transcripts_Participant 7_20170304

No	0.0028	1
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1

So, in anal sex ... yeah ... you should disclose."

Nodes\\Q2 Disclosure vary by sex role or type\\No will disclose\\Q3 Harder to disclose if anal sex

Document

Internals\\Qualitative Study_Transcripts_Participant 2_20170212

No 0.0138 1

1 SLN 2/23/2017 12:44
DMM

OK, if you're going to be like ... OK ... having intercourse, I'd be like whoa, let's talk about it more. So, yeah."

Researcher: "So, what I'm hearing you said is that it's definitely easier when it comes to just oral sex or mutual masturbation but it's definitely harder when it comes to anal intercourse."

Participant 2: "Uh huh"

Internals\\Qualitative Study_Transcripts_Participant 3_20170212

No 0.0429 2

1 SLN 2/23/2017 2:36
DMM

think it's harder because for me I have to use Grindr as a way to meet other gay partners (I guess). Uhm, it's harder because I want to have a relationship and so disclosing ... yeah.... Disclosing is either make or break the potential like relationship. Yeah."

2 SLN 2/23/2017 2:36
DMM

anal ... I guess ... it's not because they will get really afraid about the positive."

Researcher: "... that you might contract the virus when you're engaging in anal sex or intercourse as opposed to you just having oral sex ... Correct?"

Participant 3: "Yes."

Internals\\Qualitative Study_Transcripts_Participant 5_20170218

No 0.0272 3

1 SLN 2/27/2017 8:28
AMM

Uhm, you know, I would have to say that as a top, I disclose because even though there's protection ... Uhm, I want them to go into these situations with their eyes open ... like they know ... like they have all the information available to them ... and they can decide if they would like to proceed or not. As a bottom ... again, still with protection ... I haven't always disclose because they're the top and they're using a condom and I'm a bottom and I'm undetectable ... I mean, the risk is so negligible that (like) ... I don't know ... I haven't always ... Yeah, [Laughing] ... I feel bad for saying that but ... in my head it seems rational [Laughing]."

2 SLN 2/27/2017 8:29
AMM

Well, uhm, I would say (uhm) ... I definitely feel more of a responsibility to disclose when having anal sex. That's probably the number one where I feel the most responsibility in disclosing

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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			3	SLN
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2/27/2017 8:36 AM

so like specifically anal sex, I feel like that's something that I always let people know or that's when I'm most likely to tell people.

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

No		0.0191	1
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1

I think it's (uhm) ... I think it's easier to disclose your status when it's just oral sex because there's no risk involved. Uhm, when the partner wants penetration – anal sex – then it's harder (you know) because you've moved past first and second base already (uhm). Uhm, and then there is more risk involved with anal sex.

Internals\\Qualitative Study_Transcripts_Participant 8_20170305

No		0.0113	2
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1

Yeah. I think (uhm) ... it's harder for (uhm) ... it's harder for people to disclose during ... anal .. I think (uhm)... Yeah. Absolutely. If someone (uhm) ... I guess they weigh out the risks involved and when you're just ... when you're at a ... when you're just masturbating then ... there's very risk involved.

2

people who want to go ... I guess ... to go all the way, they (uhm), they definitely find it harder ... (uhm) yeah... It just depends on the risk involved..”

Nodes\\Q2 Disclosure vary by sex role or type\\Oral sex no disclosure of HIV status

Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

No		0.0258	1
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1

SLN

2/23/2017 10:22 AM

now that you mentioned oral sex – if that’s the emphasis of the question – maybe there is less an inclination to discuss it because oral sex tends to be more or can become more spontaneous. Gay men sexual habits – including myself – can become more spontaneous and that could lead to oral sex, which in some cases does not lead to disclosure because of its spontaneity. Usually when you’re just ... speaking of spontaneity and when you’re in the moment, you don’t go into these types of conversation about status. You just like ‘go for it’. So, I would say that the disclosure thing or the disclosure that I mentioned in

Internals\\Qualitative Study_Transcripts_Participant 2_20170212

No 0.0291 2

1 SLN 2/23/2017 12:34
DAA

Pretty the same but uhm. Well, let’s say oral sex, in particular (uhm), I feel like it’s different in oral (you know) oral sex because (uhm) well, every time sex happens, it usually happens spontaneously.

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Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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2 SLN 2/23/2017 12:35
DAA

When you’re HIV-positive (you know) ... there is a difference between HIV-positive and HIV undetectable. People just argue about it (you know). You can talk about it all day (you know). Ah, so, I now undetectable so I don’t have to tell people about my status if we’re not going to go ... or if we’re not going to do it all the way. You know what I mean? If we’re not going to have like sex ... like (you know) ... we’re going to like oral sex so ... I don’t think that’s important because ... Yeah. ”

Internals\\Qualitative Study_Transcripts_Participant 5_20170218

No 0.0253 1

1 SLN 2/27/2017 8:26
DAA

the times that I’ve been giving oral sex, I would say that probably half of the time I disclose and the other half of the time I don’t disclose because ... I ... As long as I feel like I’m not giving them at risk, then ... I don’t necessarily feel that I need to disclose.”

Researcher: “And what decision-making process are you going through ...”

Participant 5: “Uhm, I guess it’s just based on the situation like ... It’s just ...this is going to sound bad [Laughing] ... but if it’s a person who I have just met and just to like get off together ... I don’t know if I would necessary ... if there’s been some texting and ... there’s been some engagement (uhm), then I’m more likely to disclose than just some random hookup, then I think I’m less likely ... as long as I’m not putting them at risk. Again, I’m like specifically speaking as if I’m giving them oral sex and not

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

No 0.0438 3

1 SLN 3/7/2017 11:25
DAA

In regards to oral sex, I typically do not disclose my status (uhm). If it’s someone who I have been talking for a while and then we engage in oral sex, and then (yeah) maybe ... but if it’s anonymous casual oral sex, then I typically don’t

2

“Oral sex is still ‘no no’. Yeah.”
 Researcher: “Typically you don’t?”
 Participant 7: “Yeah, typically I don’t.”

3

I feel that they should disclose their status to all sexual partners but they don’t have to in regards to mutual masturbation ... because it’s just masturbation. You’re not having any bodily fluid exchanged (uhm). In regards to oral sex, I don’t believe that you have to disclose your status (uhm) because there has not been any documented cases where oral transmission of HIV was

Internals\\Qualitative Study_Transcripts_Participant 8_20170305

No 0.0238 2

1

but the oral ... what it’s called ... when I was with that gentleman who was bi- (uhm) ... he was frightened by the fact that we did have unprotected oral sex. Uhm, which a lot of people do ... (you know) ... anyway, it’s very common ... (but uhm) ... and the chances of getting HIV that way is very ... slim to none. So, when I had broken the news to him, he freaked out of course and he said ... that’s what he had mentioned, he said well we did have oral sex ... so ... (uhm) ... and I tried to comfort him, I tried to talk

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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2

But, uhm, I could see how people that just want oral sex or that want oral sex – receive or give – don’t tell partners or don’t tell the other person (uhm) about it because ... just because studies show that the chance of getting anything ... well, getting that – the big one – (uhm), I don’t know if it’s the big one anymore (uhm) [Laughing] ... that they don’t disclose that information with oral sex ... they just don’t feel like it’s necessary.

Nodes\\Q2 Disclosure vary by sex role or type\\Oral sex no disclosure of HIV status\\Depends on giving or receiving oral sex

Document

Internals\\Qualitative Study_Transcripts_Participant 5_20170218

No 0.0163 1

1 SLN 2/27/2017 10:19

Uhm, in terms of a casual way, I ... it really depends on the situation ... If I ... let's just say randomly like I met them out ... like I don't know... some bathhouse or something (uhm) ... let's just say. Likelihood of disclosing? Uhm, low if I'm not putting them at risk... like if I'm just going down on them... probably not likely that I would tell them. Yeah, uhm. If they are going to reciprocate, then ... even if it's just a casual thing ... I would like to let them because I ... you deserve to know this and (uhm) ... so that you can make that decision on your own ... even though in my head

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

No 0.0197 1

1

I (uhm). Well, when you're giving, it's less risk involved translates to having to disclose or not then it's up to you ... but ... If you're the receiver, then ... Well, if you're the positive person and you're receiving the blowjob, then (uhm) the other person has a higher risk than if they were the person receiving the blowjob from you.

Nodes\\Q2 Disclosure vary by sex role or type\\Oral sex no disclosure of HIV status\\Q3 Easier to disclose if oral or masturbation

Document

Internals\\Qualitative Study_Transcripts_Participant 2_20170212

No 0.0175 2

1 SLN 2/23/2017 12:38

feel like it's actually easier if you are just doing oral sex. Uhm, yeah. It actually a lot easier (uhm), because people get it (you know) ... like you're not technically contagious.

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number	
			2	SLN	2/23/2017 12:38 DAA
People usually ... gay men in general, I feel like they are more comfortable like (you know), it's just oral sex, masturbation. OK, if you're going to be like ... OK ... having intercourse, I'd be like whoa, let's talk about it more. So, yeah."					

Internals\\Qualitative Study_Transcripts_Participant 3_20170212

No		0.0186	1		
			1	SLN	2/23/2017 2:36 DAA
Telling them is really hard because ... I don't know ... I have to like (uhm) ... get a feel that they'll be OK when talking to them but then when it becomes to like oral sex (uhm), it's very easy to tell them that I'm positive.					

Internals\\Qualitative Study_Transcripts_Participant 4_20170212

No		0.0231	1		
			1	SLN	2/23/2017 2:58 DAA
I'm going to say it doesn't make it easier (uhm) unless (uhm) ... if ... based on my experience or history (whatever), it does matter if I'm having sex with a bisexual or straight man. Uhm, it would be easier to ... to disclose it probably if it's just going to be (uhm) just oral sex and sometimes I have encountered in the past that once I disclosed that I am HIV-positive, they only want to do oral sex. But with gay guys, most of the time, it really doesn't matter. With straight guys or [Laughing] discrete or in-the-					

Nodes\\Q4 SHOULD HIV + disclose to casual sex partners\\No

Document

Internals\\Qualitative Study_Transcripts_Participant 6_20170228

No		0.0158	1		
			1	SLN	3/6/2017 2:46 DAA
from my point of view I think we don't have to. We don't have to because (uhm)... this is something like private ... We don't have the responsibility to tell other people and if some random people (you know) ... like casual hookup or something (uhm), if they're interested in you and then they can ask actually and ... If they don't ask you, then you don't have to tell ... That's my					

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

No 0.0229 2

1 SLN 3/7/2017 11:29

I feel that they should disclose their status to all sexual partners but they don't have to in regards to mutual masturbation ... because it's just masturbation. You're not having any bodily fluid exchanged (uhm). In regards to oral sex, I don't believe that you have to disclose your status (uhm) because there has not been any documented cases where oral transmission of HIV was

3/7/2017 1:24 PM

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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2

In regards to oral sex, I don't believe that you have to disclose your status (uhm) because there has not been any documented cases where oral transmission of HIV was involved

Internals\\Qualitative Study_Transcripts_Participant 8_20170305

No 0.0101 1

1

When it comes to masturbation, I don't think that (uhm) ... I don't think they should be inclined to (uhm) ... uhm... what is it called ... to disclose their status ... That ... Because the risk ... the risk is so low that I don't think that they should ... and the people receiving it ... whatever ... the people involved know that (uhm) that they... what do you call it ... their chances of getting

Nodes\\Q4 SHOULD HIV + disclose to casual sex partners\\Yes

Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

No 0.0349 1

So, my attitudes toward it is that there should be a more open conversation, definitely. I think there's definitely fear. Being on both sides of the fence, there's fear of rejection, fear of disappointment. So people tend to not discuss it openly. So that, I understand. I feel that people should have a better way of being able to communicate and that's why I'm always for these social media apps because it helps you disclose without having to engage in that type of conversation. Uhh, it also allows you to have ... it gives you options and it gives you freedom (you know) for you to be able to say openly without having to bring it up in a more spontaneous encounter. Uhh, I don't know what kind of casual sex you have or the other people you had but there has been some that I've had where (you know) ... when you go online and they come to your door and it's like pizza, you consume it

Internals\\Qualitative Study_Transcripts_Participant 2_20170212

No 0.0311 1

yes. I feel like everybody should (you know) tell (you know) their partners about it but ... I totally get it because I tried on my own and I had good experiences and that experiences ... so, it's not an easy situation ... makes you feel uncomfortable but I think everybody should ... and at the same time, I feel like we should educate (you know) like people (you know) about HIV more and how it's transmitted and all of that so that they have a good understanding because you want to feel like accepted. Uh huh."

Researcher: "So, uhm, people should disclose their status ..."

Participant 2: "For sure."

Researcher: "...regardless if it's oral sex, anal sex, or other sexual situations or behaviors like mutual masturbations?"

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Internals\\Qualitative Study_Transcripts_Participant 3_20170212

No 0.0323 1

Yeah, I definitely do believe that we need to disclose because even though you're undetectable, there's still a little small chance of transmitting the disease. I've always been telling people ... telling my sexual partners about status because I really believe people should know. Ugh. Also, because I'm scared of I do like transmit to them, I'm scared of the legal lawsuit like that."

Internals\\Qualitative Study_Transcripts_Participant 4_20170212

No 0.0282 2

1 SLN 2/23/2017 3:00

think we all have the responsibility to disclose it because it is a disease and you don't want to just give it to somebody else. Uhm, you know ... I think that's just being responsible. Uhm, I think we all have the responsibility to disclose it. Uhm, Yeah.

2 SLN 2/23/2017 3:00

Yes. I do, however, think that disclosing it in person would be a lot harder than doing it on the apps or (uhm) online ... in that ... basically. So, I think everybody should have responsibility to disclose it online, on their profile of their status (uhm) to start with (uhm) ... then if it didn't happen ... then ... uhm ... uhm ... what do you call that? Naturally when you go to the bar, then we all should disclose it in person if it's not through online."

Internals\\Qualitative Study_Transcripts_Participant 5_20170218

No 0.0301 1

1 SLN 2/27/2017 8:35

Yes. I do feel that disclosure is important because ... when I was negative ... like ... I would have wanted people to let me know regardless whether it was a casual thing or a non-casual sexual thing. Now... having been ... on this side of things where I am positive, I understand that there are more ... there are more considerations ... and (uhm) ... because sometimes (like, like) ... for something so casual where ... and the other person is not at risk of getting it ... one can make the argument that why do they need to know? I mean, before ... and still today ... it's sensitive information about someone health status ... uhm ... so that person is being put in (uhm) a more vulnerable position, then (I guess) the other non-positive person is also in a vulnerable position as well ... But see that's the thing, I think ... I'm really specifically talking about ... like where they're not at risk, then I would say why would they need to know. So, I don't have a very good answer to that ... I mean, I guess... My answer is yes but

Internals\\Qualitative Study_Transcripts_Participant 6_20170228

No 0.0116 1

1 SLN 3/6/2017 2:47

but for myself, I would always tell them just to ... just to make sure they won't ask me about my status afterward and then I tell them that I'm HIV-positive and they would be too panicked and then like blame me and (you know) like do crazy things. So, just

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

No 0.0412 2

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"I feel that they should disclose their status to all sexual partners but they don't have to in regards to mutual masturbation ... because it's just masturbation. You're not having any bodily fluid exchanged (uhm).

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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			2	SLN	3/7/2017 11:29 ^ ^ ^
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So, in anal sex ... yeah ... you should disclose.”

Researcher: “OK, So, with oral sex, does it matter if it’s giving or receiving or”

Participant 7: “I (uhm). Well, when you’re giving, it’s less risk involved translates to having to disclose or not then it’s up to you ... but ... If you’re the receiver, then ... Well, if you’re the positive person and you’re receiving the blowjob, then (uhm) the other person has a higher risk than if they were the person receiving the blowjob from you.”

Internals\\Qualitative Study_Transcripts_Participant 8_20170305

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But to answer your question. No. If you’re just involving in mutual masturbation ... no, you don’t need to disclose your status. Oral sex ... yeah... you should ... Uhm, I made the mistake of not telling that one guy ... thank God he didn’t catch anything ... (uhm) ... Yeah, uhm, and if you’re going all the way, most definitely. Uhm, you should absolutely ... absolutely because (you know) ... not only ... not only is it like ethically or morally wrong ... it’s just (uhm) ... or legally or ... or it’s also legally wrong because (uhm) ... (you know). If you do... if you decide to practice unprotected sex ... (uhm), then you should definitely (you

Nodes\\Q4 SHOULD HIV + disclose to casual sex partners\\Yes \\Easier to disclose now than earlier

Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

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I’m sure attitudes have shifted and it has been an easier conversation. There has been partners who I have encountered where they asked me ... and almost in the heat of the moment they asked me and I told them the truth and they said, ‘fine, I’m on PrEP so let’s do it’. They say things like that. Those conversations don’t or won’t happen like 10 years ago. Right, if you think about it. Right? So, uhmm, there’s definitely been improvements. There’s definitely still stigma there .. I’m sure ... I’ve had friends who have encountered rejections because of their status. So, uhmm, we have work to do but it’s gotten better.

Internals\\Qualitative Study_Transcripts_Participant 2_20170212

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I kept it for like eight years until I moved to L.A. (you know) ... I think we have ... We're so lucky that we have like so many good doctors, so many good healthcare (you know) in L.A. So, that kinda opened up my doors so, so. And, then, yeah, yeah. I feel like it gets easier and easier (you know) over time

3/7/2017 1:24 PM

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
Internals\\Qualitative Study_Transcripts_Participant 5_20170218				
No		0.0046	1	

1 SLN 2/27/2017 8:34

I think I'm getting to come to a point where I'm more comfortable with it ... where I don't actually care if anybody knows ... who knows ... but I'm not at that point yet.

Nodes\\Q4 SHOULD HIV + disclose to casual sex partners\\Yes \\Stigma still attached to HIV +

Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)				
No		0.0339	2	

1 SLN 2/23/2017 10:36

There's definitely still stigma there .. I'm sure ... I've had friends who have encountered rejections because of their status. So, uhmm, we have work to do but it's gotten better. I feel that in general, we have more work to do."

2 SLN 2/23/2017 10:37

People go out ... somebody gets diagnosed with cancer and everybody puts in donations and it's all public and everybody feels sorry for them. For someone to get HIV, it's .. there's a stigma. You can't say it publicly. If you have diabetes, you can say, 'I have diabetes'. And (you know), people would say, 'I'm so sorry'. If you have a mental illness, more often than not, people would say, 'I'm sorry that you're feeling depressed ... ta ta ta, you know. Uhm, definitely not the same for HIV. So, there's definitely a lot of work that can be done in terms of having a better conversation around it. Not just in the context of disclosure, but in the

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1 SLN 2/23/2017 2:47

would disclose ... oh ... I don't know because I actually ... it never happened to me before ... It's kind of be harder to disclose. Yeah."

Researcher: "Because of the face-to-face interaction?"

Participant 3: "It just never happened to me. I never had to disclose in person like face-to-face at a club. But if it does happen (you know), I think it would be really hard for me to do."

Researcher: "OK. Tell me why it would be harder for you to do?"

Participant 3: "Because I fear of like being rejected right in front of my face. And stigma. People are still afraid of this disease. On

Internals\\Qualitative Study_Transcripts_Participant 8_20170305

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Uhm, yeah, the stigma is still alive... (you know) ... PrEP is doing the best it can (uhm). There is hope out there but a lot of people just from what they've heard or seen on TV, they really have like negative (uhm) ... a negative view on ... on positive people.

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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people's perception on HIV will never change because there is ... ultimately, there is no cure for the disease.... You know what I mean? That's how people look at it. There is no cure.

Nodes\\Q5 Ethnic identity\\Asian American

Document

Internals\\Qualitative Study_Transcripts_Participant 2_20170212

No 0.0204 1

1 SLN 2/23/2017 12:46
D M A

That's a tough question. I don't identify with neither, which is really weird. I feel like (you know) I'm a well-rounded citizen so I identify with every group but if I have to choose in comparison, then I would identify with my people more because of cultures. I think (you know)."

Researcher: "OK, you typically would not put yourself in one group or category but if you had to ... then you would identify more with your own ethnic and Asian groups in America?"

Internals\\Qualitative Study_Transcripts_Participant 3_20170212

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1 SLN 2/23/2017 2:38
D M A

So you identify more closely with your own ethnic group?"

Participant 3: "Yes."

Researcher: "And what is your ethnic background?"

Participant 3: "I'm Chinese."

Researcher: "So, you associate more or have more friends who are similar to you?"

Participant 3: "Yeah."

Internals\\Qualitative Study_Transcripts_Participant 5_20170218

No 0.0839 2

1 SLN 2/27/2017 8:37
A A A

I would say growing up and up until maybe about 10 years or so ... I would say I identify with more White mainstream groups. And within the last 10 years, I definitely much more identify with my own ethnic background and other Asian groups."

Researcher: "And what is your ethnic background?"

Participant 5: "Filipino and Chinese."

Researcher: "So now you're more identified with your own and other Asian groups ..."

Participant 5: "Yes. Yeah, I definitely more closely identify with that ... with Asian groups with (uhm) ... with my own or other Asian groups... I would just say Asian in general. I do identify with them more but that being said ... typically I would have to say Asian groups but who are more here, like me. So I guess that's culturally more Americans but more with roots in their ethnic background. Do you know what I mean? So, it's kind of a mix of both."

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number	
			2	SLN	2/27/2017 10:21

Asian born in Asia but he has living here at the time .. and (uhm) he found out that he was and (uhm) ... I was helping him through it... At that point, I disclosed to him that I ... I wanted him to not feel alone ... I wanted to make sure that he knew someone who could understand where he was coming from ... I just didn't want him to feel alone. So, (uhm), I started to go with him to an Asian American support group ... No, sorry, an Asian positive support group and he ended stopped going and I continued on even though I've known for sometimes and I found that I was really getting a lot out of it. Uhm, I didn't think I really needed ... I didn't think I really needed to be there but (uhm) ... when I actually got there, like (uhm) ... Wow, I'm actually getting a lot from this ... like I was getting ... I wasn't aware that I ... there was some kind of a need ... it just organically happened and I have kept going and I really felt like there were people that got it, understood, and who knew ... because I had gone to other support groups ... to a couple of other support groups. They were good, the people were great but they were all non-Asian and (uhm), I really didn't think that was an issue until I went to an Asian group and I'm like ... there something that just clicked (uhm) ... There's something that just felt like more familiar and a little bit more supportive. I don't know why. I can't explain why but ... I just felt better surrounded by people who come from that same thing, who has shared my same background. Uhm, and so, I think that, I know that it's hard for people to disclose in general. I think there are even more even more sophisticated hurdles with an Asian community but I do find that it would be more ... it would be beneficial for people to ~~discuss more well, just be a little bit more honest with it because other people can benefit from it and then (uhm) again~~

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

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now that I'm growing older, I identify more with Asian groups in America.

2

And (uhm), the fact that there are Asian Americans who are positive and those groups exist in California has helped me to bond and accept myself as an Asian American male who is positive, which is different than another mainstream whether it would be White, Latino, or African American who may be positive.

Nodes\\Q5 Ethnic identity\\Neither

Document

Internals\\Qualitative Study_Transcripts_Participant 6_20170228

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			1	SLN 3/6/2017 2:50 DM

From China and literally what they called Fresh Off The Boat [Laughing]. So, (uhm) I don't really feel ... I don't really get the sense of belonging to any group. So, that's not a big difference for me."

Researcher: "OK. Would you say you have more friends who are Asian ethnicity or more White mainstream?"

Participant 6: "Uhm, not Asian. I have more friends that are not Asian. I couldn't say they're White because (uhm)... there are some White but also other like Latino (you know) Latinos in California everywhere and (uhm) other races likeBut to be honest, I have less Asian friends than the other races."

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Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
Internals\\Qualitative Study_Transcripts_Participant 7_20170304				

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Yeah, previously ... before I didn't know where I belong ... Yeah."

Researcher: "And how long ago was that when you said previously?"

Participant 7: "Uhm, maybe three or four years ago"

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I didn't really identify myself as Asian to be honest with you ... and this is a complete truth like....[Laughing]. I didn't know that I was Asian ... Every time it comes to test-taking time and (you know) like legal application or whatever, I would just like (uhm)... I would always marked (uhm) ... uhm, 'Other' because I didn't know that Pakistani was part of Asian and my whole life people

2

So you don't identify with either group?"

Participant 8: "No, I don't really ... I mean... I don't know ... Like I said ... I didn't find out until later ... after high school ... like after high school that I'm Asian and so (uhm) ... So ... but growing up I was treated ... I was treated ... I wasn't treated with respect by either ... you know what I mean?"

Nodes\\Q5 Ethnic identity\\White mainstream

Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

No	0.0322	1			
			1	SLN	2/23/2017 10:39

I would say that I would be more accustomed to the White mainstream groups. I am a Filipino. I lived there for over 20 years and moved here seven or eight years ago and I know for a fact that a lot of my Filipino friends tend to go into these small Filipino cells that they have where they have their TFC and talk about politics and (you know) and eat all those fun foods that Filipino have ..."

Researcher: "Can you tell me what TFC is?"

Participant 1: "TFC. The Filipino Channel. So they ... and it's great (you know) ... I love the Philippines but I'm here to meet people and although I have some Filipino friends, I don't necessarily spend most of my time with them. I spend most of my time with people who want to spend time with me. So, in terms of group identification I would lean towards the mainstream groups."

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Internals\\Qualitative Study_Transcripts_Participant 4_20170212

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			1	SLN	2/23/2017 3:01

Uhm, probably White mainstream groups."

Researcher: "So, what is your racial ethnicity or background?"

Participant 4: "I'm Southeast Asian."

Researcher: "Southeast Asian. OK, you typically have more friends who are not Asian and they are more considered to be in the White mainstream group?"

Participant 4: "I have more White friends than Asian friends."

Nodes\\Q6 Influence of cultural mores on HIV disclosure to casual sex partners\\Immigration to US enabled acceptance of self

Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

No 0.0281 2

1 SLN 2/23/2017 10:51

Has your values or cultural backgrounds influenced or changed in any way since you have moved to the United States?
Participant 1: "Significantly. I think that there's (uhmm) ... there's things that changed and things that don't change (you know) with people and ... For me, for moving here taught me to be less afraid of myself."

2 SLN 2/23/2017 10:52

When I moved here I started looking for .. that I could be gay ... to the other side of the spectrum I could do whatever the fuck I want (you know). So, that has led me to better understand (you know) that it's OK to talk about it. It also led me to understand that sometimes you just want to have sex for the sake of having sex and just do it (you know) throw 'caution to the wind' and (you know) it's free me in a sense (you know).

Internals\\Qualitative Study_Transcripts_Participant 6_20170228

No 0.0273 1

1 SLN 3/6/2017 2:57

And then when I came to America and I actually changed a lot (uhm) ... Well, it's ... the change also happened along with .. I know myself better (uhm) .. better knowledge about this disease and I saw a lot of examples ... positive examples around me. I ... I go those supporting groups ...Uhm, I saw other people ... a lot of people they just ... a lot of people also go for their dreams and their goals in life (uhm) ... they live a very positive life (you know) ... That pretty changed me ... changed me ... My whole point of view (you know towards this .. this whole thing. So, uhm, uhm...."

Researcher: "So, has it gotten easier ... over time?"

Participant 6: "Easier. Yeah. Yeah. It's easier"

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Nodes\\Q6 Influence of cultural mores on HIV disclosure to casual sex partners\\Immigration to US enabled acceptance of self\\Better medical care Document

Internals\\Qualitative Study_Transcripts_Participant 2_20170212

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1	SLN	2/23/2017 12:51 PM
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I kept it for like eight years until I moved to L.A. (you know) ... I think we have ... We're so lucky that we have like so many good doctors, so many good healthcare (you know) in L.A. So, that kinda opened up my doors so, so. And, then, yeah, yeah. I feel like it gets easier and easier (you know) over time

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1	SLN	3/6/2017 2:52 PM
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I actually got infected when I was in China and that's also (uhm) the biggest reason I want ... one of the biggest reason I (uhm) chose to come to America to get access to better treatment and (you know) to have a better quality of life because back in China the ... like the discrimination ... They are very, very out of time... how do I say this? The treatment is very, very out of time ... medication sources are very limited and side effects.... I suffered a lot of side effects Like the depression from certain kind of medication. I try to suicide in China because of depression and but I had no other choice ... I have to take the medication ... that was the best (uhm) combination that I could get when I was in China. Things were different when I came to America, I got

Nodes\\Q6 Influence of cultural mores on HIV disclosure to casual sex partners\\Immigration to US enabled acceptance of self\\Greater access to information and support groups Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

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1	SLN	2/23/2017 10:53 AM
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So, that didn't necessarily go away until I did my homework. When I did my homework and I was surrounded by a really good support group (you know) I have a few friends that are HIV-positive and met several people in groups in L.A. and it's ... Those resources have helped me understand the disease and myself."

3/7/2017 1:24 PM

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
Internals\Qualitative Study_Transcripts_Participant 5_20170218				
No		0.0970	2	

1 SLN 2/27/2017 10:21

Asian born in Asia but he has living here at the time .. and (uhm) he found out that he was and (uhm) ... I was helping him through it... At that point, I disclosed to him that I ... I wanted him to not feel alone ... I wanted to make sure that he knew someone who could understand where he was coming from ... I just didn't want him to feel alone. So, (uhm), I started to go with him to an Asian American support group ... No, sorry, an Asian positive support group and he ended stopped going and I continued on even though I've known for sometimes and I found that I was really getting a lot out of it. Uhm, I didn't think I really needed ... I didn't think I really needed to be there but (uhm) ... when I actually got there, like (uhm) ... Wow, I'm actually getting a lot from this ... like I was getting ... I wasn't aware that I ... there was some kind of a need ... it just organically happened and I have kept going and I really felt like there were people that got it, understood, and who knew ... because I had gone to other support groups ... to a couple of other support groups. They were good, the people were great but they were all non-Asian and (uhm), I really didn't think that was an issue until I went to an Asian group and I'm like ... there something that just clicked (uhm) ... There's something that just felt like more familiar and a little bit more supportive. I don't know why. I can't explain why but ... I just felt better surrounded by people who come from that same thing, who has shared my same background. Uhm, and so, I think that, I know that it's hard for people to disclose in general. I think there are even more even more sophisticated hurdles with an Asian community but I do find that it would be more ... it would be beneficial for people to ~~discuss more ... well, just be a little bit more honest with it because other people can benefit from it and then (uhm) ... again~~

2 SLN 2/27/2017 10:22

Well, I would say any support group but it does help. I think the more (uhm) the more you share in common whether sex ... or gender I should say ... well (you know) age, (uhm) ... ethnicity. I think that the more you share in common that I think it does help (uhm) because I don't know. You just kinda find people that kinda can get it or in the same situation as you. So, it's like ... Oh, OK, you can learn a lot from them and they can learn a lot from you. Your experiences. Their experiences. But that being said, I mean, if there isn't something available where it is their ethnic background ... you know, any support group would help. I mean, in a place like L.A., we're so big, we're going to have all of that available to us but some place more remote, there might not be an Asian group (you know) and so then ... yeah, getting any kind of support ... going to any support group would be beneficial but I'm very much an advocate of joining something where you could share your experiences and feel not so alone. That's very ... that is so important. That feeling of aloneness ... (uhm) it's awful, you don't ... you feel like you can't fit ... like you just feel so overwhelmed and left behind... like it's very separate and so... To get rid of that feeling, I think that's why I'm just an

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

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			1	SLN	3/7/2017 11:38 ^^^

I'm not originally from L.A. but ever since like moving to L.A. (like) I feel more comfortable with myself ... not because I'm more comfortable financially but I feel that the support group that they have here and meetings that they have here ... and even the educational seminars and the events that they have here has helped ... helped me understand more about the diagnosis. Uhm, even though I am in the medical profession, I still didn't know as much about HIV until I actually went to the seminars and that I feel that the education and the support helped me coming out and understanding ... and accepting the diagnosis. And (uhm), the fact that there are Asian Americans who are positive and those groups exist in California has helped me to bond and accept myself as an Asian American male who is positive, which is different than another mainstream whether it would be White, Latino, or African American who may be positive. So having those subcultures to connect with and those education and I feel

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Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Nodes\\Q6 Influence of cultural mores on HIV disclosure to casual sex partners\\Media-driven information of disease Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

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			1	SLN	2/23/2017 10:49 ^^^

was raised Roman Catholic in the Philippines and things like that (you know). And growing up in the 1990s, during that times there was a lot of news (you know) regarding what's happening here in the United States and other countries. I was a kid when they had a travel ban in Africa all about AIDS and things like that. In my head, it was inculcated that if you have this disease, you're dead. And I got diagnosed when I was like 27. So I was pretty old and should have been smarter than this (you know) but when I got diagnosed I really legitimately thought that I was going to die. Literally, I have like six months to live and gone ... but literally .. that's what I saw the pictures that ... I heard the news that's what (you know) my ... I'm making that up that my

Nodes\\Q6 Influence of cultural mores on HIV disclosure to casual sex partners\\Minority sub-group Document

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

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Uhm, I feel that being an Asian American you are already a minority. So being positive also makes you a subgroup of a minority. So I feel ... yeah... definitely it's harder because you're not only a minority, you're a triple minority now.

Nodes\\Q6 Influence of cultural mores on HIV disclosure to casual sex partners\\Religion compels honesty Document

Internals\\Qualitative Study_Transcripts_Participant 5_20170218

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SLN

2/27/2017 8:39

OK, how my cultural backgrounds or values might influence or affect ... OK, I was brought up in a pretty religious household ...uhm ... Protestant Christian background ... and uhm ... I would say that ... uhm... because of that I feel that responsibility to be honest and open and that has ... that has really Pretty, I mean ... it's kinda of like the core of who I am. It affects I should say and decisions come from that (but uhm). So,... so I That's where I feel I guess a responsibility to disclose and because I just ... I

3/7/2017 1:24 PM

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Internals\\Qualitative Study_Transcripts_Participant 6_20170228

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1 SLN 3/6/2017 2:56

base on my Christianity (uhm) and being Asian. I don't want to ...(uhm) I don't want to pass the virus to anybody else and so I kind of like limited myself even if I had the physical needs ... I ... of course I got horny sometimes but I just ... I didn't want to do anything in China when I was in China. Even when I learned that as long as I was receiving the treatment ... the treatment was effective in my system and (uhm) undetectable ... remain undetectable. So, that actually pretty safe to have sex with others ... But, well, on the other hand I ... I don't like condoms so ... [Laughing]. I don't ... I know that the risk is really, really, really small ... real, real small, I just don't want anybody innocent to take the risk

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

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Uhm, my family is Buddhist .. Uhm, I feel that my religion plays a little part of it. I try to live life in a good way and I try not to harm other people. So whenever I have casual sex, I do feel awful when I don't disclose my status to a partner. I feel horrible.

Nodes\\Q6 Influence of cultural mores on HIV disclosure to casual sex partners\\Religion compels honesty\\Conflicts with stigma of HIV status and being gay Document

Internals\\Qualitative Study_Transcripts_Participant 5_20170218

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1 SLN 2/27/2017 8:41

was brought up in a pretty religious household ...uhm ... Protestant Christian background ... and uhm ... I would say that ... uhm... because of that I feel that responsibility to be honest and open and that has ... that has really Pretty, I mean ... it's kinda of like the core of who I am. It affects I should say and decisions come from that (but uhm). So,... so I That's where I feel I guess a responsibility to disclose and because I just ... I would want that respect so that I would give that respect. Culturally, (uhm), I

would have to say ... if ... I think Asians in general are private ... generally more private ... and don't talk so many things so openly whether sexuality in general ... and even more so HIV because there's stigma attached. Uhm, and so ...(uhm) ... I being ... It's definitely So, those two things are at odds with each other ... because one part of me is like well I want to be very private, the other part of me, well, you have a responsibility ... and so, uhm, The responsibility generally with ... There are times that I haven't disclosed when there has been negligible risk to them. If there's any kind of risk, then I feel (like, uhm), I need to

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Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Nodes\\Q6 Influence of cultural mores on HIV disclosure to casual sex partners\\Topic of sex taboo Document

Internals\\Qualitative Study_Transcripts_Participant 3_20170212

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				1 SLN 2/23/2017 2:39

My culture as Chinese Buddhist doesn't really affect how it is for my private life sexually. Uhm, you don't talk about it. Yeah."
 Researcher: "So, it doesn't hinder or prevent you or help you in any way?"
 Participant 3: "I don't talk to ... it's kind of like taboo in my culture to talk about sex ... in general."
 Researcher: "Taboo to talk about sex?"
 Participant 3: "Yeah. In general ... let alone HIV ... that would freak everyone out, especially your family."

Internals\\Qualitative Study_Transcripts_Participant 5_20170218

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				1 SLN 2/27/2017 8:40

I think Asians in general are private ... generally more private ... and don't talk so many things so openly whether sexuality in general ... and even more so HIV because there's stigma attached

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

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I think being Asian American ... yes, sometimes it's hard to discuss about sex, sexual preference even in an LGBT community ... but since I live in L.A. ... it's a very open society so ... I feel for me personally, it's not as hard as if I were to live elsewhere."

Internals\\Qualitative Study_Transcripts_Participant 8_20170305

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So cultural background and values do not preventing you from talking about sex or the topic of HIV-positive at all?"
 Participant 8: "Uhm, no. In fact, it encourages me because ...(uhm) ... I don't know ... had I been told ... because sex was never discussed (you know) ... Although religion wasn't really like a hot topic at home ... sex was never to be talked about.

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Nodes\\Q6 Influence of cultural mores on HIV disclosure to casual sex partners\\Unacceptable to be gay in home country Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

No	0.0327	3
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1	SLN	2/23/2017 10:50 ^ ^ ^
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I think my own previous experience of growing up in the Philippines has eroded and I've come to learn that this disclosure ... I should not be afraid of it .. afraid of disclosure ... for one thing ... it's not as much a big deal as it was for me (you know) and for other people who I have encountered

2	SLN	2/23/2017 10:51 ^ ^ ^
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Growing up gay in the Philippines (you know) really didn't only give me a really, really terrible idea of what HIV is but it also really gave me a terrible idea of what it's like being gay is (you know) and I grew up being afraid or angry or upset about being

3	SLN	2/23/2017 10:53 ^ ^ ^
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even though I was raised in a certain way back in the Philippines, being able to embrace myself and move away from the negativity that I had growing up as a kid, as a gay man in the Philippines, I was able to like reinvent myself here essentially (you know) and not be too tied down to what I used to previously believe

Internals\\Qualitative Study_Transcripts_Participant 2_20170212

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1	SLN	2/23/2017 12:47 D M M
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Oh my gosh, (uhm) ... I feel like where I came from (uhm) ... people would never do that because you'd be rejected ... like right away. You'd be put to shame and (you know) uhm, like very badly like (uhm). It's because I think they do that out of their ignorance (you know). Like I said earlier, we should educate them more. The place where I came from (uhm) they don't understand the difference between HIV and AIDS. So, it's kinda hard just to like tell people (you know) because people talk. [Laughing] You know, when you disclose to someone, they would just like (you know), that's it, you're done with your gay scene, your gay life (you know). Uhm, yeah. And, I feel like that affect me a lot so that I have to overcome.

2	SLN	2/23/2017 12:50 D M M
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Well, for the first five years, it was so difficult. I only told like (uhm) three people that I trust. They were my best friends. My parents didn't even know until like 2010 so like (uhm) basically eight years later I ... I told them eight years later. It was so difficult because I thought I was going to die for sure. For sure, there was no way that I was ... there was no hope for me (you know) for the future and like I said in Thailand, that's the end of it. You have HIV, you're going to die (you know) lonely and (you know) that's the background that I was coming from. So, I didn't want to tell anybody (you know). People wouldn't sit at the same table as you or eat with you or drink with you. It was just so weird. They think that they might catch it ... and they even

3	SLN	2/23/2017 1:01 D M M
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As opposed to someone who are a lot more educated may be not so easy? Is that what you're saying?"
Participant 2: "It depends. Wow, this is hard. Uhm. I think it depends on where we are really ... like Thailand is different from here for sure. Because my family is still in Thailand. I told my mom and I'm sure my mom would tell everybody (you know) in her family. Also my dad ... like I said his education is like less than high school for sure. I don't think he graduated from middle school. Ugh ... so I told him ... I'm pretty sure he told everybody (you know). I'm sure of that. I'm sure of that. Uhm, so, that's a weird thing ... you're telling them ... right ... they tell everybody. But for me, that's my privacy (you know) uhm, I think I'm careless about it here now and not there. So, yeah, in Thailand ... if you tell ... even though if they have education (you know) and all that. they would probably ... they know what it is but they would probably not accept you compared to like people here

3/7/2017 1:24 PM

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Internals\Qualitative Study_Transcripts_Participant 4_20170212

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1	SLN	2/23/2017 3:01 PM
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Uhhmmuhmmm... as far as my Asian background? Uhm ... if I were to say and have sex in this country, I don't think it matters much. But if ... if I go back home ... if I go back home, then I would be more cautious about disclosing or not disclosing my status and just because, the values over there, they still have stigma that people with HIV ... and not many people are educated about HIV."

Researcher: "And where is home?"

Internals\Qualitative Study_Transcripts_Participant 6_20170228

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1	SLN	3/6/2017 3:13 PM
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can't say that good education but (uhm) ... much better educated than people in China because people in China even get confused about (uhm) those simple ideas like what is AIDS, what is HIV, what's the ... and how are they related to each other ... They don't know about that. So, they just ... they just say whoever has HIV or have infected with HIV, they just say, "Oh, he got AIDS." You know ... even ... there are so lack of basic knowledge ... so ... it's very hard to ... to explain any ... to educate them [Laughing]. You know ... so the discrimination in China is very solid ...it's hard ... but I feel like ... I can't say it's very easy but it's

Nodes\Q6 Influence of cultural mores on HIV disclosure to casual sex partners\Unacceptable to be gay in home country\Fear persists even tho now in US Document

Internals\Qualitative Study_Transcripts_Participant 2_20170212

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1	SLN	2/23/2017 12:49 PM
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So, in Thailand, people are not as educated or shun you if you were to disclose your status and that carries through because you're still part of that Thai culture. Does it affect you in any way even though you are living the States now?" Participant 2: "Yeah, it does (you know) because every time I think about it (uhm) I feel like, oh my gosh, I shouldn't do that because that fear has haunted you. I guess. It's haunting. OK (uhm) some people would not accept you in the community ... even in the workplace environment (you know) if you disclose your status and they might not (you know) hire you. And, here it's a fear ... living with this fear that has been with me for decades and I just have to overcome it every day. It's another step, it's another layer I have to like overcome before like telling people (you know)."

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Nodes\\Q6 Influence of cultural mores on HIV disclosure to casual sex partners\\Unacceptable to be gay in home country\\Freer now that in US Document

Internals\\Qualitative Study_Transcripts_Participant 6_20170228

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1 SLN 3/6/2017 2:51 PM

What's more, I'm from a very, very strict ... very traditional family. So, uhm, it's part of the reason why I chose to leave my hometown behind and come to this country alone. Uhm, I kinda like try to escape from the cultural environment ... you know, my background. And, what's more (uhm) ... when I was in Chinese ... so ... I feel like ... my perspective ... my point of view towards all those things are kind of different from the mainstream in China. So, I feel like (uhm) more free, less depressed in America. So, I don't really (uhm) ... I don't really feel any impact, influence based on my cultural background or values."

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

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And even being an American (you know) ... you're just straightforward, open ... and I feel that it's definitely helped me living in America and having that culture to be more open (uhm) to disclose my status versus if I had grown up in Asia then I might not

2 SLN 3/7/2017 11:31

And even being an American (you know) ... you're just straightforward, open ... and I feel that it's definitely helped me living in America and having that culture to be more open (uhm) to disclose my status versus if I had grown up in Asia then I might not

3

but ever since like moving to L.A. (like) I feel more comfortable with myself ... not because I'm more comfortable financially but I feel that the support group that they have here and meetings that they have here ... and even the educational seminars and the events that they have here has helped ... helped me understand more about the diagnosis.

Nodes\\Q7 How discuss or disclose changed over time

Document

Internals\\Qualitative Study_Transcripts_Participant 8_20170305

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like I said ... it has come a lot easier to find someone in the same boat with HIV when you have Adam4Adam, Grindr, and what have you. You know, there are ways to filter your results (uhm) and so that's (you know) ... that has made it easier for people like me ... but (uhm) a lot of those people ... they're not what I'm looking for

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Nodes\\Q7 How discuss or disclose changed over time\\Age related

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Internals\\Qualitative Study_Transcripts_Participant 2_20170212

No 0.1111 1

1 SLN 2/23/2017 1:06

It used to be easier but now it's a lot harder. Makes sense? I feel like five years ago it was easier for me, here you go, this is my status, are you cool with that? What's your status? Because I didn't really care about my image that much ... but now the last time I went back on Grindr, for example, so yeah. I don't know. I kinda care about my image ... a lot more ... So it was so difficult to tell people."

Researcher: "Because you changed, meaning that you worry about your image more as opposed to the app being easier or harder to allow people to disclose if they choose to ..."

Participant 2: "I think it's more about me. Yeah. So. I think the older you are ... the older you are, you tend to have more fear [Laughing] I mean that's just me."

Researcher: "I liked what you said. I want to dive into this if you don't mind because you said that it gets easier, the longer you've been diagnosed to disclose but yet the longer you are going to be diagnosed you also in the meantime getting older and that makes it harder. So how does that work?"

Participant 2: "That's so funny because like I'm hitting like 30, 40, ... this is the end of the gay world. I might not find anybody. Right? At the same time, you say fuck it, I don't even care, just tell people because it's the right thing to do and then you start to have like insecurities. Right? Insecurities, oh, oh my gosh... I might die lonely (you know) uhm. So, it's such a weird dynamics. It would change from time to time I believe. I think when you get older, you get wiser too so it's that kind ... You have to make that kind of decision (you know) very quickly for yourself. Like, who do I want to have as a partner or a hookup partner? You know, it's kinda different so you. I don't know. Some people just like I don't care (you know) they just don't give a fuck. Yeah, so, but ... I think for me ... right now, I'm just looking for someone long-term. So, it's slightly different ... I'm in a different place (you know) compared to where I was about a year ... I just didn't want to have a relationship (you know). I only wanted something temporary. So, uhm, It makes me think, I like it. [Laughing]"

Researcher: "So the older you get ... let me just makes sure I'm clear, is it easier or harder for you ..."

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

No 0.0159 1

1

it has definitely changed since I was first diagnosed in my early 20s and now I'm in my late 30s. As maturity ... (uhm) as maturity happens (you know) ... the way you disclose to your partners also changes ... so... At first, I was not disclosing because I was

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Nodes\Q7 How discuss or disclose changed over time\No since honest about it since dx

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Internals\Qualitative Study_Transcripts_Participant 1_20170208 (1)

No	0.0600	2	1	SLN	2/23/2017 10:56
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So, in terms of how that reflects as my own disclosure habits (you know), I come to initially .. I thought that now I'm like marked. (You know) I got to tell everybody. I have to call all my previous sexual partners and things like that and make sure that they all know. It's a tough exercise but moving forward and knowing and learning about undetectability, I think my own previous experience of growing up in the Philippines has eroded and I've come to learn that this disclosure ... I should not be afraid of it .. afraid of disclosure ... for one thing ... it's not as much a big deal as it was for me (you know) and for other people who I have

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believe it was six months after .. six months after I was diagnosed I eventually learned that (you know) I just got to get out there again. And just (you know) why not? And, at that point I had to make a choice ... I had to make a choice whether (you know) you want to pretend that everything is normal or you want to go out there and (you know) that's when I made a choice that I gotta to disclose right upfront. Even though not all apps had that option before ... like three or four years ago ... I don't think Grindr had it four years ago but I had in my profile ... like it's there ... it said that I'm undetectable (you know). And if they ask (you know) ... if they know it, they ask. They ask and then I'll let them know (you know) that I'm positive and I'm taking my meds and things like that. So, uhmm, in that sense (you know) my disclosure haven't changed over times. It's just that I made a choice that

Nodes\Q7 How discuss or disclose changed over time\Role of support groups

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Internals\Qualitative Study_Transcripts_Participant 4_20170212

No	0.0628	3	1	SLN	2/23/2017 3:07
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mean today, at the present time, the only value that I follow is the ... right now is the 12 steps from the CMA program ... and that ... and that value teaches me to disclose my status regardless who ... whether [Laughing] ... the value is that is not to hurt other person, basically ... so (uhm) by not disclosing it and contracting HIV to somebody else involuntarily ... I think that it's hurting somebody. So, uhm, so that is the value that I follow today."

2 SLN 2/23/2017 3:07

Yes. Like I said, I go to that CMA, HIV-positive meeting every week. Without going every week and say that I am a positive addict ... by saying it out loud ... I probably still going to be covering my status or not necessary disclosing my status more freely. So."

3/7/2017 1:24 PM

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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3 SLN 2/23/2017 3:08

"Social class ... I don't think it will matter to me. It matters more like (uhm) who you are disclosing to (uhm) and how (you know) ... uhm, Uhm, what your personal character is really (uhm). I mean the program of 12 steps (you know) ... there might be (you know) certain people that I would not disclose... Uhm, (you know), I might still be lying about my status ... I don't know [Laughing]. So."

Researcher: "So, the CMA group that you go to has really helped ..."

Participant 4: "Yeah, my character. So ..."

Researcher: "That's good to hear. That's great."

Participant 4: "Yeah."

Researcher: "You feel 'quote' like you're a new person ... You referenced the new and old version of you ... and a lot of that is because you regularly going to CMA groups."

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1 SLN 3/6/2017 4:35

Well, it's ... the change also happened along with .. I know myself better (uhm) .. better knowledge about this disease and I saw a lot of examples ... positive examples around me. I ... I go those supporting groups ...Uhm, I saw other people ... a lot of people they just ... a lot of people also go for their dreams and their goals in life (uhm) ... they live a very positive life (you know) ... That pretty changed me ... changed me ... My whole point of view (you know towards this .. this whole thing. So

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

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And then over the years I went to counseling and developed ways to (uhm) cope with it. I gather friends who knew about my status and through those relationships; I knew that it was OK to live with it

Nodes\\Q7 How discuss or disclose changed over time\\Self-educated so knows science of HIV Document

Internals\\Qualitative Study_Transcripts_Participant 6_20170228

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1 SLN 3/6/2017 2:55
DAA

but soon I tried to go online and study more about this ... but then (uhm) because I speak a little English ... a little English so I ... What I did was that .. I went on those websites like based in America or European ... those European websites instead of websites in China because (uhm) those information are also out of time and those people ... they don't know much about this disease and they ... they just say a lot of wrong information, spread a lot of wrong information and make people feel like desperate. So, I pay a lot of attention to the frontier of the studies and research and those kind of things. I tried to ... I tried to find hope and then ... and also [Laughing]. So, during this process, I decided to (uhm) to get out of China ... to, to, to get better

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Uhm, yeah, definitely I feel that if you're educated on the disease itself (uhm) you will be more likely (uhm) understand its transmission and you would be more likely to disclose to other sexual partners

Nodes\\Q7 How discuss or disclose changed over time\\Talking in general about HIV is easier

Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

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In terms of verbal communications, it's gotten better. I think there's talking about the disease or the virus or my experience that how I'm now it's definitely gotten easier. That I can say, in general. Outside of sex."

Nodes\\Q7 How discuss or disclose changed over time\\Will disclose now not before

Document

Internals\\Qualitative Study_Transcripts_Participant 2_20170212

No	0.0581	2
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Yes but before let's say about 10 years ago or five years ago, it would be .. I had a hard time. It was so difficult dealing with it. But I think nowadays since I turned ... well, about three years ago ... something has happened to me that I said, 'OK, why don't we just like be straightforward to each other (you know). They have the right to know, I have the right to tell and it would eliminate (you know) a lot of drama and complications. So, I don't need that in my life. So I decided that I'm going to do this (you know). It's fair and square (you know). Yeah. I've been doing that ever since."

2

Well, for the first five years, it was so difficult. I only told like (uhm) three people that I trust. They were my best friends. My parents didn't even know until like 2010 so like (uhm) basically eight years later I ... I told them eight years later. It was so difficult because I thought I was going to die for sure. For sure, there was no way that I was ... there was no hope for me (you know) for the future and like I said in Thailand, that's the end of it. You have HIV, you're going to die (you know) lonely and (you know) that's the background that I was coming from. So, I didn't want to tell anybody (you know). People wouldn't sit at the same table as you or eat with you or drink with you. It was just so weird. They think that they might catch it ... and they even

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Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
Internals\Qualitative Study_Transcripts_Participant 3_20170212				
No		0.0601	1	

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It's gotten easier because now it's like ... I don't feel any difference now. I feel kinda normal now because being undetectable and that realizing that we could live a normal life. Right now with modern medicine ... so, over time ... I've been positive for two years now and over time it has gotten easier to talk about it or to disclose because to me, if I say it ...if you don't want to be with me because I'm positive, then it's meant to be. I don't fight it."

Researcher: "OK. You've been diagnosed for two years and looking back it has gotten easier to disclose your status as opposed to when you first diagnosed ..."

Participant 3: "Maybe actually it's not two years ... maybe 1.5 since July 2015. So maybe 1.5 years."

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No		0.0342	2	

1

SLN

2/23/2017 2:56
PM

Yes, and I've always disclosed ... not always but the past, I would say (uhm) three or four years, especially, I always put my status as positive or undetectable."

2

SLN

2/23/2017 3:03
PM

It definitely was hard after I found out that I was positive (uhm) to disclose my HIV status and uhm... I probably lied a few times [Laughing] Uhm, in the past (uhm) but once I found out an online website that is more targeted to people who have HIV or people who have HIV-positive, then I just stay with that hookup site ... and ... and now I disclose my status online and not really seek sex outside anything else ... I'm not comfortable with (uhm) ... without disclosing my status. So, it's changed. Yes, it has changed since I found out but it was harder at the beginning but once I found a group or the support or the online hookup, that

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SLN

2/27/2017 10:12
AM

Yes. Uhm, I've learned to bring it up faster because I was really (uhm) really hesitant before and I kinda of like more put it out there upfront because why waste either of our times if they're not interested in engaging in somebody who's positive, then I'd rather know upfront. Same for them ... and not just continue on ... and so ... it comes up faster (uhm).

Internals\\Qualitative Study_Transcripts_Participant 6_20170228

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1	SLN	3/6/2017 2:58
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I was really afraid of ... So I didn't disclose it until (uhm) I feel like I need to (uhm) ... I need to see this relationship like serious ... So, I disclosed it to him (uhm) very, very carefully but still (uhm) ... he was in shock .. he was (you know) ... So, after that I changed like more ... after that I just prefer to tell people even before we met each other. So, to avoid this situation from happening again. Uhm, and as for now I don't ... I don't intentionally (uhm) hide it. So, I can pretty ... because ... Well, this is a big city and who knows about me? I'm just a FOTB. I'm new here. Nobody knows about me. Whatever. I just tell people

3/7/2017 1:24 PM

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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1	SLN	3/7/2017 11:26
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.... (yeah) maybe ... but if it's anonymous casual oral sex, then I typically don't. In regards to (like) penetration, when I'm a top or a bottom, then I usually do. Uhm, in the past there has been instances where I did not [Laughing] ... when I use condoms so I do not disclose. So, yeah."

Researcher: "So it's inconsistent is what I'm hearing, right?"

Participant 7: "Lately, I've been more consistent to tell people about my status. Uhm, in the past, not so much."

Researcher: "OK. When you said in the past, how long ago was that?"

Participant 7: "I've been positive for five years now."

Researcher: "OK. And in the past ... meaning ..."

Lately, I've been more consistent to tell people about my status. Uhm, in the past, not so much."

Researcher: "OK. When you said in the past, how long ago was that?"

Participant 7: "I've been positive for five years now."

Researcher: "OK. And in the past ... meaning ..."

Participant 7: "I would say, in the past four years ... Well, in the past year, I've been more consistent."

Researcher: "So this past year you have been more consistent disclosing in any situation whether it's oral sex or intercourse?"

3 SLN 3/7/2017 11:33

At first, I was not disclosing because I was frozen (you know) ... I didn't know what to say or what to do and (uhm) it was hard to find support ... And then over the years I went to counseling and developed ways to (uhm) cope with it. I gather friends who knew about my status and through those relationships; I knew that it was OK to live with it. And then I was able to disclose to more people ... first to friends and then to sexual partners ... Uhm, at first it was happening while they were in bed with me and then later it happened ... now I try to disclose before they meet me so that we don't get disappointed

Nodes\\Q7 How discuss or disclose changed over time\\Yet bad experience with rejection impacts disclosure

Document

Internals\\Qualitative Study_Transcripts_Participant 2_20170212

No 0.0431 2

1 SLN 2/23/2017 12:54

Used it to find his way out. Uhm, after that experience, it got a little harder again (you know) uhm ... so..."

Researcher: "Because of that one negative or bad experience of rejection?"

Participant 2: "Yeah. Yeah. You know like ... if someone can't understand me, the doctor can't understand me ... Right, so, I don't know. So that bad experience actually (uhm). Yeah, ruined everything."

Researcher: "It's interesting for you to share that with me even though it gets easier and easier over time, somebody or an experience like that can take you a few steps back."

Participant 2": "Oh, yeah, yeah. So, I actually am now very picky (you know) uhm with whom I tell actually. I don't really tell like everybody (you know) ... at the same time. I don't want to meet people like I used to anymore. I'm not online or like OK that's

2 SLN 2/23/2017 12:55

I feel like I'm more picky. Yeah, yeah. So, I just have to know that this is the person that I want to get to know like looks like we have something (you know). Yeah, I would tell."

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Internals\\Qualitative Study_Transcripts_Participant 7_20170304

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well, there's something that I have to tell you and promise that you won't get upset and then I told him that I was positive. Uhm, his reaction was really nice and that he said, thanks for telling me ... however, he lost his erection [Laughing] so I kind of knew that [Laughing] that it was a negative experience in his mind ... We continued to mess around but after that (like) ... coming out to him was a very emotional process so I kind of lost interest in doing anything and so we never even saw each

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We've been together for about six months after I told him, I ... (uhm) ... it just ended up abruptly. So, uhm, ... does that answer your question? [Laughing]."

Researcher: "Do you think it ended abruptly because you shared with him that you were HIV-positive?"

Participant 8: "Yeah. Absolutely."

Nodes\\Q8 Specific influence of ses or ed level on disclosure

Document

Internals\\Qualitative Study_Transcripts_Participant 8_20170305

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When people don't give a shit, they don't give a shit ... that's just it... You could be (you know) ... you could be completely smart (you know) or not have nothing ... When people ... If someone who doesn't care, they just don't care. You can't teach someone to care I guess. You know? It just ... that' show they are (uhm) ...

2

To be honest with you... like rich bastards who really don't give a shit about someone who ...someone from (uhm) ... uhm, a different socioeconomic class. Yeah. I'll say it. I don't think ... I think they ... they find ... they don't ... they feel like they don't have to disclose anything because when I got it nobody ... I would ask everybody ... I would ask ... especially when it came to unprotected sex... Uhm, so... you know... people lie all the time.

3

No ... like I said ... like in hindsight ... now that I think about it .. it's ... I really think that people that are well off ... like (you know) from like more affluent area (you know) ... whatever ... theyre more educated or just have more money or whatever They honestly don't give a shit about ... that kid in Santa Ana or whatever ... He's probably going to get it anyway. You know what I mean? If there's drugs involved, then people really don't give a shit ... you know...

3/7/2017 1:24 PM

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
Nodes\\Q8 Specific influence of ses or ed level on dislosure\Don't know				

Document**Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)**

No	0.0265	1
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Let me think about this for a moment. I honestly have no idea. It's plausible It's plausible just because you're more educated, you get more information but then again I have a master's degree and I was crying and freaking myself out. I had a master's degree! I had a master's degree in psychology and here I was telling this doctor in the park over at Olympic crying myself that I was going to die (you know). I think about it now and it's absurd, it's silly, it's funny but I was seriously misinformed at 27 with a master's degree. So, uhm, (you know), level of education I would question a little bit (you know). Socioeconomic status I don't

Internals\\Qualitative Study_Transcripts_Participant 5_20170218

No	0.0153	1
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1

Socioeconomic class though ... I feel like ... because I feel like when you're coming from (uhm) ... there's almost like more of a protectiveness about their status when they're coming from a higher society [Laughing] place. Uhm, so, I don't know if they're more likely to talk about it or not but ..."

Researcher: "It's almost like an inverse relationship..."

Participant 5: "Yeah. It's almost. Right. Because they have more to lose in a way ... but that's just my opinion, I don't know because ... yeah... I'm not in that socioeconomic class [Laughing]."

Internals\\Qualitative Study_Transcripts_Participant 6_20170228

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1 SLN 3/6/2017 3:11 PM

Yes. Yes.”
 Researcher: “OK. But not sure about socioeconomic class ...”
 Participant 6: “I’m not really sure about that....”
 Researcher: “OK.”

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

No	0.0214	1
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1

But for socioeconomic class (uhm) ... not so much.... It doesn’t play a factor.”
 Participant 7: “It only plays a factor when it’s affecting like your living situation or your basis needs like water and food and things like that ... but if you have money to pay for those things, then I don’t think it affects your ability to disclose your status to

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Internals\\Qualitative Study_Transcripts_Participant 8_20170305

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Uhhmm. Uhhmm... People... I don’t know It’s ... The gay (like) community ... it doesn’t have any (like, uhm) ... you know ... you have like a rich guy who live in a mansion on the Coast (you know) who is like ... who’s like (uhm) looking for a young Latin boy in Santa Ana (you know) who aren’t as (uhm) ... who aren’t as well off (you know) as the person... the older gentleman in Laguna ... They ... like ... there’s no ... When it comes to sex and stuff, I don’t really think education or socioeconomic class ... I

Nodes\\Q8 Specific influence of ses or ed level on disclosure\Higher ed = more informed so makes big diff Document

Internals\\Qualitative Study_Transcripts_Participant 2_20170212

No 0.0329 3

1 SLN 2/23/2017 12:57

think it plays such a huge, huge part. Uh, I think if you are educated ... I feel like you are informed. Right. I feel like it's easier. You just talk openly about it (you know) I feel like everyone should just at least (you know) like study or read some articles about it and know the truth instead of like being so judgmental

2 SLN 2/23/2017 12:58

So are you saying that the more educated you are it tends to be easier to disclose your status?"
Participant 2: "Uh huh.

3 SLN 2/23/2017 1:01

in the Western world. (You know) I think the more education you have here, I think the easier it gets when it comes to like telling ... disclose your status. You know what I mean? People who are open ... who know about the world ... who have more education, I think they would understand it. I feel like it's easier just to talk to them. Yeah."

Internals\\Qualitative Study_Transcripts_Participant 4_20170212

No 0.0196 2

1 SLN 2/23/2017 3:05

think education has a lot of things to do with it. The more educated you are ... somebody ... hopefully [Laughing] but not necessarily true (uhm) (uhm), the smarter they are about it, and the more willing they would disclose their HIV status

2 SLN 2/23/2017 3:06

Yeah, if you're educated ... if you have higher education level, hopefully it would be easier to disclose and then vice versa the other person you're disclosing it to ... the more education they have, the easier ... the more ... to disclose to that person."

3/7/2017 1:24 PM

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Internals\\Qualitative Study_Transcripts_Participant 5_20170218

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1	SLN	2/27/2017 10:14
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Definitely education as well as socioeconomic class... I would say that the way that it would ... I would say that it is more likely to be discussed when there is a higher level of education or they're coming from a socioeconomic class that is a little bit more stable. I don't know if that's the right word. Uhm, but I feel like that they are more likely to disclose because there is more education in terms of like how things are transmitted, how it ... what's risky, what's not risky... Uhm, so, when there isn't that level of education I feel like people (uhm) ... they don't know how ... or they're not aware of how things are transmitted and (uhm) ... so maybe there is less likely to engage if there's more fear when there's less education

2	SLN	2/27/2017 10:15
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I would say that the higher the education, the higher Let me just say it this way, the higher the education, I feel like they're more OK with discussing it

Internals\\Qualitative Study_Transcripts_Participant 6_20170228

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1	SLN	3/6/2017 3:11
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Well, education ... so it depends on how I understand this education... For the general education level ... but usually this is the case that ... the better, the higher education you get and that the better understanding you will have about (uhm) HIV ... about this ... Again, you will be more (uhm) worry-free to disclose your status even when the situation happens and the other people may be confused ... may worry, may be hesitant and they You yourself are very well educated and then you can educate other people. Even if it ended up (like) the other people decide to not have anything with you ... but still it's a good thing to educate other people and it's a positive thing to (uhm) ... to (uhm) weaken the discrimination I think.

2	SLN	3/6/2017 3:13
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can't say that good education but (uhm) ... much better educated than people in China because people in China even get confused about (uhm) those simple ideas like what is AIDS, what is HIV, what's the ... and how are they related to each other ... They don't know about that. So, they just ... they just say whoever has HIV or have infected with HIV, they just say, "Oh, he got AIDS." You know ... even ... there are so lack of basic knowledge ... so ... it's very hard to ... to explain any ... to educate them [Laughing]. You know ... so the discrimination in China is very solid ...it's hard ... but I feel like ... I can't say it's very easy but it's

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

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1

That that person would disclose ... The more educated you are, the more likely that you would disclose?"
 Participant 7: "Yeah. Yeah."
 Researcher: "And inversely, the less educated they are, the less likely they would disclosed?"
 Participant 7: "Yes."

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
Internals\\Qualitative Study_Transcripts_Participant 8_20170305				
No		0.0094	1	

1

"Educated about HIV?"
 Researcher: "Just having more education"
 Participant 8: "OK, just in general?"
 Researcher: "Yeah."
 Participant 8: "Uhm, no. I don't think that makes a difference ... to be honest with you. Uhm, the people who are educated tend to be older (uhm) ...they don't ... they don't (uhm) ... they're usually out ... they're usually out for something long-term (uhm) ..."

Nodes\\Q8 Specific influence of ses or ed level on disclosure\\Lower ses don't disclose

Document

Internals\\Qualitative Study_Transcripts_Participant 3_20170212				
No		0.0571	1	

1

do feel it's harder for other people of a certain class ... maybe of a lower socioeconomic class to disclose because I know some people who don't disclose when they're positive. Yeah."

Researcher: "Why do you think that's so?"

Participant 3: "I think because of stigma."

Researcher: "Because they're of a lower socioeconomic class, there's a lot more stigma so therefore it's harder for them to disclose?"

Participant 3: "Uhm. I feel like it's harder because of lower socioeconomic class to disclose they would feel ... they would be

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

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1

In regards to socioeconomic class, (uhm) I guess it depends like ... if you're in the middle or upper class, I don't see a huge difference because you're living comfortably anyway. I could see if you like not making money, then maybe you are more

2

It only plays a factor when it's affecting like your living situation or your basis needs like water and food and things like that ... but if you have money to pay for those things, then I don't think it affects your ability to disclose your status to sexual partners.

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Nodes\\Q8 Specific influence of ses or ed level on dislosure\\Urban or progressive v rural or conservative Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

No	0.0199	1
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1

SLN

One factor that I do know is that I'm in L.A. (you know). I'm in Los Angeles and the more that you're closer to West Hollywood or Downtown L.A., it's easier to have that conversation. You see more profiles. You see more people congregate and be OK to discuss their status. So, in New York. I was visiting ... I visited New York – it's the same thing. Recently I visited Oklahoma – not the same thing (you know). Trust me. So, I think it's ...uhm ... I don't know if it's socioeconomic status. It could be. Oklahoma is

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

No 0.0166 1

1 SLN 3/7/2017 11:32

but since I live in L.A. ... it's a very open society so ... I feel for me personally, it's not as hard as if I were to live elsewhere."

Researcher: "Elsewhere meaning a city that is not so metropolitan or"

Participant 7: "Yeah, any city in the South or (uhm) any city in Asia."

Nodes\\Q9 Key influences on disclosure\Don't want friends to find out

Document

Internals\\Qualitative Study_Transcripts_Participant 3_20170212

No 0.0408 1

1 SLN 2/23/2017 2:45

I have thought about it because I have friends who have introduced me to their friends to start dating with each other. I've had that happened but I don't want to because if I disclose to that date, that person might tell my friend and I don't want them to know. So I always don't meet (uhm) a person who my friend wants me to meet. You know?"

Researcher: "Because you are fearful that if you disclose, that person that you meet might tell your friends?"

Participant 3: "Yeah. Yeah."

Internals\\Qualitative Study_Transcripts_Participant 5_20170218

No 0.0149 1

1 SLN 2/27/2017 10:19

The first question goes more into like ... well, do I want to even open that door and have sex with them because then I feel the responsibility to tell them and then my friends ... uhm, our mutual friends would know... blah, blah, blah. So, I will look at that situation a little more ... I would analyze that a little bit more. How badly do I want to hook up with this person? Do you know what I mean? Which a lot of times, it's not worth it because I'd rather not have friends discussing it. So, is that what you're kind

3/7/2017 1:24 PM

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
Internals\\Qualitative Study_Transcripts_Participant 7_20170304				
No		0.0193	1	

1

If it's through friends, it's probably not going to be disclosed the first time you meet someone ... at least not for me ... because they're your friend's friends. And your friend doesn't know about your status, then you might not disclose to that person who might go back and tell your friends or make everyone else uncomfortable.

Nodes\\Q9 Key influences on disclosure\\Feelings for person

Document

Internals\\Qualitative Study_Transcripts_Participant 3_20170212

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1

SLN

2/23/2017 2:43

What makes me disclose because I see a potential in a relationship, not just sexually ... and I want to be with this person, so I would disclose and I feel like if they won't accept my status ... it's kind of not accepting me. It doesn't hurt me (uhm) if they would reject you. It made it easier for me to disclose now because ... it's like ... if you don't like me, then I'll just find another

Internals\\Qualitative Study_Transcripts_Participant 5_20170218

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1

SLN

2/27/2017 8:22

Well, yeah, it's easier for me because I find that ... well, there's more riding on the ... if there's a possibility for a relationship like ... I feel like there's more at stake because I guess my hopes are up ... maybe I'm a little bit more invested whereas somebody who's casual, they would say 'no' ... well OK, I can shrug that one off. But, yeah, if it's somebody who I actually like ... that I want to get to know better ... interested in, then if there's rejection, then it's harder to deal with. So, that's why I say that it's a little more difficult in terms of that disclosure (uhm). I find it to be it's more pressure. Yeah."

2

SLN

2/27/2017 8:30

the difficulty in disclosing doesn't come from the acts, it comes from the situation. It has to deal with am I interested in them, is it a possible relationship, or is it a casual thing. That's where I find the difficulties because if it's casual ... for me, there is less riding on it so I find it easier to disclose. Where I was interested and there is more riding on that, then I ... (you know), there's hope ...whatever ... I don't know ... whatever you want to call it. So, that's what it's making it harder for me to disclose ...or

3 SLN 2/27/2017 8:32

Now, if they're somebody who I met through mutual friends who I actually like and there's a possibility for a (like) a relationship, then, thenyes, I would be disclosing and I would have to take into consideration that it is a good possibility that our mutual friends will end up finding out.

3/7/2017 1:24 PM

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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4 SLN 2/27/2017 10:16

Uhm, are they someone that I actually am interested in or it just purely a casual (uhm) So you're just wanting to know with the casual ... not necessarily somebody who I would be interested in ..."

Researcher: "Share with me anything you like."

Participant 5: "OK. Well, OK. If I'm interested in the person, I am more likely to disclose but I also find it harder to disclose. Uhm, because there's more riding on it and I feel like (uhm) OK, I'm going to be let down. Uhm, ... I could be let down

Nodes\\Q9 Key influences on disclosure\\Geographic location

Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

No 0.0194 1

1 SLN 2/23/2017 11:04

Yeah, where I meet the person. In terms of states [Laughing].”
 Researcher: “You know like not just at a club or ...”
 Participant 1: “No, I mean like physical like ... It’s easier to have ...
 Researcher: “You referenced Oklahoma versus New York City.”
 Participant 1: “Exactly, it’s easier to have a conversation about HIV status here in L.A. and New York than in Oklahoma, for example. For sure. Uhm, that I can tell you.”
 Researcher: “OK.”
 Participant 1: “At least from my experience. Uhm. So there’s that. Ahh. what else?”

Internals\\Qualitative Study_Transcripts_Participant 4_20170212

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			1	SLN	2/23/2017 3:16

You said that there are differences in geography or city life – well, Atlanta is actually a city too – but in metropolitan areas, do you feel like it’s different ...”
 Participant 4: “Oh yeah.”
 Researcher: “And how so? Is it easier in Los Angeles to disclose from your experience?”
 Participant 4: “It is definitely easier in a city like Los Angeles. Uhm, people are more vibrant and more educated [Laughing]uhm, than Atlanta. Atlanta You have to be really careful who you disclose your status with because not everybody is educated about HIV and I think a lot of it is just because of uhm ...uhm... ignorance really... Uhm, if I’m not positive, why would I want to know about being positive now ... I’d wait until I become positive ... [Laughing] Sadly, uhm, I’ve seen people who (uhm) ... who would not have sex with me when they found out that I’m positive. Yeah, it was easy for them to just say no

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Nodes\\Q9 Key influences on disclosure\\Location of encounter

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Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

No 0.0247 1

1 SLN 2/23/2017 11:07
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the other thing is that I belong to certain organizations where I know people are HIV-positive, there's almost this silent assumption that other people in that group is also HIV-positive. So there is no discussion. So I guess there's less disclosure in when I'm in a peer group or when I know people are HIV-positive ... or I'm at a location where I think people are HIV-positive. So, for example, uhm, uhm, this is not from my experience but I've heard people say that when they go into a bathhouse, they assume people are HIV-positive right away just deal with that (uhm) reality. Whether they use condoms, go on PrEP, or just go

Internals\\Qualitative Study_Transcripts_Participant 2_20170212

No 0.0702 2

1 SLN 2/23/2017 1:02
D M M

think (uhm) how you met that person ... I think the surroundings like yeah ... you met in person, you met through friends, or you met through Grindr ..."

Researcher: "Tell me more about ..."

Participant 2: "Well in the club scene ... I feel like that's hard Just to find like a time ... just to find the time to talk about it ... because in the club scene you don't really talk about it ... you just like drink, dance, and like (you know) physical ... when you get too physical, you don't ... you just go, you know. You release you ... yeah [Laughing] whatever your energy. It's easier like just to go straight to bed. It's easier that way. Hooking up, you know. It's quick, like you know ... you're like in bed in 20 minutes. I think in the past, there were a lot of people that I didn't tell. There were many people that I didn't tell because I met them through like clubs, hooking up, like hookup websites or apps or like. So, if I actually meet (you know) that person like I said in a social setting (you know) outside of that world. Yeah I feel like it's easier to talk to to have a conversation "

2 SLN 2/23/2017 1:03
D M M

You touched on a couple of things like when you meet someone in the club and it's more random and more spontaneous and in the heat of the moment, you tend to not have the time to disclose but when you meet them in other settings or through friends, face-to-face, then there's more opportunities for you to disclose? Is that right?"

Participant 2: "Yeah. Yeah. You're not going to like, hey do you want to go to bed right now, let's do this, you know. And, I think you settle into that risky situations when you meet people through like social media, hookup apps or websites, whatever."

Internals\\Qualitative Study_Transcripts_Participant 3_20170212

No 0.0518 1

1 SLN 2/23/2017 2:44
D M M

It does affect ... Like in a club or in public, I haven't met a person to disclose before and I think it would be harder for me but it has never happened. You're meeting face-to-face rather than ... but on the computer it's definitely easier to disclose (uhm)."

Researcher: "So have you disclosed through hookup apps?"

Participant 3: "Yeah, like Grindr. Like, I wouldn't put like I'm HIV-positive on my profile mainly because I don't want like people who I know like co-workers that I'm positive ... but when we do start chatting, then I would disclose and it's not really. I'm kinda like open to disclose now about it."

3/7/2017 1:24 PM

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
Internals\\Qualitative Study_Transcripts_Participant 7_20170304				

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If I meet someone online ... sometimes it's a lot easier to disclose because I don't know the person ... it's just a text message away ... I just have to message him ... so that's it. If I meet someone at the bar, it's harder. Now you see this person in person. You met them, you talk to them and then it's like ... you want to go home with me or not?

Nodes\\Q9 Key influences on disclosure\Not situational Must be honest

Document

Internals\\Qualitative Study_Transcripts_Participant 6_20170228

No		0.0295	1	
			1	SLN 3/6/2017 3:12 PM

For me personally, I don't like to lie to people. Right, so I don't like to lie to people and if he asks you like that ... means that .. he's very worry about and then ... When you tell them, "Oh, I'm HIV-positive" and then (you know) that's going to be a lot of drama. I don't like drama so ... to avoid that situation I would say that if we're really going to do something ... because ... before we are really going to do something .. I don't know what's going to happen between us ... If we never go that far ... so I think it's not necessary to tell [Laughing]. So, I don't know .. I don't know what I said ... if what I said answer your question because to be honest this question is kinda hard for me to ... to organize the answer because

Nodes\\Q9 Key influences on disclosure\Physcial aspects

Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

No	0.0353	2			
			1	SLN	2/23/2017 11:05 ^ ^ ^

I'm not speaking for myself but some people would say how cute the guy is ... that's a terrible reason. And again, that's not from my experience."

Researcher: "Tell me more about what you mean ..."

Participant 1: "Well, some people would say that if the guy was cuter, they would preferred not to disclose because they don't want to run the risk of being rejected. So, people would be more open to disclosing to (you know) less handsome people ... I dunno know [laughing]. I don't know [laughing]. Uhm. So. There's that Uhm, like the hotter the guy ... and I guess the more spontaneous it gets in the heat of the moment, the heated sexual encounter it gets."

3/7/2017 1:24 PM

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number	
			2	SLN	2/23/2017 11:07 ^ ^ ^

Uhm. I'm like thinking of everything: age, dick size [laughing]."

Researcher: "OK, tell me about the size of someone's anatomy."

Participant 1: "[Laughing] I dunno know. I'm just thinking of all the possibilities. Is it possible? Is that a factor for me or other people that I know? I don't think so"

Nodes\\Q9 Key influences on disclosure\Safety will not be physically assaulted

Document

Internals\\Qualitative Study_Transcripts_Participant 4_20170212

No	0.0376	2			
			1	SLN	2/23/2017 3:10 ^ ^ ^

I think to me personally ... if I feel safe meaning I would not be physically or verbally – at least, not right away – uhm ... attacked by the other person. Uhm, as far as being rejected, I think all HIV-positive people understand that (you know) there might be rejection ... uhm ... it's something that you just have to live with it and get used to I [Laughing] Uhm, but, if I'm going to be like ... For example, if I go home, I'd be more discrete about who I disclose my status to because I might get (uhm) attacked (uhm) being (uhm) ridiculed. Uhm (you know) by society (you know) at home ... [Laughing]"

Researcher: "Home, meaning in Indonesia."

Participant 4: "Yeah. Yeah. So, I think it's about ... really ... about being safe"

2 SLN 2/23/2017 3:11 PM

I've seen a couple of gay bashing in this neighborhood a couple of times. So, you just never know ... you just have to be smart, you just have to be aware with who you're with before you disclose your status. Really."

Nodes\\Q9 Key influences on disclosure\\Spontaneity

Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

No 0.0104 1

1 SLN 2/23/2017 11:02 AM

I mentioned this earlier on spontaneity. The more spontaneous it is, the harder it is to disclose when you're like ripping your clothes off and going at it (you know) you're not going to fucking stop. (You know) it's [long sigh]. You know? So, that's one. I

3/7/2017 1:24 PM

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
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Internals\\Qualitative Study_Transcripts_Participant 2_20170212

No 0.0245 1

1 SLN 2/23/2017 1:03 PM

You touched on a couple of things like when you meet someone in the club and it's more random and more spontaneous and in the heat of the moment, you tend to not have the time to disclose but when you meet them in other settings or through friends, face-to-face, then there's more opportunities for you to disclose? Is that right?"

Participant 2: "Yeah. Yeah. You're not going to like, hey do you want to go to bed right now, let's do this, you know. And, I think you settle into that risky situations when you meet people through like social media, hookup apps or websites, whatever."

Nodes\\Q9 Key influences on disclosure\\Substance abuse -under the influence so less talk

Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

No	0.0199	1
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1	SLN	2/23/2017 11:08
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Drug use maybe a factor and I think that's ... uhm ... that's something that there's been a lot of studies regarding this ... but drug use leads to lower inhibition, which leads to less talky talky. (You know) when there's drug use involved regardless your drug of choice, there's definitely less discussion about disclosure. Uhm, unless you're really talking to somebody (uhm, you know) who's really nice. Uhm, that's more of an exception than what really happens out there. So drug use affects HIV disclosure. More drug

Internals\\Qualitative Study_Transcripts_Participant 4_20170212

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1	SLN	2/23/2017 3:11
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don't know – uh, do you think that drugs use has an influence or factor in ..."

Participant 4: "Hmmm. Of course [Laughing] The drug ... it basically takes over .. takes over your brain ... really ... your sex drive and everything. And if I'm under the influence, I may say ... if the guy is so hot and that I want to have sex with ... I would just say that, oh, I'm negative (you know) [Laughing] So ... but (uhm)."

Researcher: "Meaning, you tend to probably not disclose if you're under the influence."

Participant 4: "Probably ... the drug alters your mind (you know)...Uhm."

Internals\\Qualitative Study_Transcripts_Participant 7_20170304

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But then you're probably drunk so your decision would be impaired to disclose or not

3/7/2017 1:24 PM

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number
Nodes\\Q9 Key influences on disclosure\Timing of encounter -ie first date				

Document

Internals\\Qualitative Study_Transcripts_Participant 1_20170208 (1)

No		0.0214	1			
				1	SLN	2/23/2017 11:06 AM

like a date, you would first talk about it (you know). You just get it out of the way. (You know). The date and the possibility of sex. Yeah. Talk about it on the first date (you know) as opposed to letting it fester because you're going to get there. You gotta talk about it on a date as opposed to say you're in a club, you're a little bit drunk, or you're high, or whatever ... There's this cute guy (you know) ... you want to give a blow job whatever ... you just go at it ... there's no talky talky when you're like there's loud,