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Objective: HIV/AIDS is a terminal disease which has increasingly taken on chronic illness characteristics (Nokes, 1989). Life expectancy has increased for persons living with HIV/AIDS through the use of protease inhibitors taken in combination with other HIV/AIDS drugs. However, the relationships of persons living with HIV/AIDS are faced with the stress of not only the HIV disease itself, but also the social stigma associated with AIDS and homosexuality. The purpose of this study was to explore the relationship maintenance strategies and behaviors which gay male couples where either one (discordant couples) or both partners (concordant couples) have HIV or AIDS. Method: A qualitative grounded theory approach (Glaser & Strauss, 1967; Strauss, 1987) was employed. In-depth interviews were conducted with 20 gay male couples (N=40). The sample consisted of 15 discordant and 5 concordant couples. Participants were interviewed separately, however, both partners were interviewed so that the individual and the dyad were units of analysis. Forty one-hour interviews were audio-taped and transcribed, resulting in 459 pages of transcription. Transcripts were analyzed using the method of constant comparative analysis (Glaser & Strauss, 1967) resulting in the emergence of dominant themes and categories of
relationship maintenance. **Findings:** A grounded theory of normalization of illness is proposed as the primary relationship maintenance strategy utilized by these couples. This analysis reveals that these couples achieve normalization through several means: (a) coping through acceptance, (b) managing the dialectic of HIV communication engagement and avoidance, and (c) negotiating the dialectic of health autonomy and partner involvement. In addition, evidence for the use of the maintenance behavior typology proposed by Canary and Stafford (1991;1992)/Dainton and Stafford (1993) was found. Evidence of these behaviors in this sample indicates additional support for the applicability of the typology in more diverse populations than previous studies have investigated. These findings increase our understanding of relationship maintenance in this under-studied population.
Dedicated to couples living with HIV
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CHAPTER 1

INTRODUCTION

Chronic illness has become the number one health problem in the United States (Curtin & Lubkin, 1995; Strauss & Corbin, 1988; Strauss et al., 1984). In a recent analysis of the 1990 National Health Interview Survey and Vital Statistics of the United States, Hoffman, Rice, and Sung (1996) found:

90 million Americans were living with chronic conditions, 39 million of whom were living with more than one chronic condition. Over 45% of noninstitutionalized Americans have 1 or more chronic conditions and their direct health care costs account for three fourths of US health care expenditures. (p. 1473)

As medical expertise and technology has increased in areas such as bacteriology, immunology, public health, and pharmacology (e.g., antibiotics), the mortality rate from communicable and acute diseases has decreased steadily since the turn of the century (Curtin & Lubkin, 1995). As a result, life expectancy has continued to increase. As human life span increases, so does the likelihood of the development of chronic illness.
Along with the growing number of persons who have chronic conditions comes increases in medical costs surrounding an ongoing need for health care. One solution imposed by managed care organizations for reducing health care costs has been a general trend toward increasing home health care in the United States over the past decade which, in turn, has increased caregiver burden in families (Strauss & Corbin, 1988). According to Hoffman et al. (1996), due to the high prevalence, nearly every family in America is now affected in some respect by chronic illness.

The issue of what is considered a "chronic" illness or condition is quite complex, and continues to be debated by scholars and health care professionals (see Bachrach, 1992; Cluff, 1981; Curtin & Lubkin, 1995; Emanuel, 1982). Cluff (1981) has defined "chronicity" as "a condition not cured by medical intervention, requiring periodic monitoring and supportive care, both formal and informal, to reduce the degree of illness and maximize the person's ability to function and care for self" (p. 300). Chronic conditions take multiple forms and can occur suddenly or progressively over time. Chronic conditions resulting from illness or injury may be continuous or episodic, and may remain in remission for extended periods of time between recurrences. Thus, chronic conditions are highly variable depending on the "severity of the illness or injury, the symptoms it presents, the possibility and degree of comeback, the variations in symptoms, and the type of activity one wishes to engage in" (Corbin & Strauss, 1988, p. 9). Today, chronic conditions include diabetes, stroke, cancer,
cardiovascular disease, spinal cord injury, muscular dystrophy, arthritis, Alzheimer's disease, kidney disease, severe migraine headaches, chronic obstructive lung disease, schizophrenia, chronic pain from injury, and more recently, human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS).

HIV infection increasingly has taken on chronic illness characteristics (Nokes, 1989). Through the introduction of new medications, known as protease inhibitors, taken in combination with other antiretroviral and prophylactic drugs, the death rate from AIDS dramatically decreased in 1997-1998 for the first time in a decade and a half (CDC, 1998). With these new combination drug therapies, individuals' immune systems have shown improvements in increased CD4 counts, the number of helper T-cells in the bloodstream (Kelly, Otto-Salaj, Sikkema, Pinkerton, & Bloom, 1998). In addition, the amount of HIV in the bloodstream of many individuals has been reduced to levels that are below the detection capabilities of current HIV blood tests. With these medical improvements, persons with an HIV infection are living longer through an increasing ability to "manage" the illness. In this way, HIV/AIDS shares in common several of the issues involved in managing other chronic conditions, such as periods of recurring symptoms, regular medication regimens, and periodic medical visits.

Conrad (1987) argues that at the same time there are issues shared by chronic conditions, because of variations in symptom manifestation, physical disability, symptom observability, and differing degrees of stigma associated
conditions, it is problematic to group chronic conditions together for study. HIV/AIDS has several aspects of the disease which may create unique issues for persons living with the illness, such as the risk of disease communicability, opportunistic infections unique to HIV (infections experienced due to a depleted immune system), a younger age group affected relative to more common chronic conditions of the elderly, and a high degree of social stigma for the disease because of its identification with homosexuality and IV drug use. Social-scientific research specifically on HIV infection as a form of chronic illness increasingly has focused on gaining a better understanding of how the lives of individuals are impacted as they manage the disease (see Derlega & Barbee, 1998). When a chronic illness or condition develops, individuals’ personal relationships permanently are affected. Depending on the type of illness and its severity, chronic conditions bring new levels of uncertainty and stress into relationships. Individuals who develop chronic conditions often face increased levels of anxiety, depression, and anger which negatively impact their relationships. As a result of the onset of chronic illness, relationship roles often are altered, family or friends may be called upon to provide caregiving functions for which they are unprepared, additional emotional and financial support is usually necessary, and lifestyles often are impacted negatively. The stress of these relationship changes may make it much more difficult to sustain existing personal relationships. In essence, chronic illness often incurs changes in the nature of personal relationships that can be quite dramatic and stressful.
Social-psychological research of persons living with HIV/AIDS (PLWHs) increasingly has focused on issues of social support, caregiving, and quality of life. Research suggests that partners/spouses and close friends provide the majority of social support and informal caregiving to PLWHs (Hays, Catania, McKusick, & Coates, 1990; Park & Folkman, 1997; Schwarzer, Dunkel-Schetter, & Kemeny, 1994; Wrubel & Folkman, 1997). These relationships, however, exist under conditions of high levels of stress and uncertainty related to both the illness itself and social stigma surrounding the disease. Yet, little is known about how couples coping with HIV and AIDS are able to maintain their relationships in the face of extraordinary life stressors. Clinical observations from AIDS Clinical Trials Units' (ACTUs) nursing staff suggests that the abrupt end of a romantic relationship frequently results in lapses in both patient visits and self-reported medication adherence (Neidig, 1999). Other research has found that emotional distress can lead PLWHs to increase instances of alcohol and substance abuse (Hays, Turner, & Coates, 1992). Researchers theorize that failure to adhere to HIV drug regimens could have serious health implications for both the individual and the general public health because of the ability of the HIV virus to mutate and become resistant when exposed to low levels of antiretroviral medications.

The specific aim of this study is to examine the relationship maintenance behaviors used to sustain the intimate relationships of gay male couples coping with HIV or AIDS (both concordant and discordant). A concordant couple is one in which both partners are HIV positive or have AIDS; whereas, in a discordant
couple only one partner is HIV infected. Despite increases in HIV in the heterosexual population over the last decade in the U.S., gay males remain the largest subgroup in the HIV infected population (CDC, 1998). Therefore, this study specifically will focus on gay male couples coping with HIV/AIDS. In general, few systematic studies of relationship maintenance in gay or lesbian couples have been conducted (except see Haas & Stafford, 1998), and no research has yet examined how gay couples coping with HIV/AIDS manage to maintain their relationships under the extreme stress of this highly stigmatized illness.

In exploring this area, first, chapter 2 contains a review of the communication literature on relationship maintenance. Next, issues surrounding gay and lesbian couple relationships are explored through examining an interdisciplinary body of literature. In the following section, issues of HIV/AIDS illness-related uncertainty and stress, coping, and social support are explored. Specifically, communication variables underlying the exchange of social support as a coping mechanism are addressed. In Chapter 3, the design and method of a qualitative study exploring the relationship maintenance behaviors of 20 gay male couples coping with HIV/AIDS is described. In Chapter 4, findings from this study are presented and discussed. Chapter 5 contains a summary and suggestions for future research, as well as, a discussion of the theoretical implications of the study and the potential for interventions for couples dealing with HIV/AIDS.
Communication is central to human interaction and the formation of relationships which help meet human needs, such as inclusion, affection, and control (Schutz, 1971). Relationships are dynamic and always changing as they attempt to meet these needs. Wilmot (1994) describes relationships as having continual ebbs and flows forming spirals of growth and decline. When relationships are in decline, they require “rejuvenation” or else they will continue toward dissolution (Wilmot, 1994). Relationship maintenance refers to sustaining a relationship to prevent termination (Duck, 1988) through “parties’ efforts to sustain a dynamic equilibrium in their relationship definition and satisfaction levels as they cope with the ebb and flow of everyday relating” (Baxter & Dindia, 1990, p. 188).

To date, research on relationship maintenance has focused primarily on intimate romantic relationships. Romantic relationships have been found to
provide particular relational benefits such as love, affection, sexual activity, psychological intimacy, advice, encouragement, and social support. In fact, Brown and Harris (1978) found that other confiding relationships, such as parent, sibling, or friend, could not compensate for the confiding intimacy of a romantic partner. However, much remains to be discovered about effective strategies and behaviors of maintaining intimate romantic relationships. The existing relational communication research has focused primarily on two broad perspectives of maintaining intimate relationships - social exchange and dialectic management. These two perspectives are based in a larger theoretical perspective of symbolic interactionism. Symbolic interactionism will be discussed in the next section, followed by research in the areas of social exchange and relational dialectics.

The Theoretical Basis of Maintenance Research: Symbolic Interactionism

The two areas of social exchange and dialectic relationship maintenance research are based in the theoretical perspective of symbolic interactionism. Underlying the examination of behaviors that persons use to maintain their relationships is the premise that relationships are social constructions based on two persons' interpretations of how their lives are interconnected.

Symbolic interactionism was initiated by the work of George Herbert Mead (1934), a social behaviorist, and continued by his student Herbert Blumer, a University of Chicago sociologist. Blumer (1969) asserted that symbolic interactionism is based in three fundamental assumptions. First, “human beings
act toward things on the basis of the meanings that the things have for them” (p. 2). Second, these meanings arise out of social interactions with other individuals. And third, these meanings are shaped and revised through an interpretive process engaged in by each person in making sense of the world around them. What is fundamentally important about these three premises is that they take the notion of human understanding of the world around us and transform it from an objective, logical positivist conception to an intersubjective, socially co-constructed interpretation.

This perspective is important in its radical opposition to the idea of an "objective" reality. It places understanding of what “reality” means in social actors’ abilities to roughly align their constructions and interpretations of the world, situations, and other persons through use of language symbols and communicative interaction. Symbolic interactionism does not refute the existence of physical objects outside of human beings’ ability to perceive them, but rather what takes on meaning for humans as “objects” and their relation to them exists only through intersubjective coordination and interpretation with others. Blumer explained, "symbolic interactionism sees meanings as social products, as creations that are formed in and through the defining activities of people as they interact” (1969, p. 5). As a result, meanings are derived from encountering and processing the ways that others interpret and act towards the world.
Yet another important fundamental principle of a symbolic interactionist perspective is the basic assumption that “human groups or society exist in action and must be seen in terms of action” (Blumer, 1969, p. 6). As such, it is of central importance that social interaction be seen as more than simply a channel for the transfer of individual meanings. Instead, meanings are co-constructed, negotiated, revised, and dynamic by their very nature of being intersubjectively created. Therefore, symbolic interactionism can be seen as an ontological perspective that is based fundamentally in the notions of coordinating and co-constructing understandings through communicative interaction of social actors.

The symbolic interactionist perspective is a “grand-level” theory that lays the theoretical foundation for a transactional view of communication. A transactional perspective is based in the premise that communication is a continuous dynamic process (Watzlawick, Beavin, & Jackson, 1967). The transactional view has become the predominant approach in the field of communication over the past 30 years. A transactional view of communication tends to be pragmatically focused on actual communicative behaviors. The result of transactional communication is the creation of co-constructions of meaning. Thus, the ontology underlying a transactional communication perspective consists of symbolic interactionist assumptions of the social construction of meaning which are often implicitly taken-for-granted. As a result, the assumptions of symbolic interactionism underlie much of the current research in interpersonal communication. The issues of social construction of
reality (also see Berger & Luckman, 1966) are central to understanding relationship co-creation and maintenance.

In communication research, Duck (1985, 1990, 1992, 1994a, 1994b, 1995; Duck, Rutt, Hurst, & Strejc, 1991) is one example of a scholar who has maintained a body of work at the theoretical level of symbolic interactionism with a focus on relational meanings as they are created and maintained through everyday, routine talk in relationships. Duck’s work also has applied Kelly’s (1955) theory of personal constructs which hypothesizes that individuals develop schema (collections) of meaning which are shaped, expressed, and modified through the assumptions of symbolic interactionism (socially-constructed meaning). Duck (1994a, 1995) has argued that individuals share and help create a mutual relational cognitive schema and relational definitions through everyday talk.

In general, the theory of symbolic interactionism has proved to be extremely influential in interpersonal communication as a world view. This intersubjectively-based world view has become the theoretical basis for a transactional view of interpersonal communication, and subsequently, the basis of the two dominant approaches of relationship maintenance research: social exchange and relational dialectics. These two areas of relational maintenance research are addressed in the following sections.
Relational Maintenance as Social Exchange

Interest in relationship maintenance in romantic relationships has increased among communication researchers over the past 15 years (e.g., Ayres, 1983; Baxter & Dindia, 1990; Baxter & Simon, 1993; Bell, Daly, & Gonzalez, 1987; Canary & Stafford, 1992; Dainton & Stafford, 1993; Dindia & Baxter, 1987; Dindia & Canary, 1993; Shea & Pearson, 1986; Stafford & Canary, 1991). Social exchange theory (Blau, 1964; Homans, 1950, 1961; Thibaut & Kelly, 1959) is an economic, market-based model of relationships which proposes that individuals seek to maximize relational profit, and has formed the basis of much of the research on relationship maintenance (e.g., Ayres, 1983; Burleson & Samter, 1994; Canary & Stafford, 1992; Dainton & Stafford, 1993; Shea & Pearson, 1986; Stafford & Canary, 1991). According to social exchange theory, a relationship consists of resources that are exchanged between two persons. Preferred resources are considered to be rewards and lost resources are considered costs. The theory proposes a formula for social exchange: rewards minus costs equals excess rewards (profit). As long as both relational partners perceive themselves receiving profit, the theory proposes that each individual will seek to maintain the relationship. If an individual perceives relational costs to outweigh the rewards, they likely will be dissatisfied. As a result, the relationship is unstable and in jeopardy of disintegration (Thibaut & Kelly, 1959).
Stafford and Canary (1991; Canary & Stafford, 1992; also see Canary & Stafford, 1994) have suggested that their programmatic research on relationship maintenance behaviors “may be usefully understood within a developmental framework based on social exchange theory” (p. 219). Stafford and Canary asked married and dating couples to describe behaviors that they perceived using to maintain their relationship. These researchers have suggested that “perceptions of behaviors reflect persons’ interaction experiences more than actual behaviors do” (1991, p. 221) because perceptions of self and partners’ maintenance behaviors reflect the personal interpretations and constructions of relationships. Based on these self-reports, Stafford and Canary developed a typology of strategic behaviors that both married and dating couples perceived they exchanged in maintaining their intimate relationships. The five primary relationship maintenance strategies (defined as purposive maintenance behaviors) resulting from their analysis were: (a) positivity (e.g., cheerfulness and being positive); (b) openness (e.g., self-disclosure and meta-relational communication); (c) assurances (e.g., expressions of love and comfort); (d) shared tasks (e.g., household duties and relationship responsibilities); and (e) social networks (e.g., seeking mutual friendships and kinship ties). Additional evidence for the use of these strategies by heterosexual couples has recently been replicated (Ragsdale, 1996).

Underlying these behaviors, Canary and Stafford found that equity is an important relational dimension. Equity is relational exchange where the overall
ratio of each persons' costs to rewards are roughly equal. Equity was found to be a salient predictor of both personal use, and perception of partner's use, of relationship maintenance behaviors for married couples. In addition, self-reported and partners' perceived maintenance strategies combined to predict several other relational characteristics. For instance, positivity was the primary predictor of both control mutuality (i.e., the amount of agreement of each partner's control over the relationship) and liking of partner. Perceptions of partners' maintenance behaviors, in general, were especially predictive of liking; whereas, sharing tasks and social networks were correlated with commitment to the relationship.

Dainton and Stafford (1993) extended this work by examining behaviors partners report enacting which may be routine in addition to behaviors being strategically planned. Seven primary behaviors which partners described as "routine," defined by Dainton and Stafford as "taken-for-granted, seemingly mundane, trivial, yet regularly occurring behaviors... not used intentionally for maintenance purposes," emerged: (a) joint activities (e.g., spending time together and rituals); (b) small talk (e.g., discussing daily events); (c) affection (e.g., touching, kissing, and sexual intimacy); (d) avoidance (e.g., avoiding topics and conflict); (e) anti-social (e.g., acting jealous); (f) focus on self (e.g., watching weight and furthering career); and (g) mediated communication (e.g., leaving notes or phone calls). This research currently is being expanded to examine more diverse populations, such as the relationship maintenance strategies of gay and

**Relational Maintenance as Dialectic Management**

In addition to the social exchange approach, Baxter (1988, 1990, 1993a, 1993b, 1994; Baxter & Dindia, 1990; Baxter & Simon, 1993; Dindia & Baxter, 1987) has examined relationship maintenance from a dialectical perspective. Relational dialectic theory is rooted in the 1920's conceptual work of Soviet philosopher Bakhtin on dialogism. Bakhtin conceived of dialogism as contradictory and embattled societal forces (Baxter, 1994). These notions of contradictory forces are centuries old and can be seen in symbols such as the Chinese “yin-yang.” Baxter (1988, 1990) extended Bakhtin’s work to apply to the dialectical forces existing in relationships. A dialectic is a “tension” between two polar opposites that are contradictory, and yet, necessary and central within a relationship.

Baxter (1993a, 1993b) identified three primary relational dialectics that occur both internally and externally in relationships — integration-separation, stability-change, expression-privacy. The internal dialectic of integration-separation is the tension individuals feel to establish inclusion in relationships, and at the same time, maintain a sense of self-identity. The external dialectic of integration-separation is the conflicting pull a couple feels to maintain outside relationships that connect them with society, and yet, to isolate themselves to increase relational intimacy. The internal dialectic of stability-change reflects the
conflicting needs of feeling secure in a predictable relationship, while avoiding boredom through seeking out novelty. Externally, the dialectic of stability-change represents a couple's struggle to manage enactment of cultural norms, and also to maintain a unique relational identity. The dialectic of expressiveness-privacy manifests itself internally as conflicting needs for open self-disclosure of self, and for protection of self and other from being hurt. Externally, in the dialectic of expressiveness-privacy a couple must manage their privacy from family and members of society, and also, connect with others revealing their life as a couple.

Baxter and colleagues (Baxter, 1988, 1990, 1993a, 1993b; Baxter & Dindia, 1990; Baxter & Simon, 1993; Dindia & Baxter, 1987) applied a dialectical perspective to examine how relational partners behaviorally "manage" these relational tensions to maintain their relationships. The dialectic of expressiveness-privacy (openness-closedness) was balanced through managing self-disclosure activity. In addition, the dialectics of integration-separation (autonomy-connection) and stability-change (novelty-predictability) were found to be managed through communicative behaviors. For example, the use of verbal messages, such as, saying "I love you," "We have a great relationship," or "We need to spend some time apart" to balance connectedness in a relationship can help manage the autonomy-connection dialectic.

In three studies in particular, Baxter and colleagues attempted to examine actual relational behaviors that are used as both maintenance and repair
strategies that these researchers have argued reflect attempts by partners to manage the dialectical tensions in their relationship (see Baxter & Dindia, 1990; Baxter & Simon, 1993; Dindia & Baxter, 1987). Many of the strategies reported in these three studies are quite similar to the relationship maintenance behaviors found by Stafford and Canary (1991; Canary & Stafford, 1992) and Dainton and Stafford (1993). For example, Baxter and Dindia found maintenance behaviors such as (a) communication strategies (e.g., openness, small talk, mediated communication); (b) avoidance (e.g., avoid troublesome topics); (c) antisocial strategies (e.g., partner testing -acting cold, jealous, difficult); (d) prosocial strategies (e.g., be nice, cheerful, warm, doing favors); (e) togetherness (e.g., shared activities, social networks, shared leisure time); and (f) seeking/allowing autonomy (e.g., doing things for self). These behaviors are suggested as ways relational partners manage the dialectical tensions in the relationship.

To date, the research on relationship maintenance has focused exclusively on mainstream American white middle-class heterosexual couples. Although this emerging body of literature has revealed several insights into the ways these couples maintain their relationships, there may be limitations in generalizing these findings to other types of couples of theoretical and social interest in American society, such as other racial, ethnic, and minority groups. Currently, there is little evidence that the relational maintenance strategies and routine behaviors heterosexual white middle-class Americans utilize apply to the lives and relationships of other groups.
In one recent study, Haas and Stafford (1998) examined the relationship maintenance behaviors used by gay male and lesbian couples to sustain their relationships. Replicating the open-ended survey approach used by Dainton and Stafford (1993) to explore the maintenance behaviors of heterosexual couples, gay and lesbian partners were found to utilize many of the same basic maintenance behaviors as heterosexual couples found by Canary and Stafford (1992) and Dainton and Stafford (1993). Importantly, however, several unique maintenance behaviors did emerge, for instance, (a) being "out" as a couple to one's social networks, and (b) seeking out gay/lesbian supportive environments. These unique maintenance behaviors were seen as a means of strengthening the relationship in the face of social stigma and general lack of acceptance in American society. These behaviors appear to be particularly salient for gay and lesbian couples as a stigmatized group in maintaining their intimate relationships. In general, the findings challenge several common assumptions as to differences between same-sex and heterosexual long-term relationships. This study also found initial evidence that subtle differences may exist between gay and lesbian relationships. Much more research on maintenance in gay and lesbian couples is required to explore these differences. In the following section, the research on gay and lesbian relationships that does exist is addressed.
Research on Gay and Lesbian Relationships

As previously discussed, in recent years, several communication scholars in the area of relational communication research have begun to focus on the ways couples maintain established relationships over time (see Canary & Stafford, 1992; 1994; Dainton & Stafford, 1993; Dindia & Baxter, 1987; Stafford & Canary, 1991). Relationship maintenance has come to be understood in this literature as communicative behaviors that both keep a relationship at a certain level of intimacy, thus, keeping it from deteriorating, and also communication that promotes growth within the relationship as it continues (Shea & Pearson, 1986). Studies have shed light on the communicative maintenance strategies and routine behaviors individuals employ in intimate relationships to achieve maintenance and growth (Canary & Stafford, 1992; Dainton & Stafford, 1993). In addition, some scholars have investigated the attempted ways couples deal with inherent dialectical tensions encountered as individuals strive to achieve a balance between autonomy/connectedness, openness/closedness, and novelty/predictability in ongoing relationships (Baxter, 1988; 1990; Baxter & Simon, 1993).

The maintenance of gay and lesbian relationships is one example of minority relationships that have been virtually ignored by relational communication scholars. Through an increased public acknowledgment of gay and lesbian relationships, a considerable gap in the relational communication
literature exists. Because there is little existing literature in the field of communication on gay and lesbian relationships, this section will present existing literature on gay and lesbian relationships from several disciplines, such as social psychology, sociology, family relations, and family therapy.

In the last 20 years, gay men and lesbian women in American society are one minority group that has slowly been studied by academic researchers. Walsh-Bowers and Parlour (1992) argued that a major limitation of the existing literature on gay and lesbian relationships is the fact that it is laden with heterosexual relationship assumptions. For example, there is a common assumption that dominant male and submissive female roles are taken on by gay men and lesbians in their relationships, and yet existing research does not support this assumption (see Kurdek, 1985/86, 1987, 1993; Kurdek & Schmitt, 1986a; Lynch & Reilly, 1985/86). Despite heterosexual relationship assumptions, the existing literature does offer insight into gay and lesbian relationships.

Early research presumed a "deviance model" in investigating gay and lesbian deviation from the heterosexual societal norm. It was not until the American Psychiatric Association removed homosexuality from its list of pathological illnesses in 1973 that academic researchers began to rethink the study of homosexuality. Slowly, in the mid- to late 1970s, researchers began to shift their focus away from "studying homosexuality exclusively from the perspective of ‘deviance’ toward studying homosexuality as part of work on ‘alternative life-styles’ or ‘sex roles’" (Peplau, 1982, p. 3). As a result of this
gradual shift, research studies have moved away from investigating homosexuality as a "pathology" to studying gays and lesbians as individuals in society. In fact, in recent years, researchers in several disciplines, such as social psychology and sociology, have begun to examine the lasting intimate and close relationships of gays and lesbians (Peplau, 1991; Reece, 1982).

Much of the early research on gays and lesbians assumed that all gays and lesbians were "promiscuous," and therefore, unable to establish and maintain meaningful, long-lasting relationships. Several studies on gays and lesbians in the 1970s referred to homosexual lasting relationships merely as ongoing "affairs" (see Bell & Weinberg, 1978; Saghir & Robins, 1973). For example, Bell and Weinberg (1978) explained that in their survey of 4,639 gay men and women "virtually all of the male respondents had been involved in at least one affair (defined as a 'relatively steady relationship' with another man) during the course of their lives" (p. 86). Furthermore, Bell and Weinberg considered only homosexuals who actually live together to be "coupled"; even then, these researchers referred to the "coupled" subjects simply as "roommates" (1978, p. 91). In another study, Weinberg and Williams (1975) interviewed 1,057 gay men about their sexual activity, but failed to ask if any of these men considered the other man a long-term partner/lover. However, many of the early survey results indicated that both gay men and lesbians expressed a strong desire to establish a long-term relationship with a person of their same sex (Bell & Weinberg, 1978; Harry, 1984; Jay & Young, 1977).
By the late 1970s and early 1980s, researchers began to understand that many gay men and lesbians did have partners, and that these relationships could be long lasting. Mendola (1980) sampled 405 gay men and lesbians in long-term relationships and found 63% of the gay men and 70% of the lesbians reported being in a committed "marriage-like" relationship. The sections that follow review the literature that has examined aspects of gay and lesbian ongoing relationships. The sections are organized according to predominant topical areas in gay and lesbian research: sexual exclusivity, relationship quality and satisfaction, sex-role ideology, power dynamics, couple types and stages, social influences, and the impact of HIV/AIDS.

**Sexual exclusivity.** The 1970s have been described as a time of "sexual revolution" and openness for both heterosexuals and homosexuals. Many early studies in the 1970s found that the occurrence of sexually-open relationships was fairly common among homosexuals, especially gay men (Bell & Weinberg, 1978; Saghir & Robins, 1973). Most of this early research focused exclusively on sexual activity as the impetus for and maintaining feature of homosexual relationships.

From the earliest research, the major point of focus has been on the dichotomous distinction between couples that are sexually exclusive versus sexually open. Sexual exclusivity, or monogamy, has long been claimed as the heterosexual "model" of relationships. Just as many heterosexual couples have reported that they maintain monogamous relationships, studies of gay and lesbian relationships also have indicated that there are many monogamous
homosexual relationships (see Bell & Weinberg, 1978; Berger, 1990; Blumstein & Schwartz, 1983; Kurdek, 1986b; Mendola, 1980; Peplau, 1991). For example, in Mendola’s (1980) study, 83% of lesbians reported having sex only with their partner, and Fitzpatrick, Jandt, Myrick, and Edgar (1994) found in their study that “70 percent of gay males and 80 percent of lesbians had never broken their monogamy agreement” (p. 273).

Where the research on gay and lesbian couples diverges from research on heterosexual couples, and has spurred the major interest of researchers, is with admittedly sexually-open relationships. Research indicates that some gay men, in particular, openly admit to either having an occasional outside sexual encounter, or having discussed an “open agreement” with their partner to allow outside sexual encounters (Hickson, Davies, Hunt, Weatherburn, McManus, & Coxon, 1992). For example, Harry (1984) found that many gay male couples began their relationships as exclusively monogamous, but became more open as the relationship lasted longer. Lee (1991) asserted that one positive aspect of homosexual couples negotiating the sexual exclusivity of the relationship is that it may lead to increased levels of trust and relational satisfaction compared to the betrayal often experienced in heterosexual relationships where monogamy is assumed. In one study, Tuller (1978) found that:

monogamy was desirable, and indeed necessary, for some of the relationships involved...whereas, it could possibly be fatal for others. As to be expected there was a great variance of opinion on this issue. Again, there is a close parallel between the opinions of these couples and heterosexual couples in our society. (p. 342)
Mendola (1980) also made the connection that the 49% of gay males admitting to having an occasional outside sexual experience in her sample was very similar to Pietropinto and Simenauer's (1979) heterosexual male sample in which 43% reported having an occasional sexual experience outside their marriage. Tuller (1978), however, observes that:

The question of monogamy is more likely to come up in a homosexual relationship than in a heterosexual one because homosexuals have no model to imitate as do heterosexuals. Further, the socialization process does not teach what a good gay marriage should be like as it does with heterosexual marriages. Some gay people use the heterosexual model and remain monogamous; some are influenced by religious doctrines and remain monogamous; and others simply do whatever works best for their particular relationships. (p. 336)

In comparison, several studies on sexual exclusivity in heterosexual couples show that not all heterosexual relationships are strictly monogamous. In addition, these studies found no difference in relationship satisfaction or stability between sexually open versus closed heterosexual marriages (Knapp, 1976; Knapp & Whitehouse, 1977; Ramey, 1975, 1976; Watson, 1981). In studies involving heterosexual couples who "swing," or partner swap, no evidence was found that swinging was harmful to marital or family stability (Cole & Spanier, 1974; Gilmartin, 1972; Paulson & Paulson, 1971). In fact, Rubin (1982) found in a sample of 130 sexually-open and 130 sexually-exclusive married and formerly married respondents that those couples who were in sexually open marriages were no more poorly adjusted; and of the couples who had split-up, those in
sexually-open marriages were no more unhappy than those in sexually-exclusive ones. Rubin asserted, "nothing in this data argues for the view that sexual openness or exclusivity, in and of themselves, make a difference in the overall adjustment of a married couple" (1982, p. 107). In his study, Harry (1984) came to the same conclusion for homosexual couples, even going so far as to recommend sexual openness for success in homosexual long-term relationships.

Kurdek and Schmitt (1985/86) found that open and closed gay male couples were actually more similar than different in psychological adjustment, especially on the three variables of dyadic attachment, positive beliefs in partner changability, and overall relationship quality. The existing research, therefore, suggests that an overemphasis of the dichotomy between open versus closed relationships may, in fact, be of less significance in understanding the quality of both homosexual and heterosexual relationships than other factors.

**Relationship quality and satisfaction.** The most general finding in studying the relationship quality of gay and lesbian couples is that these relationships are for the most part based in expectations of equality, reciprocity, and autonomy (Blumstein & Schwartz, 1983; Kurdek & Schmitt, 1986a; Lynch & Reilly, 1985/86; McWhirter & Mattison, 1984; Peplau, Padesky, & Hamilton, 1982; Reilly & Lynch, 1990). Bell and Weinberg (1978) found that most of the homosexuals in their study wanted to be in a steady long-term relationship rather than engaging in casual one night stands. More specifically, Peplau and Cochran (1981) found that lesbians and gay men seek out their relationships with
the primary goals of love, affection, and companionship, much like heterosexual couples. Peplau and Cochran (1981) also found that when comparing a sample of 50 lesbians, 50 gay men, 50 heterosexual women, and 50 heterosexual men, there were no differences in their indications of how “in love” they were or in relationship satisfaction. Also, in comparing relationship adjustment and degree of love and liking of heterosexual and homosexual couples again no differences were found (Peplau & Cochran, 1981). However, both lesbians and gay men reported higher degrees of positive feelings for their partner than heterosexuals.

Peplau (1991) also indicates that gay, lesbian, and heterosexual relational “likes” and “dislikes” are very similar. In fact, a panel of judges blinded to the sexual orientation of respondents were unable to differentiate between gay, lesbian, or heterosexual partners’ open-ended responses. In general, gay men, lesbians, and heterosexuals in relationships tend to report fairly equal levels of satisfaction on standardized scales, such as Spanier’s Dyadic Adjustment Scale (see Dailey, 1979; Duffy & Rusbult, 1986; Kurdek & Schmitt, 1985/86, 1986a, 1986b, 1987).

In addition, Dailey (1979) investigated the assertion that “homosexuals may love each other, but the love expressed is ‘unnatural,’ and really not love at all” (p. 155). Using the Caring Relationship Inventory (CRI) scale, Dailey found no difference between homosexual and heterosexual assessments of love in their relationships. In assessing dyadic cohesion, married heterosexual couples actually showed greater variability than homosexual couples. Dailey
hypothesized that this may be the result of homosexual partners’ greater commitment and effort in making their relationship work in the face of a lack of social acceptance and support. Schmitt and Kurdek (1987) found that being in a relationship actually strengthened individuals’ positive gay identity and increased self-concept over those not in a relationship. Additionally, maintaining a relationship led to a greater belief in one’s ability to have control over life events and lowered levels of anxiety and depression.

In examining relational characteristics surrounding quality and satisfaction, Blumstein and Schwartz (1983) interviewed 120 heterosexual, 90 lesbian, and 90 gay male couples about several aspects of their relationships, such as work, sex, and money. Blumstein and Schwartz found that mutual dependency and egalitarian power sharing was important for lesbians’ relationship quality; whereas, gay male couples reported that having similar education levels and values, and sharing financial responsibilities were important to their relationship quality. While these differences may exist, other research suggests that gay and lesbian couples may be more similar than different. For example, Lewis, Kozac, Milardo, and Grosnick (1981) found no statistically significant differences in relationship commitment between 50 gay male and 32 lesbian couples. Also, Kurdek (1988) found gay male and lesbian relationship satisfaction to be based in five similar relational elements:

a) low autonomy, b) strong intrinsic and instrumental motivations for being in the relationship, c) high trust, d) few beliefs that disagreement is destructive, e) high satisfaction with social support, and f) frequent shared decision making. (p. 94)
Furthermore, Kurdek and Schmitt (1986) found that for both homosexual and heterosexual couples, relationship quality revolved around a high level of dyadic attachment, few relationship alternatives, shared decision making, and especially holding few beliefs that disagreements are destructive to the relationship. Also, similar to other studies, they found a major factor in lesbian relationship satisfaction was equality in power sharing between partners.

In general, Tuller (1978) found in his study that “most of the gay couples claimed they were very happy with their relationships” (p. 340). In addition, the ingredients gay male and lesbian couples said they needed for a successful relationship included “understanding, love, mutual interests, caring, communication, honesty, openness, lack of extreme possessiveness, sensitivity, mutual respect, accenting and building on a partner’s strengths and playing down their weaknesses, tolerance, sharing, being direct, and having faith in one another” (Tuller, 1978, p. 341). Kurdek (1988, 1989) found that the most important predictors of gay and lesbian relationship quality from his study were a focus on trust, similarity, and intrinsic motivation; whereas, emotional expressiveness and equality of power were particularly important for lesbian couples. For both gay male and lesbian couples, sexual exclusivity was found to be unrelated to overall relationship quality (Kurdek, 1988).

**Sex-role ideology.** One of the most common myths pertaining to gay and lesbian relationships is the belief in stereotypical male-female sex-role playing. This assumption is based in the belief that homosexual couples model
themselves after heterosexual relationships where one partner assumes a masculine role and the other a feminine role. In general, the research on gay and lesbian couples indicates that this stereotype is not supported (see Kurdek, 1985/86, 1987, 1993; Kurdek & Schmitt, 1986a; Lynch & Reilly, 1985/86).

Peplau (1982) found evidence that traditional heterosexual gender/sex roles do not provide the structure for homosexual relationships. According to Peplau, "traditional heterosexual marriage is not the predominant model or script for current homosexual couples" (1982, p. 4). Her findings suggest that "most contemporary gay relationships do not conform to traditional 'masculine' and 'feminine' roles; instead role flexibility and turn-taking are more common patterns" (p. 4). In another study, Tuller (1978) indicated that "all of the couples claimed that they did not have any butch-femme roles in their relationships—that, in fact, they shared household tasks and definitely did not sexually imitate conventional heterosexual roles" (p. 340). Dailey (1979) also found no evidence of cross-gender role assignment in gay male and lesbian couples. Dailey’s findings indicated that when instances of cross-gender roles were found, they existed equally across homosexual and heterosexual couples. While Marecek, Finn, and Cardell (1983) did find some evidence of cross-gender role-playing in a few homosexual couples, it was considerably less than in heterosexual couples in their sample.

In general, masculine and feminine sex-roles appear to be blended in gay and lesbian relationships towards more androgynous roles; as opposed to
heterosexual partners, whose sex-roles are more extreme towards one role or the other (Schullo & Alperson, 1984). Kurdek (1987) found that homosexual women tended to be more instrumental in their sex-role orientation than heterosexual women, whereas, homosexual and heterosexual men were equivalent. Homosexual men were found to be more expressive than heterosexual men, while homosexual and heterosexual women were equivalent. The general findings were that homosexual men and women indicated their gender/sex-role self-schemas to be more androgynous than heterosexuals.

In another study, Kurdek and Schmitt (1986a), using Bem’s Sex-role Inventory (1974), found a fairly equal distribution and random pairings among gay, lesbian, and heterosexual couples according to Bem’s four sex-role categories: masculine, feminine, undifferentiated, and androgynous. Masculine individuals are more task-oriented, hostile, dominant, ego-centric, temperamental, and low in nurturing qualities. Feminine persons are submissive, dependent, and nurturing. Undifferentiated individuals tend to be self-centered, withdrawn, depressed, possess underdeveloped social skills, and are lacking in intimacy. Androgynous persons are socially adaptive, extroverted, empathic, high in self-esteem and self-disclosure. Kurdek and Schmitt (1986a) found that androgynous and feminine individuals reported the highest level of relationship quality. Couples with one or both partners being undifferentiated or masculine reported the lowest relationship quality.
Finally, relative to undifferentiated and masculine persons, both Kurdek
and Schmitt (1986a) and Reece and Cecco (1982) indicate that androgynous and
feminine individuals report greater relationship functioning. According to Reece
and Segrists (1981), androgynous couples scored high on relational cooperation
and remained together longer than those couples scoring low on cooperation.
Kurdek (1987) asserted that the large number of androgynous gay and lesbian
partners is surprising in light of the frequent negative reactions experienced by
children from parents, teachers, and peers to non-conforming sex-role behavior.
Perhaps the increased occurrence of androgyny in gay and lesbian partners could
reflect an unwillingness to accept societal pressures to conform to either
masculine or feminine sex roles during childhood, and instead represent the
desire to express themselves "naturally" however their behavior may manifest
itself. In rethinking the traditional dichotomous descriptions of gender/sex
roles, Marecek, Finn, and Cardell (1983) argued that "masculine" and "feminine"
gender roles are very likely not linked to biological sex, but rather lie on a
continuum much like personality traits. Furthermore, Schufllo and Alperson
(1984) have suggested there is a need to rename the polar extremes of this
continuum as instrumental and expressive qualities which are independent of
biological sex. Bem (1974) has argued that even a gender continuum does not
accurately capture the multiple manifestations of gender orientation. Bem
contended, for instance, that androgynous individuals possess both instrumental
and expressive characteristics which means these qualities cannot exist as polar
opposites of the same continuum, but rather must be independent of one another. To date, research has indicated that gay men and lesbians tend to be more androgynous in their gender-role orientation. As a result, the butch-femme myth in gay and lesbian relationships seems not to be applicable in these couples.

**Power dynamics.** Because gay and lesbian relationships tend not to adhere to traditional heterosexual sex-roles, issues surrounding “power imbalances manifested in unequal influence in decision making, unfair division of household labor, or biased allotment of rights, resources, and privileges” are areas that must be negotiated for these couples (Huston & Schwartz, 1995, p. 108). In heterosexual couples, adherence to cultural sex-role norms often serve as a relational script regarding power allocation. Traditional sex-roles have assigned males the role of primary income earner, and females responsibility for household duties. However, in gay and lesbian relationships, roles and duties appear to be negotiated based on individual desires, skills, and earning potential (Kurdek, 1993). Both gay male and lesbian couples express a strong desire for equality and egalitarian power dynamics as ideals (Kurdek & Schmitt, 1986; Peplau, Padesky, & Hamilton, 1982; Reilly & Lynch, 1993). The way equity is carried out in each gay and lesbian couple naturally differs. Several trends, however, have emerged.

First, Blumstein and Schwartz (1983) found that, like heterosexual couples, gay male couples tended to use financial contribution to the relationship as a
guide for establishing which partner would have more decision-making power. They found male partners who earned more money took on a more dominant role in those relationships. However, many gay male couples were quite unhappy if one partner earned more money because of the resulting power imbalance. The idea of financially supporting one's partner was found to be largely unacceptable in homosexual relationships, due to underlying beliefs in relational equality.

For lesbian couples, however, money does not seem to play as important a role in determining decision-making and power dynamics (Lynch & Reilly, 1985/86; Reilly & Lynch, 1990). Lesbian couples appear to avoid constructing their relationships based on financial issues. Instead, lesbian couples report much more concern and focus on emotional closeness (McCandlish, 1982), interdependence of lives, and relational equity (Lynch & Reilly, 1985/86). For satisfied lesbian couples, power tends to be shared equally by both partners (Reilly & Lynch, 1990). In instances when power imbalances do occur, lesbian couples work very hard to resolve the issue and reinstate equity.

Additionally, Harry (1984) found that age played a role in decision making for gay male couples. In couples where one partner was at least five years or more older, the older partner tended to take on more power in making decisions for the couple; however, only couples who desired an age difference in their relationship reported themselves as satisfied with this imbalance in
decision-making power. In general, most gay men preferred and sought out partners similar in age in order to achieve egalitarian relationship ideals.

Regarding issues of power related to household labor, both gay males and lesbians have been found to share household tasks (Kurdek, 1993). For gay men, McWhirter and Mattison (1984) found that gay couples tend to distribute household duties based on skill, interest, and work schedules. Kurdek (1993) found that gay couples worked to balance household tasks, but that each partner did not perform every task equally. Instead, one partner may perform the shopping and cleaning, while the other is responsible for cooking and household repairs based on ability. Lesbian couples have been found to attempt to actually share in all household tasks equally (Kurdek, 1993). This emphasis on sharing in all tasks is likely related to the strong emphasis on interdependence and time spent together for lesbian couples. Kurdek (1989) found that lesbians reported slightly stronger degrees of expressiveness and equality of power in their relationships, but in general, for both gay male and lesbian couples, gender roles did not influence the distribution of household tasks or decision making. Instead, these are negotiated on an individual basis.

Finally, in comparing the conflict resolution styles of gay, lesbian, and heterosexual parents and non-parents, Kurdek (1994) found no difference between the power dynamics of these couple types. However, in heterosexual parent couples, wives complained that men did not engage in enough problem-solving conversations. Gay male and lesbian partners were found to engage in
more discussion, but partners were more likely to be highly compliant with the biological parent's decisions concerning their child/children.

**Gay and lesbian relationship types and stages.** Some researchers have attempted to classify gay and lesbian relationships either by type or assessing different relationship stages. As previously discussed, some studies have categorized same-sex couples according to their sexual exclusivity. For example, Bell and Weinberg (1978) were one of the earliest to place same-sex couples into either "open coupleds" or "close coupleds." Subsequently, most research on same-sex couples utilized this dichotomy of open versus closed sexual relationships as the major typological distinction.

More recently, Fitzpatrick, Jandt, Myrick, and Edgar (1994) have attempted to place gay and lesbian couples into a typology developed for heterosexual couples. This typology consists of three couple "types": traditionals, independents, and separates. According to Fitzpatrick et al. (1994), traditionals are couples who are characterized by conventional ideological values (i.e., wives change their names, infidelity is unacceptable), strong interdependence (i.e., spending free time together, looking to each other for companionship), and describe their communication as nonassertive, but do engage in rather than avoid marital conflicts. Independents adopt more nonconventional ideological values regarding relationships and family (e.g., relationships should not constrain individual freedom), are interdependent, and yet maintain more time for individual goals and may have separate spaces (e.g.,
bathrooms, offices), value positive and negative self-disclosure, and often engage in conflict. Finally, separates combine conventional relational and family values with upholding individual freedom, demonstrate significantly less time sharing and companionship (i.e., maintain emotional/psychological distance, as well as, having separate physical space), and describe their communication as persuasive and assertive, but they avoid open conflict. Relational partners may describe the relationship similarly, or as some combination of these types.

In a combined sample of 163 gay and lesbian couples who completed the Relational Dimensions Instrument (RDI), Fitzpatrick et al. (1994) found the couples were 51% traditionals, 20% independents, and 29% separates. When compared to another sample of heterosexual couples, there were the same amount of gay male traditionals and more lesbian traditionals than the heterosexual sample. There were significantly fewer independent gay males and lesbians, and more gay male separates, but fewer lesbian separates than the heterosexual couples. Fitzpatrick et al. (1994) assessed that the majority of gay men and lesbians reported higher degrees of traditional “family values” than the comparable heterosexual sample. These findings warrant further investigation into the myths regarding gay and lesbian relational values.

In her study of lesbian couples, specifically, Tanner (1978) also proposed a typology consisting of three couple types. Tanner labeled lesbian couples with a more dominant-submissive relationship, where one partner was primarily “in charge,” as Traditional-Complementary prototypes. The Flexible Nurturing-
Caretaking prototype occurred in lesbian relationships where role allocations for activities, such as work and household chores, are much more equally balanced, but one partner is still the primary "adult/caregiver" to the other. Finally, the Negotiated-Egalitarian prototype relies on complete equality of both partners in most every sense. This relationship is bound by affection alone and both partners negotiate to achieve equal input on all relationship concerns. This couple type most closely resembles the "ideal" lesbian relationship found to be expressed in other research.

In one of the only longitudinal studies of gay male couples, McWhirter and Mattison (1982, 1984) developed a stage model for long-term gay male relationships. Over the course of a five year period, these researchers studied aspects of gay male relationships lasting between one and 37 years (mean 8.7 years). McWhirter and Mattison found in their sample of 156 gay couples, many were quite long lasting, with several lasting 20 years or more. In studying these couples over time, these researchers observed enough similarities across couples to propose a flexible stage model for long-term gay male relationships. The stage model consists of six levels: (a) Blending, (b) Nesting, (c) Maintaining, (d) Building, (e) Releasing, and (f) Renewing. These stages are dynamic, and couples may move quickly through one or several, or even skip certain stages, however, the stages serve as a general relationship model. Because McWhirter and Mattison's stage model is one of the few to be based in a longitudinal examination of gay male couples, each stage will be briefly described.
In the first stage, Blending (first year), the partners experience a very intense sense of togetherness. Their similarities draw them together and they tend to ignore their differences. They spend a large amount of time together, almost to the exclusion of others. Feelings of “falling in love” are very intense in this stage, but vary by individual. Equality is preferred in financial concerns and household chores. Sexual activity is frequent, and almost always sexually exclusive.

In the second stage, Nesting (2 to 3 years), gay couples turn their attention increasingly to their surroundings. The desire to establish a home together becomes a goal. Couples begin to notice each others shortcomings and discover ways to cope with them, or complement each other to increase compatibility. This stage also involves a gradual decline in the intense feelings of love felt in the blending stage. McWhirter and Mattison observed that the combination of searching for compatibility, and a lessening of intense feelings of love, often create what they termed ambivalence.

Maintaining (4 to 5 years) involves couples learning to manage relational dialectics of togetherness vs. independence. After the intense togetherness of the blending stage, partners in this stage begin to try to re-establish their own sense of personal identity within the relationship. Risk-taking begins to occur—sometimes through outside sexual encounters, more time apart, increased self-disclosure concerning the relationship, and new separate friends. This increased risk-taking often results in high conflict which must be negotiated and resolved.
The quality that seems to maintain the relationship in this stage is the sense of both time and emotional investment, and the feeling that the relationship had taken on a life of its own. Additionally, it was found that outside recognition of the relationship by family and friends did not occur until after 3 years together.

During Building (6 to 10 years), gay couples tend to enter a stage of “cooperation.” By this time, the couple has developed a sense of security in the relationship. However, this stage may also bring feelings of boredom and entrapment. But at this point in the relationship, couples usually have developed coping mechanisms for dealing with these types of relational threats. Complementarity is managed successfully, and the individualization of the maintaining stage is strengthened by partner support.

In stage five, Releasing (11 to 20 years), the couple has established mutual trust and conviction to the relationship as time has strengthened positive mutual regard for each other. By this time, partners have merged their financial assets and possessions completely. But gay men in this stage express less caring and concern for both self and other which sometimes leads to increased isolation. Also, by this stage, both partners may become guilty of taking the relationship for granted.

The final stage, Renewing (20 years and beyond), marks a special time for couples around or beyond their twentieth anniversary. Couples in this stage experience a renewal of their relationship. Partners focus on enjoying each other’s company more. Also, establishing future financial security and
professional achievements become a focus. These couples assume they would be together until death. However, partners do worry about health, financial security, fear of loneliness, and death of partners, or themselves.

Overall, McWhirter and Mattison (1984) found gay couples to be quite satisfied and capable of maintaining long-lasting relationships. However, they did observe that individuals reported lacking gay relationship role models and often had expectations based on heterosexual couples that caused distress when the relationship did not match those expectations. There was common curiosity and worry concerning how other gay couples functioned in everyday life, and deal with finances, family, outside relationships, compared to their own relationship. Regarding communication, McWhirter and Mattison found that gay couples may have the tendency to “over-communicate” about their relationship. They observed in some gay couples that “at times they process their feelings and behaviors ‘to death,’ causing relationship fatigue and distress” (1982, p. 88). These findings and proposed stages seem promising for understanding the relationship trajectory of gay male relationships and warrants further investigation by relational researchers.

**Societal influences on gay and lesbian couples.** In the research on gays and lesbians, the impact of the larger society on same-sex couples’ long-term relationships is often ignored. In research on heterosexual relationships, social and cultural frames often are bracketed as taken-for-granted. This perspective increasingly is being questioned by communication scholars because it ignores
the important role of society and context in the lives of heterosexual couples. Consideration of the impact of society on relationship formation and maintenance becomes more salient and critically important when examining gay and lesbian relationships.

Gays and lesbians experience differing degrees of social discrimination and stigma in American society. Goffman (1963) proposed that stigma occurs when an individual or group is viewed as deviant from the "mainstream" social norms of society. Gays and lesbians experience stigmatized reactions from others based on their sexual orientation and relationships throughout their lives (Harry & Lovely, 1977). Social discrimination and stigma can take many legal, economic, and social forms. Regarding legal and economic discrimination, Huston and Schwartz (1995) observe that:

The lack of institutional recognition for homosexual couples also plays a very powerful role in their stability. Heterosexual unions are sanctioned by the church and the state through the marriage ceremony. The state rewards such unions with family health insurance, property rights when breakups occur, and institutional prerogatives such as untaxed inheritance and the right to distribute property after a partner's death. (p. 114)

The lack of recognition from both church and state creates many stigmatizing problems for gay and lesbian couples. In fact, in several states same-sex sexual activity remains a criminal offense. As a result, homosexuals are not always protected equally under the law, or treated equally by law enforcement officials. These issues affect the protection of gay and lesbian rights and are of great concern for same-sex couples.
According to McWhirter and Mattison (1982), four forms of societal discrimination, either overt or covert, most profoundly affect gay and lesbian relationships on a daily basis: ignorance, prejudice, oppression, and homophobia. Ignorance stems from a simple lack of knowledge about gay and lesbian lifestyles. Prejudice is negative attitudes based on ignorance of the group. Homophobia results from a persistent fear of homosexuals or homosexual activity. Oppression is manifested as action intended to deprive the individual rights of gays and lesbians in society. All of these attitudes and behaviors can have a serious impact on the lives of gays and lesbians, such as loss of jobs, housing, physical and verbal assault, and the like.

When these types of negative attitudes become internalized by gays and lesbians, they are particularly damaging to both individual and their relationships (McWhirter & Mattison, 1982). Self-oppression, learned and internalized from a lack of societal acceptance, can result in many devastating emotional effects for gays and lesbians; for example, low self-esteem, unwillingness to self-disclose sexual orientation, and an internal lack of acceptance of homosexuality and same-sex relationships. These forms of internalized homophobia can result in barriers to establishing and maintaining long-term relationships.

Another form of social discrimination is a lack of emotional acceptance by family, friends, co-workers, and others. Many gay and lesbian individuals refrain from disclosing their sexual orientation to family members and friends.
out of a fear of emotional rejection. This lack of openness can cause particular problems for homosexual couples in the form of added relational stress and lack of emotional social support from important family and friends (Berger, 1990).

Because of the lack of legal and social sanctioning that serve to bind heterosexual couples, same-sex couples must rely largely on emotional commitment to sustain their relationships. This can be extremely difficult in times of relational stress. Despite the fact that research has pointed to the positive impact of gay networks for couples, little is known about the actual role gay networks serve in maintaining gay and lesbian couples, particularly in times of stress.

In addition to the stigma experienced by many gay or lesbian couples, Wooden, Kawasaki, and Mayeda (1983) found Japanese-American gay couples to experience a "double stigma" belonging to two stigmatized minorities. Homosexual individuals or couples who are HIV infected also experience a societal "double stigma" of being gay and having a communicable terminal virus. Perhaps the most devastating discrimination is felt by ethnic HIV positive persons who may actually experience a "triple stigma" belonging to three stigmatized groups. The impact of HIV/AIDS on gay couples will be discussed in more detail in the following section.

Summary. In summarizing the research on gay and lesbian relationships, much of the literature has used sexual activity (open vs. closed) in these couples as the defining feature of these relationships. However, more recent surveys in
the era of AIDS indicate that this dichotomous distinction does not accurately capture the multiple dimensions of gay and lesbian relationships (Berger, 1990). For instance, the myth of butch-femme role playing in same-sex couples has not been supported by the research. Both gay men and lesbians seem to be more androgynous in their sex-role behavior than heterosexuals. Sex-role androgyyny would seem to support the relational ideal of equality in power relations reported by both gay males and lesbian women. The high degree of androgyyny in gay and lesbian relationships may be linked to high levels of relationship quality and satisfaction reported in the literature.

Regarding types and stages of gay and lesbian couples, Fitzpatrick et al. (1994) found support for applying the three heterosexual couple types (traditionals, independents, and separates) to homosexuals. Surprisingly, homosexuals, especially lesbians, were found to be more traditional in their relational values than heterosexuals. Tanner also suggested a three couple typology for lesbian couples consisting of traditional-complementary, flexible nurturing-caretaking, and negotiated-egalitarian. In addition, McWhirter and Mattison (1982, 1984) have developed a stage model for gay male couples consisting of blending, nesting, maintaining, building, releasing, renewing.

Finally, the impact of societal stigma and homophobia on gay and lesbian relationship formation and maintenance was discussed. Research indicates that societal stigma condemning homosexual relationships, and the lack of legal and
economic sanctioning, does appear to cause relational barriers and stress for gay and lesbian couples.

**Limitations of imposing a heterosexual model on gay and lesbian relationships.** Throughout the literature on gay and lesbian relationships, there are predominant underlying assumptions that the heterosexual "model" for relationships should be the ideal. However, the research findings seem to contradict this notion, for example, in most studies, homosexuals either showed no difference or scored higher on relationship satisfaction than heterosexuals (Kurdek & Schmitt, 1987; Peplau & Cochran, 1981). These findings may be the result of such factors as increased partner similarity and lack of unequal power dynamics experienced in heterosexual sex-role norms. Despite these findings, there is frequent comparison between gay and lesbian couples and the heterosexual relationship "norm." While some knowledge obviously is gained through comparisons between these groups, this approach has dominated the research to the detriment of fully increasing knowledge of gay and lesbian relationships.

Many of the early studies of gays and lesbians were concerned primarily with examining sexual activity and practices. These studies failed to ask important questions regarding participants' lives such as "Is this person a long-term partner?" These types of biases are examples of possible problems with imposing "heterosexual model" assumptions on gay and lesbian relationships.
(Walsh-Bowers & Parlour, 1992), while ignoring the perspectives of the individuals and groups whose lives are being studied.

In general, the research comparing same-sex and heterosexual couples have found many similarities in relational dimensions and values, and yet differences still exist. Using only a "comparison approach" could limit our understanding of gay and lesbian relational dynamics. Therefore, we need to devote effort to studying these relationships in and of themselves. When combined, both of these approaches may aid in the discovery of enlightening dimensions of gay male and lesbian relationships.

The Impact of HIV/AIDS on Gay and Lesbian Relationships

The existing research on gay and lesbian couples, surprisingly, has paid little attention to the tremendous effect the AIDS epidemic has had on homosexual relationships. In the United States, the AIDS epidemic continues to negatively impact the lives of many Americans, particularly the homosexual population. As of June 30, 1998, a total of 612,078 persons with Acquired Immunodeficiency Syndrome (AIDS) have been reported to the CDC by state and local health departments; 511,934 cases reported in males, and 92,242 cases in females. 379,258 persons have died of AIDS (CDC, 1998). From 1992-1997, AIDS was the leading cause of death for men age 25-44 in the United States surpassing heart disease, cancer, suicide, and homicide, and for women age 25-44, AIDS was the fourth leading cause of death (CDC, 1997).
The AIDS epidemic has had a large impact on the gay male population. Of the AIDS cases reported to the CDC, 337,622 (56%) have openly self-identified as men who have sex with men (CDC, 1998). Many gay men have seen their partners and friends die premature deaths. Berger (1990) found that many individuals felt depressed over the loss of close friends to AIDS, or reported fear, anxiety, stress, and depression over one or both partners testing HIV positive. Many gay partners face the emotional and physical hardship of becoming carepartners for their lover (Folkman et al., 1994), and also must worry about who will take care of them after their partner’s death if they too are HIV infected and need care (McCann & Wadsworth, 1992). Because lesbians engage in fewer HIV high risk sexual activities, the AIDS crisis has less directly affected their relationships (Carl, 1986). However, AIDS has resulted in the loss of friends and relatives for many lesbians, and through sharing the bond (and stigma) of a homosexual orientation, many lesbians lives have been deeply affected by the AIDS epidemic. As a result, the AIDS crisis has served as a gay human rights issue for many politically-active lesbians and gay men.

Recent AIDS-era research indicates the AIDS epidemic has had an important influence on increasing coupling and monogamy in gay male relationships (Carl, 1986). In one of the only studies to examine the effect of AIDS on gay male relationships, Berger (1990) found evidence that gay couples have made “significant changes in their sexual behavior as a result of AIDS awareness” (p. 44). Berger noted that “Of 83 couples who responded... 96.4%
described their relationships as monogamous. This differs from pre-AIDS surveys which showed that only a minority of gay couples were strictly monogamous (p. 44). In addition, one finding in particular has important implications for the study of gay male relationships in the AIDS-era:

When asked "Has the AIDS crisis affected your relationship?" over two-thirds acknowledged that it had had a significant impact. The most common response was that AIDS awareness had led to changes in sexual behavior; many couples said it led them to remain or become monogamous, and that it led to modification in the nature of sexual activities with their partners in the direction of safe sex....Many couples said the crisis had brought them closer together and increased appreciation for their partner. A few said they became more aware of the political implications of being gay and got involved in gay community organizations. (Berger, 1990, p. 44)

These preliminary findings provide initial evidence that gay male couples in the 1990s may not be accurately described by the early research of the 1970s and early 1980s prior to the devastation of the AIDS epidemic. More current studies on homosexual relationships in the time of AIDS are needed to better understand the current nature of these relationships.

HIV and AIDS

HIV/AIDS continues to affect the lives of an estimated 1 million infected persons in the United States and the millions of persons whose lives are interconnected with those who have the disease (CDC, 1995). Recent advances in combination-drug therapies have given new hope for survival to those infected with HIV/AIDS (Dunlap, 1997; Sullivan, 1996). And yet, even the possibility of
extended life brings with it a whole new set of uncertainties surrounding living with HIV or AIDS (Brashers et al., 1999).

This disease has had a tremendous physical and psychological impact on infected persons and the people who share their life, particularly family members (Brown & Powell-Cope, 1991; Morin & Batchelor, 1984). An HIV or AIDS diagnosis is highly stress provoking for both individuals (Chuang, Devins, Hunsley, & Gill, 1989) and their family members (Powell-Cope & Brown, 1992). At present, HIV/AIDS is a terminal illness which increasingly has taken on chronic disease characteristics (Curtin & Lubkin, 1995; Nokes, 1990). HIV becoming a chronic terminal illness is a severe stressor in the lives of PLWHs and their families. A life stressor may be viewed as an event occurrence that is undesired and disrupts normal life activities (Pearlin, 1989). Because the disease has taken on a chronic illness pattern, families are often put under chronic strain and family resources often are depleted after an HIV/AIDS diagnosis (Brown & Powell-Cope, 1991; Park & Folkman, 1997).

Uncertainty is one primary source of stress in the lives of PLWHs (Brashers et al., 1999; Brashers, Neidig, Reynolds & Haas, 1998; Brown & Powell-Cope, 1991; Neidig, Brashers, & Haas, 1996; Weitz, 1989). Weitz (1989) found that persons with HIV/AIDS are faced with uncertainty about many issues, such as interpretation of symptoms, illness severity and ability to function day-to-day, issues of control over one’s life, and facing early death. Brashers et al. (1998) have suggested that degrees of uncertainty related to HIV/AIDS vary across
stage of illness and symptom severity. Brown and Powell-Cope (1991) suggested that uncertainty surrounding HIV/AIDS consists of a continuous series of unpredictable transitions for PLWHs and their family. These researchers proposed five primary transitions PLWHs and family encounter: (a) managing and being managed by the disease, (b) living with loss and dying of a loved one, (c) renegotiating the relationship, (d) going public to others about the illness, and (e) uncertainty about containing the spread of HIV. Due to the highly variable nature of HIV/AIDS, how the PLWH and their family cope with uncertainty in their lives will influence how successfully they are able to function.

**HIV/AIDS and Coping**

In general, coping refers to cognitive or behavioral attempts to avoid being harmed by life stressors (Pearlin & Schooler, 1978; Moos & Schafer, 1993). Pearlin and Schooler (1978) described three types of resources persons may have at their disposal to cope with life stressors: (a) psychological resources - personality characteristics people draw upon to help withstand life stressors, (b) social resources - the interpersonal networks that persons are part of that may act as a potential source of support, and (c) tangible resources - economic and physical objects that help persons reduce the effects of stressors. According to Pearlin (1989):

> all coping-regardless of the nature of the stressors - serves either to change the situation from which the stressors arise, to manage the meaning of the situation in a manner that reduces its threat, or keep the symptoms of stress within manageable bounds. (p. 250)
Lazarus and Folkman (1984) have suggested two broadly-defined types of coping: (a) problem-focused coping - cognitive and behavioral attempts to actively deal with a stress-provoking situation, and (b) emotion-focused coping - affect-centered attempts to reduce stress. Folkman and Lazarus (1988) have detailed multiple strategies within these two types of coping. For example, cognitive problem-focused coping strategies include positive reappraisal (re-examining a situation highlighting positive aspects) and realistic acceptance (accepting a situation while emphasizing aspects that can be positively influenced through action), with behavioral strategies taking the form of information seeking and seeking social support. Cognitive emotion-focused strategies are represented by distancing, denial, and wishful thinking; behavioral attempts include escape and avoidance.

Some researchers have suggested that problem-focused coping strategies are more effective than emotion-focused strategies (Aldwin & Revenson, 1987; Felton & Revenson, 1984; Mitchell, Cronkite, & Moos, 1983). Pearlin and Schooler (1978), however, caution that the effectiveness of a coping behavior cannot be judged by whether or not it does away with the stressor, but instead by how successfully it helps to mediate and buffer emotional distress. For example, Taylor and Brown (1988, 1994) have argued that creating positive illusions can be a successful means of coping with life stress, and may be a necessary part of the human ability to function in the face of adversity. Thus, the most successful
types of coping behaviors are those that help persons from becoming overwhelmed by life stressors (Pearlin & Schooler, 1978).

In addition, researchers have found that several personality characteristics may have a positive influence on successful attempts at coping with HIV/AIDS. For example, hardiness (a desire to persevere) (Nicholas & Webster, 1993), and mastery (feelings of control and competence in one’s life) (Tiblier et al., 1989) are personality factors that have been found to have positive correlations with an ability to cope with HIV/AIDS. In addition, optimism has been found to be a personality characteristic associated with better mental and physical health (Hooker et al., 1992; Wrubel & Folkman, 1997). Taylor et al. (1992) found that more optimistic persons living with HIV/AIDS were less symptomatic. Also, Folkman (1993) found that one of the most successful cognitive coping strategies helping PLWH’s psychological well-being was the ability to focus on the positive. With a disease that is highly unpredictable, focusing on the positive is suggested as one aspect of HIV/AIDS-related uncertainty that can be controlled (Wrubel & Folkman, 1997). The ability of PLWHs to feel they had gained some control over uncertainty in the course of the disease helped to reduce overall reported stress (Folkman, 1993).

In addition, self-efficacy has been found to be an important coping mechanism for HIV/AIDS (Folkman, 1993; Katz, 1996). Efficacy has been described as “a generative capability in which component cognitive, social, and behavioral skills must be organized into integrated courses of action to serve
innumerable purposes” (Bandura, 1982, p. 122). Bandura (1982) emphasized that in addition to the centrality of self-efficacy is the importance of what he terms “collective efficacy,” the ability of several people working together to accomplish their needs. The concept of collective efficacy underscores the importance of social support in the lives of PLWHs.

HIV/AIDS and social support

In recent years, researchers have found added support for the hypothesis that social support serves as a buffer against the negative effects of physical and psychological stress (Cohen & Wills, 1985; Hobfoll & Parris-Stephens, 1990; Kaplan & Toshima, 1990; Kennedy, Keicolt-Glaser, & Glaser, 1990; Kessler et al., 1991). Also, recent immunological research indicates that stress can impair immune system functioning and that social support helps buffer stress to reduce impairment of the immune response (Kennedy et al., 1990; Kessler et al., 1991). This research has obvious application to immune-dysfunction diseases such as AIDS.

The communication of social support. Many types of social support have been proposed in the literature. House (1981) suggested that the construct of social support can be divided into four types: (a) instrumental support (money, physical aid, time); (b) informational support (advice, information giving/seeking); (c) appraisal support (affirmation, feedback, social comparison); and (d) emotional support (esteem, affect, trust). Cutrona and Suhr (1994) further separated out support of esteem as a specific type of social support
because of its tremendous impact on coping. Cutrona and Suhr (1994) also have presented a taxonomy of communication variables comprising these five types of social support shown in Table 2.1. The variables are part of a Social Support Behavior Code (SSBC) (Cutrona & Suhr, 1992; Cutrona, Suhr, & MacFarlane, 1990) instrument which was developed through a combination of reviewing the social support literature, social support instruments, and open-ended questionnaires which asked married couples what behaviors they would like their spouse to enact following a stressful event. All of the communication variables they suggest are verbal messages with the exception of affection which is demonstrated by nonverbal cues such as touching, hugging, kissing, and the like. The SSBC was designed to assess support-intended communication behaviors within the five types:

- **Informational support** (providing information about the stress itself or how to deal with it);
- **tangible aid** (providing or offering to provide goods or services needed in the stressful situation);
- **emotional support** (communicating love, concern, or empathy);
- **social network support** (communicating belonging to a group of persons with similar interests or concerns); and
- **esteem support** (communicating respect and confidence in abilities). (Cutrona & Suhr, 1994, p. 120)

Cutrona and Suhr (1992) found that spouses most frequently offer each other informational support, such as giving advice or factual input. Emotional and esteem support also are offered frequently. Tangible support was offered by two-thirds of spouses. Social networks were rarely used, and two-thirds of couples engaged in at least one negative behavior during their interaction. The communication behaviors that Cutrona and Suhr highlighted (see Table 2.1) are
Informational Support
- Suggestion/Advice (offer ideas, suggesting actions)
- Situation Appraisal (reassess the situation)
- Teaching (teach how to do something or teach facts)

Emotional Support
- Relationship (express closeness or togetherness)
- Physical Affection (hug, kiss, hand hold, touch)
- Confidentiality (Promise not to tell others)
- Sympathy (express sorrow and regret for situation)
- Understanding/Empathy ("I understand," self-disclose)
- Prayer (pray with person)
- Express Concern (inquire after well-being)
- Reassurance (nonspecific comforting)

Esteem Support
- Compliment (emphasize abilities, say positive things)
- Validation (agree with and take other's side)
- Relief of Blame (say it's not other's fault)

Tangible Support
- Loan (offer money or material object)
- Direct Task (offer to do something related to problem)
- Indirect Task (offer to do something not related)
- Active Participation (offer to join in reducing stress)
- Willingness (express willingness to help anytime)
- Comply with request (agree to do something after stressed person requests it)

Social Network Support
- Presence (offer to spend time with person, be there)
- Access (offer to provide access to new companions)
- Companions (others who have been through same)

Negative Behaviors
- Interrupt (change subject or interrupt other)
- Complain (talk about own problems)
- Criticism (negative comments about other or blaming)
- Isolation (will not help other, will not discuss it)
- Disagree/Disapprove (does not agree with other)

Table 2.1: Social Support Behavior Code *(Reprinted by Permission from Cutrona & Suhr, 1994, p. 122, Sage.)
interesting variables for future research on how social support is communicated within relationships, such as relational partners coping with HIV or AIDS.

One important aspect that may mediate the communication of social support is the receiver's perception of what type of support is considered helpful and desirable from whom. Some researchers have suggested that the same type of social supportive behavior may not be equally helpful from all individuals (Gottlieb, 1981; Hirsch, 1980; Shinn, Lehmann, & Wong, 1984). In a study of cancer patients, Dunkel-Schetter (1984) found emotional support to be perceived as helpful when provided by family, friends, and medical personnel. In fact, patients actually felt medical personnel who failed to provide emotional support to be less competent. Illness-related informational support was perceived as very helpful when provided by medical personnel, but not helpful when received from family and friends because of perceived level of expertise.

Wethington and Kessler (1986) found that perceived support may be more important than actual received support in adjusting to stressful life events. These researchers found that received support may, in fact, be mediated by perceived support. If certain communicative behaviors intended to be supportive are not perceived to be helpful by the receiver, then social support has not occurred. In addition, Jacobson (1986) found that the timing of different types of social support influenced how they are perceived. For example, the same type of support, such as concern and emotional reinforcement, may not be perceived as helpful at a time when a person is seeking informational support. Cutrona and
Russell (1990) proposed the need for “matching” of needed support and enacted support. As a result, communicative competence in judging the appropriate timing and specific type of social support desired may play a crucial role in whether or not that behavior is interpreted as helpful or supportive.

Social support is based intrinsically in interpersonal relationships, but support network research has provided inconsistent findings regarding the importance of large versus small support networks. Some researchers have suggested that the larger one’s support network the more successful one will be at eliciting aid (Hart, Fitzpatrick, McLean, Dawson, & Boulton, 1990; Hays, Chauncey, & Tobey, 1990). Other researchers have found that having at least one close confidant could be adequate to help buffer life stressors (Katz, 1996; Leavy, 1983). Evidence also has indicated that intimate significant others, such as a spouse or relational partner, are one type of close confidant that may add the unique element of relational intimacy to social support that cannot be provided by others (Corbin & Strauss, 1984; Dakof & Taylor, 1990; Lowenthal & Haven, 1968; Miller & Berlin Ray, 1994; Morin, Charles, & Maylon, 1984; Rolland, 1994; Weingarten, 1991).

In examining the effect of intimate relationships on means of coping, Barbee (1990) has proposed a dyadic Interactive Coping Model shown in Table 2.2 which focuses on the communication skills of both the help seeker and help provider and the coping resources of both within a supportive interaction. First, help-seeking communication behaviors by the person in need of social support
Support Seeking Behaviors

<table>
<thead>
<tr>
<th>Direct</th>
<th>Nonverbal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal</td>
<td></td>
</tr>
<tr>
<td>Ask</td>
<td>Cry</td>
</tr>
<tr>
<td>Hint/Complain</td>
<td>Pout/Sulk/Fidget</td>
</tr>
</tbody>
</table>

Indirect

Interactive Coping Behaviors

<table>
<thead>
<tr>
<th>Approach</th>
<th>Emotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem</td>
<td></td>
</tr>
<tr>
<td>Solve</td>
<td>Support</td>
</tr>
<tr>
<td>Dismiss</td>
<td>Escape</td>
</tr>
</tbody>
</table>

Avoidance

Table 2.2: Barbee’s Interactive Coping Model
may be one of four types shown in Table 2.2: (a) **Verbal Direct** strategies in which a person directly asks for support; (b) **Verbal Indirect** strategies in which a person indirectly asks for support, such as hinting or complaining (e.g., discussing a problem while not directly asking for help); (c) **Nonverbal Direct** strategies shown through direct changes in nonverbal states, such as crying or facially conveying distress; and (d) **Nonverbal Indirect** strategies which are expressed through indirect changes in mood states or acting withdrawn. As a result of how a dyad perceives the need for coping, Barbee and colleagues have suggested four interactive coping behaviors may result:

(a) **Support**: Emotion-focused approach behaviors designed to produce positive feelings in help seeker and to convey a sense of being cared for and supported (e.g., giving affection, or a hug, telling support seeker about his or her positive qualities); (b) **Solve**: Problem-focused, approach behaviors designed to find an answer to the problem (e.g., offering suggestions); (c) **Escape**: Emotion-focused, avoidance behaviors designed to discourage the display of negative feelings or to distract the support-seeker); and (d) **Dismiss**: Problem-focused, avoidance behaviors designed to minimize the significance of the problem (e.g., saying the problem is not serious) (Derlega, Barbee, & Winstead, 1994, p. 136)

Barbee’s (1990) model emphasizes the important influence communication between individuals has on shaping the coping strategies they enact. Thus, through communication attempts with others, coping behaviors may be elicited, modified, or denied.

Researchers have found that access to social support is an important aspect of the PLWH’s ability to reduce stress and cope with the disease (Hays, Turner, & Coates, 1992; Kessler et al., 1991; Lesserman, Perkins, & Evans, 1992;
Kessler et al. (1991) found that social support is positively associated with a higher quality of life for persons with HIV. Additionally, social support has been positively correlated with PLWH's ability to maintain hope (Rabkin et al., 1990) and reduce anxiety and depression (Hays et al. 1992). In fact, in one study, gay men who did not have someone to talk to about serious problems were significantly more distressed than those who did (Ostrow et al., 1989). Morin, Charles, and Maylon (1984) found that “intimate relationships fulfill basic human desires for love and affection. Relationships can also answer sexual needs and be a haven from the fears, anxieties, and general complications of the AIDS crisis” (p. 1292).

The HIV/AIDS social support literature indicates that persons with HIV/AIDS most frequently turn to their family of choice, particularly partners and close friends, for support (Catania, Turner, Choi, & Coates, 1992; Freidland, Renwick, & McColl, 1996; Greif & Porembski, 1988; Hays et al., 1990; Johnston, Stall, & Smith, 1995; Katz, 1996; Morin & Batchelor, 1984; Powell-Cope, 1995, 1996; Turner, Catania, & Gagnon, 1994; Wrubel & Folkman, 1997). Emotional support has been found to be considered the most valued type of social support by PLWHs, and close intimates, such as spouse, partner/lover, family, and friends are perceived as having the most profound effect on emotional/esteem building support (Greif & Porembski, 1988). However, the family of origin has been found to have the potential to either be extremely helpful or emotionally harmful to persons living with HIV/AIDS depending on family members' ability
to cope with the disease stigma and willingness to provide support (Hays, Magee, & Chauncey, 1994; Kadushin, 1996; Turner, Hays, & Coates, 1993).

**Caregiving as social support.** As a PLWH becomes increasingly symptomatic, the need for caregiving increases. Caregiving is rooted in the need to provide tangible support to persons who are not completely capable of self-care. The amount of functional caregiving required varies based on symptom severity and inability to function normally. However, caregiving also may encompass all or several other social support functions, such as emotional, esteem, informational, and social network support. Most often caregiving of PLWHs is taken on by spouses, partners/lovers, friends, and family (Geis, Fuller, & Rush, 1986; McCann & Wadsworth, 1992).

Because HIV and AIDS has infected diverse populations (gays, IV drug users, and heterosexuals) the definition of family must be broadly conceptualized and inclusive in research on PLWHs (Tiblier et al., 1989). **Family** is defined here as “networks of people who share their lives over long periods of time; who are bound by ties of marriage, blood, or commitment; legal or otherwise; who consider themselves as family; and who share future expectations of a connected relationship” (Galvin & Brommel, 1996). This definition includes the family of origin (mother, father, siblings), the family of choice (spouse, partner/lover, children), and any persons considered by the PLWH to be family (friends, relatives, ex-spouses or partners/lovers).
The importance of psychological and relationship issues surrounding HIV/AIDS are becoming more central as PLWHs are living longer (Powell-Cope, 1995; Tiblier et al., 1989). In the U.S., there has been an increasing trend toward informal caregiving provided through home care for PLWHs (Folkman et al., 1994), greatly reducing the cost of hospital care and other forms of professional medical care provided by AIDS service organizations and government agencies (Turner, Catina, & Gagnon, 1994; Ungvarski, Schmidt, & Neville, 1994). Despite the societal norm for females to assume the role of caregiver, the majority of HIV/AIDS caregivers in the U.S. have been male because the largest number of persons infected with HIV have been gay males (Turner, Catina, & Gagnon, 1994).

Assuming the role of caregiver, however, can be highly stress provoking (Grieco & Kowalski, 1987). When an individual assumes the caregiving role, s/he often take on responsibilities that they are unprepared, ill-equipped, and unaccustomed to perform (Greif & Porembski, 1988; Pearlin, 1989). Frequently, when one partner in a couple becomes ill, relationship roles and responsibilities may be dramatically shifted. This type of "role restructuring" (Pearlin, 1989) and "relationship negotiation" (Brown & Powell-Cope, 1991; Powell-Cope, 1995) often may change the very nature of the relationship itself (Land, 1992; Rolland, 1994; Tiblier et al., 1989). According to Pearlin (1989):

often the restructuring of entrenched relationships is not easy; it can result in a sense of betrayal, status loss, and the violation of expectations. These kinds of strains may develop insidiously and may persist until people
readjust to the new expectations and norms governing the relationship.
(p. 246)

Over an extended period of time, as in the case of chronic illness, the responsibilities of caregiving can result in role overload (Corbin & Strauss, 1988; Pearlin, 1989). In addition to stress from caregiving itself, gay care partners may experience uncertainty about their own future health because they often have been subjected to similar HIV risks as their partners (Pearlin, Semple, & Turner, 1988). In particular, if gay care partners also are HIV positive, they may experience psychological stress over who will take care of them in the future if their partner is too ill or has died.

When significant others and family members take on the role of caregiver, they also must cope with the "double stigma" that accompanies the disease -- AIDS and homosexuality, or AIDS and IV drug use. Powell-Cope and Brown (1992) found that because of their close interpersonal ties to the PLWH, family members very often take on the social stigma of AIDS themselves. Stigma has a strong influence on a PLWH's willingness to openly disclose their HIV status to others (Greene & Serovich, 1996). Also, family caregivers often are hesitant to reveal the AIDS illness to others for fear of rejection, isolation, and harassment by co-workers, acquaintances, friends, and even other family members (Powell-Cope & Brown, 1992). The fear of social isolation can be highly stress provoking and can produce emotional suffering in the already difficult situation of caring for a terminally-ill loved one (Biordi, 1995). The effect of the intense social
stigma for family caregivers may influence a failure to seek out social support, often isolating the caregiver from needed support, and thus, increasing role strain.

And finally, economic strain for caregivers may occur, and loss of desired social relationships and activities outside of caregiving may be limited due to care responsibilities. In addition, caregivers holding outside jobs may feel stress from being torn between the duties of both employment and caring for the loved one (Pearlin, 1989). As a result, the caregiver may find it difficult to concentrate on either task successfully. Thus, AIDS caregivers, in particular, are in need of substantial social support themselves (Brown & Powell-Cope, 1991; Powell-Cope, 1994; Powell-Cope & Brown, 1992; Ferrari, McCown, & Pantano, 1993; Wight, LeBlanc, & Aneshensel, 1995; Wight, Namir, Fawzy, Gottlieb, & Mitsuyasu, 1986).

The relationship of social support, caregiving, and relational maintenance.

The constructs of social support, caregiving, and relationship maintenance appear to be interdependent in nature. In all relationships, strategies and behaviors, such as assurances (e.g., saying "I love you"), may serve both relational maintenance and social supportive functions. In particular, for couples coping with a chronic illness such as HIV/AIDS, social support, caregiving, and relationship maintenance may become reciprocallly integrated. Strategies and behaviors intended to convey social support or provide a caregiving function also may serve as a means of relationship maintenance. In couples facing chronic
conditions, the very nature of the relationship is changed as the illness, social support, and caregiving become integrated and begin to shape the "meaning" of the relationship for partners. As chronic conditions persist relational partners enact behaviors that serve multiple goals and functions.

In addition, within the existing social support research, reciprocity of supportive communication often is ignored. Cutrona, Suhr, and MacFarlane (1990) have asserted that social support is a transactional communication process within relationships, and often is enacted through everyday routine talk (also see Duck et al., 1991). Much of the HIV/AIDS social support literature has focused only on the PLWH's receipt of social support. Hays, Chauncey, and Tobey (1990) found that PLWHs reported relationships as more supportive when they were able to reciprocate support in some way (e.g., caring, concern, affection, information). PLWHs were much less satisfied with relationships in which they were the sole recipient of care or support. Thus, the relationship in which support occurs can either enhance or constrain the effectiveness of the support (Pearlin, 1989). Because many relationships do not withstand the stress of "normal" life events, more needs to be learned about the reciprocal aspects of social support manifested through communicative behaviors, particularly in very close relationships between significant others coping with chronic illness.

The interrelated nature of social support, caregiving, and relationship maintenance for couples dealing with chronic illness can be seen in the similarity of behaviors reported by couples in relationship maintenance and social
support/caregiving studies. For example, the relationship maintenance strategies reported by Canary and Stafford (1992) and Dainton and Stafford (1993) bear striking similarity to the social supportive behaviors found by Cutrona and Suhr (1994), such as (a) affection, (b) relational and self-worth assurances, (c) being positive, (d) open self-disclosure, and (e) spending time together. These studies indicate the same types of behaviors may serve multiple functions in relationships. As a result, future investigation of the strategies and behaviors that are most utilized and effective in various contexts is needed. In the case of couples coping with chronic illness such as HIV/AIDS, the inter-relationship between social support, caregiving, and relationship maintenance requires further study to determine how these constructs function within those relationships.

**Review summary.** Couples dealing with chronic illness face increased stressors in their relationships because of the presence of the disease and its impact on their lives. HIV/AIDS has increasingly taken on long-term chronic illness characteristics, and yet, unique issues are involved because of the large gay male population infected and the stigma attached to both HIV/AIDS and homosexuality. Research has found that relational partners of PLWHs are the primary providers of most forms of social support. However, the existing research on gay and lesbian couple relationships is sparse, and studies of gay male couples since the AIDS epidemic are fewer still. To date, no studies have examined the means by which gay male couples coping with one or both
partners being HIV positive or having AIDS manage to maintain their relationships under the stress and uncertainty of coping with this disease. This gap in the research has spawned the following research questions:

RQ1: What are the maintenance strategies and behaviors couples coping with HIV/AIDS use to sustain their relationship?

RQ2: Do partners' perceive maintenance behavior use to be impacted by the presence and severity of symptoms of the PLWH(s)?

RQ3: Is there evidence of the use of the Canary and Stafford/Dainton and Stafford maintenance behavior typology in these couples?

RQ4: What social or relational issues affect maintenance behavior enactment for these couples?

RQ5: What are the predominant sources of social support for couples coping with HIV/AIDS?

RQ6: Are there relationship differences between discordant and concordant couples?
CHAPTER 3

RESEARCH DESIGN AND METHOD

Due to a lack of existing research on relationship maintenance in couples coping with HIV/AIDS, this study employs a qualitative grounded theory approach (Glaser & Strauss, 1967; Strauss, 1987). According to Glaser and Strauss (1967), grounded theory is the generation of theory through inductive analysis of qualitative data. Rather than imposing theory \textit{a priori} to an area of study, hypotheses and theory emerge from the data (Pequegnat & Stover, 1995), and are "systematically worked out in relation to the data during the course of the research" (Glaser & Strauss, 1967, p. 6). Because grounded theory is directly linked to the data, it is "especially helpful - even necessary - in attempting to study complex areas of behavioral problems where salient variables have not been identified" (Stern, 1980, p. 20). Thus, grounded theory may be particularly useful in exploratory research. In addition, Glaser and Strauss assert that grounded theory may be more long-lasting than logico-deductive theory because "theory based on data can usually not be completely refuted by more data or replaced by another theory. Because it is too intimately linked to data, it is destined to last despite its inevitable modification and reformulation" (1967, p. 4).
Although the generation of a grounded theory is rooted in induction from data, importantly, Glaser and Strauss (1967) explain that a grounded theory approach also may be used to test hypotheses and theory derived through deduction. In fact, Strauss (1987) claims the "misconception" that grounded theory is purely inductive is inaccurate (p. 55). Glaser and Strauss (1967), in their original work, explain that in addition to its use in generating new theory, grounded theory can, and should be, used to test and seek verification of logico-deductive theory. From their perspective, the term "grounded" simply means that hypotheses and theory are tied directly to data, rather than abstractly "deduced from logical assumptions" (Glaser & Strauss, 1967, p. 30). As a result, grounded theory may be used to seek verification of logico-deductive theory based in the qualitative data collection of persons' lived experiences. In this study, induction was used to draw conclusions across individual responses regarding the maintenance of discordant and concordant couples dealing with HIV/AIDS. In addition, deductive analysis was employed to explore further evidence of the maintenance behavior typology proposed by Canary and Stafford (1992) and Dainton and Stafford (1993).

The method of constant comparative analysis (Glaser & Strauss, 1967) is used to continually compare and examine qualitative data for dominant themes and categories. According to Stern (1980), "considerable similarity exists between treatment of data in the continuous comparative method and in the computer method of factor analysis. . .data are coded, compared with other data and assigned to clusters or categories according to obvious fit" (p. 21).
Categories are inductively derived in the sense that they are grounded in the data. However, Berg (1989) highlights that this process is not divorced from deduction. Throughout the process, themes, categories, and sub-categories constantly are compared with other data, as well as the researcher's knowledge of pertinent existing research. In this way, constant comparative analysis combines elements of inductive and deductive methods of theory generation.

One strength of constant comparative analysis is its direct use of original data to develop theory. As a result, issues of standard error, central to the data reduction techniques of quantitative analysis, are not a primary concern in qualitative methods of analysis because the detailed variation of each subject's responses is retained throughout the data analysis until the final step of thematic categorization. Thus, the standard error concerns of quantitative methods are less of an issue in qualitative methods. Thus, issues of error through data reduction across subjects are considerably less in that data are only reduced through the final step of category clustering. In addition, original data responses are retained and presented as evidence for the existence of the conceptual categories subject to the reader's assessment of thematic representiveness.

Procedure

In this study, audiotaped 60 minute in-depth interviews (range 45-75 minutes) were used to probe the communicative strategies and behaviors discordant and concordant gay male couples coping with HIV/AIDS use to maintain their relationships. Because some relationship partners may not want
to disclose their maintenance strategies directly and openly to their partner, participants were interviewed separately, however, both partners were interviewed. While each partner was being interviewed, the other waited in a private room and was asked to complete a short questionnaire providing demographic data. Couples’ interviews were matched for comparative analysis, so that both the individual and the dyad were units of analysis. In addition, concordant and discordant couples’ strategies and behaviors were compared across these two groups. Participants had the choice to be interviewed in a private meeting room at The Ohio State University Medical Center’s AIDS Clinical Trial Unit, the University of Cincinnati’s AIDS Clinical Trials Unit, or at the College of Social and Behavioral Sciences at The Ohio State University. All names and identifying information have been changed to protect anonymity and confidentiality.

Participants

Study participants were 20 couples (N = 40) with no apparent history of AIDS-related dementia in an ongoing intimate romantic relationship in which one or both partners are HIV positive or has AIDS. Participants were recruited primarily through The Ohio State University AIDS Clinical Trials Unit (ACTU), with subsequent recruitment through the University of Cincinnati’s ACTU. Both units are full time, full service operating clinics housed in the Division of Infectious Diseases with dedicated space in the University Medical Centers.
Approximately 500 HIV/AIDS patients per month are seen in each of these outpatient clinics. In the past nine years, more than 1900 persons have enrolled in the Ohio State University ACTU cohort, and the staff of the ACTU has enrolled more than 1000 patients into AIDS Clinical Trial studies of all types (primary infection drug trials, OI, oncology, exercise and nutrition, and psychosocial). The primary recruitment site, the Ohio State ACTU, is located in Franklin County, Ohio where an estimated 3500 HIV-infected persons live (Ohio Department of Health, AIDS Epidemiology Data). OSU ACTU patients generally reflect the HIV exposure categories and gender characteristics of the infected population in Franklin County where the ACTU is located. This population is largely homosexual and IV drug users, with increasing cases of heterosexual men and women.

An agreement to recruit study participants through the ACTUs was received from Judith Neidig, R.N. Ph.D., Ohio State University ACTU research coordinator, and Jill Leonard, A.C.R.N, University of Cincinnati ACTU research coordinator. Couples were recruited in which both partners agreed to participate in the study. Participant recruitment was enhanced through the study’s integration into the activities of the ACTUs. Fliers were placed in ACTU waiting room areas, and clinic nurses personally informed patients of the study. Subjects were informed of a $30 per person reimbursement for participation in a 60 minute in-depth interview. In addition, fliers were placed at community AIDS service organizations, and an advertisement for the study was run for six months in the monthly newsletter/magazine of Stonewall-Columbus, a gay/lesbian/
bisexual/transgender civil rights community organization in the Columbus metropolitan area (See Appendix A for study recruitment materials).

Because both concordant and discordant couples were interviewed, the sample consisted of 25 persons who were HIV positive or had AIDS, and 15 HIV-negative individuals. The average age of the sample was 38 years (range = 23 - 58). Twenty-two of the PLWHs reported their ethnic identity as Caucasian, and three as African-American. All fifteen of the HIV negative participants were Caucasian. Twenty-seven percent (n = 11) of the combined sample had only completed a high school education. The majority of the sample (73%) had completed some college education; with 15 having a two-year college degree, 10 a four-year college degree, and 3 persons holding masters degrees. Ten of the PLWHs were currently employed, and 15 were unemployed receiving some form of state-funded disability or Social Security Income (SSI). Only one of the HIV-negative partners was not employed at the time of the study due to a work-related injury.

Fifteen couples were discordant, and five concordant. All of the couples reported living together in the same residence. In addition, when asked if they considered their relationship to be: (a) dating, (b) seriously dating, or (c) committed, all subjects responded "committed." The average length of relationship was 7 years 4 months (range = 4 mo. - 35 yrs 2 mo.). Comparatively, the most recent available statistics indicate that the national average relationship length of married heterosexual couples was 9.2 years in 1989 and 1990 (NCHS, 1995). Eighty percent (n = 32) of the sample reported their relationship to be
sexually monogamous. Of the 20 couples, however, 6 couples (30%) did not match on whether or not they considered their relationship to be monogamous; in other words, one partner believed the relationship to be defined as monogamous while his partner did not.

Examining the health status of the HIV positive participants, the average time since diagnosis was 6.5 years (range = 7 mo. - 12 yrs). The mean CD4 count, the level of T-helper white blood cells in the bloodstream, was 304 (range = 0 - 750). A healthy person’s CD4 count is in the range of 800-1500, with the average CD4 count being roughly around 1000. Individuals can live with a zero CD4 count, but are highly susceptible to opportunistic infections, such as pneumonia or Kaposi’s Sarcoma. The Centers for Disease Control has defined any person with a CD4 count below 200 as being diagnosed with Acquired Immune Deficiency Syndrome (AIDS) (CDC, 1993).

In this sample, 11 individuals were classified as having AIDS at the time of the study. However, several participants’ CD4 counts recently had rebounded above 200, possibly due to the inclusion of protease inhibitors in their medication treatment. This trend toward “revival” (Brashers et al., 1998) is making it difficult for PLWHs to understand the technical status of their health. As a result, the CDC’s categorization is being called into question. Another indicator of the progression of the disease is an individual’s viral load, which is the amount of virus in the bloodstream. For this sample, the average viral load was 29,987 (range = under 400 - 500,000). The viral load of twelve individuals was below 400 which was below the detectable levels of current HIV blood tests at
the time of this study. All of the 12 were taking a protease inhibitor in
combination with other HIV medications (often referred to as a "drug cocktail").
Three subjects, however, were not taking any HIV medications because they
could not withstand persistent physical side effects (e.g., vomiting, fatigue, fever,
chills). Correspondingly, their viral loads were considerably higher. As
mentioned above, 15 individuals currently were unemployed; however, 10
PLWHs were working while experiencing common HIV medication side effects
on the job (e.g., fatigue, hot flashes, and nausea). Descriptive demographic data
for this study are summarized in Table 3.1.

<table>
<thead>
<tr>
<th></th>
<th>HIV + (N = 25)</th>
<th>HIV - (N = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>38 (Range 27 - 58)</td>
<td>38 (Range 23 - 58)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td>22 Caucasian</td>
<td>15 Caucasian</td>
</tr>
<tr>
<td></td>
<td>3 African-American</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>8 High School</td>
<td>3 High school</td>
</tr>
<tr>
<td></td>
<td>10 2 yr College</td>
<td>5 2 yr College</td>
</tr>
<tr>
<td></td>
<td>6 4 yr College</td>
<td>4 4 yr College</td>
</tr>
<tr>
<td></td>
<td>1 Masters Degree</td>
<td>3 Masters Degree</td>
</tr>
<tr>
<td><strong>Employed</strong></td>
<td>10 Yes</td>
<td>14 yes</td>
</tr>
<tr>
<td><strong>Live Together</strong></td>
<td>25 Yes</td>
<td>15 Yes</td>
</tr>
<tr>
<td><strong>Committed</strong></td>
<td>25 Yes</td>
<td>15 Yes</td>
</tr>
<tr>
<td><strong>Monogamous</strong></td>
<td>19 Yes 6 No (1 Missing)</td>
<td>13 Yes 2 No</td>
</tr>
<tr>
<td><strong>Length of Relationship</strong></td>
<td>Mean = 7 yrs 4 mo. (Range 4 mo. - 35 yrs 2 mo.)</td>
<td></td>
</tr>
<tr>
<td><strong>HIV + Time Since Diagnosis</strong></td>
<td>Mean = 6 yrs 5 mo. (Range 7 mo. - 12 yrs)</td>
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</table>

Table 3.1: Study Demographics (N = 40)
Interview Schedule

A semi-structured interview question schedule (see Appendix B) generated from recent literature on couples dealing with chronic illness, including HIV/AIDS, (for example, Dakof & Taylor, 1990; Powell-Cope, 1995; Rolland, 1994) and preliminary data from pilot studies, was approved by the author’s institutional Human Subjects Internal Review Board (IRB). At the time of the interview, participants were informed (a) of the purpose of the study, (b) of the procedures involved, (c) that the study was anonymous and confidential, (d) that their participation in the study was voluntary, (e) that they may choose to withdraw from the study at any time, and (f) that they may request results from the researcher. A total of 40 hours of audiotaped interviews were completed resulting in 459 pages of transcription.

Analysis

Transcripts were analyzed and coded using constant comparative analysis. Burnard (1991) has proposed a 14-stage process for conducting constant comparative analysis. Burnard’s process has been adapted to the context of HIV/AIDS in this study and is presented in Table 3.2. In the qualitative analysis of interview data, this process is used to “produce a systematic detailed report of themes and issues contained in the interviews” (Katz, 1996, p. 23). Throughout the data collection process outlined in Table 3.2 undertaken in this study, theoretic notes were compiled, sorted, and conceptual
Stage 1: Notes taken down after the interview describing initial constructs.
Stage 2: Interviews transcribed; read with audio-tape; general themes noted
Stage 3: Transcripts re-read; specific themes and issues throughout noted
Stage 4: Themes grouped under larger categories
Stage 5: Major categories reviewed for repetition; duplicates combined
Stage 6: Review of categories by fellow HIV/AIDS researcher
Stage 7: Review of transcripts and categories by alternate HIV/AIDS researcher
Stage 8: Transcripts are coded according to categories
Stage 9: Like-coded data are grouped
Stage 10: Coded groupings are labeled with category headings
Stage 11: Participants asked to check the face validity of categories
Stage 12: Category data examined
Stage 13: Written analysis initiated
Stage 14: Data analysis is written up and tied to relevant literature and findings explained

Table 3.2: Constant Comparative Analysis in HIV/AIDS Research
insights and linkages compared (Burnard, 1991). Audiotapes were transcribed by an independent transcriber using data transcription equipment in the School of Journalism and Communication at The Ohio State University. Transcripts were examined for themes and categories of relationship maintenance until repetition, or saturation (Strauss, 1987), occurred. Dominant themes and categories were grouped into higher-order categories based on conceptual linkages.

Content face validity of the categories, then, was sought to confirm that the categories reflect the interview data. In qualitative analysis, participants' responses are retained and presented as evidence for categories. Concern for data reduction error which occurs in quantitative research is less of an issue in qualitative methods because the original data is retained (Fielding & Fielding, 1986). Validity of the conceptual categories largely is determined by the reader through confirmation of the data as representative evidence of the themes. In addition, Guba and Lincoln (1989; Lincoln & Guba, 1985) suggest several means of seeking content validity of dominant themes and categories in constant comparative analysis: audibility, fittingness, credibility, and confirmability. Audibility is established by a researcher reviewing the transcripts and audiotapes for clarity. Audio-tapes were transcribed by an independent transcriber, and audibility was established by the author. Fittingness is achieved through a separate researcher in the content area reviewing the themes for accuracy. An HIV/AIDS research colleague reviewed the themes and concurred with their fittingness. Credibility is achieved through participants' review of dominant
themes and categories to verify applicability. Toward the end of the study, after completion of each interview fifteen percent of the sample (n = 6) was asked to review the emergent themes and categories. These participants confirmed the applicability of the categories to their life experience. Finally, confirmability can be claimed if credibility, fittingness, and audibility are achieved (Katz, 1996). A written analysis tying themes to relevant literature and a discussion of the study findings was undertaken. Findings are discussed in Chapter 4.
CHAPTER 4

FINDINGS/DISCUSSION

HIV and Relationship Initiation: An Important Precursory Factor to Relationship Maintenance

To understand the means by which gay male couples coping with HIV or AIDS maintain their relationships over time, it is important to first to understand the motivations for initiating the relationship. No research questions were formulated to address this issue because factors influencing relationship initiation were not anticipated to be an important relational dimension. However, through analysis of participant interviews, factors influencing individual’s motivation to enter into their relationship emerged as an important precursory factor influencing the desire to maintain the relationship over time.

For the 20 couples involved in this study, a common theme was that HIV or AIDS was not a central factor in the decision to enter into the relationship. For the HIV-concordant couples, several participants asserted that they did not specifically seek out an HIV-positive partner. However, these couples did feel
the relationship was less stressful due to not having the fear or guilt of infecting one’s partner. In addition, the concordant couples reported a level of comfort and emotional reassurance in having a relationship with someone who shares a firsthand understanding of their experience. One concordant couple reported they did seek out concordant relationships for these very reasons. This particular couple met via the Internet in a “chat room” designated for HIV-positive individuals.

For the HIV-discordant couples in this study, they also asserted that HIV/AIDS was not a central decision factor for not entering the relationship. This finding provides initial insight into why an HIV-negative individual might choose to enter an HIV-discordant relationship taking on the stress of dealing with a partner’s terminal illness, as well as, increasing their own risk of infection. The HIV-negative partners in this study indicated that, despite knowing they would be taking on some level of risk, stress, and uncertainty in their lives, the choice to enter the relationship was not influenced by the other person’s HIV-positive status. HIV-negative and HIV-positive partners commonly reported the reasons for entering into the relationship were attraction to personality characteristics, similarity in values and interests, and companionship. These relational dimensions are consistent with the primary reasons for romantic attraction found in the literature on romantic relationship initiation in general (see Botwin, Buss, & Shackelford, 1997; Griffitt, 1974; Knapp, 1984).

For the HIV-discordant couples, a common finding was that the HIV-positive status of the one partner was revealed very early in the process of
initiating the relationship. One HIV-positive individual, Jake, explains his HIV disclosure to his HIV-negative partner this way:

On the second date, it’s something he needed to know before he got too involved. That’s just fair. I think you have to. A lot of people don’t. But to be honest with yourself you have to. It went pretty smooth. I don’t know if it was the way I explained it to him. I have a medical background because I was a nurse for 16 years. I explained it that way, and any questions he might have, I was pretty much able to answer them. And he knew a lot already. So that helped. He just didn’t have a fear of it. So, I just sat him down and said, "There’s something we’ve got to talk about before we go on." And just spelled it out like it was. And I came about it in this way, I said, "I don’t know if you ever think of this, you know. I’m going to tell you, ‘I’m positive,’ and I’m going to ask you if you are or not, and I want you to be honest with me." And we, I don’t know, we just hit it off right from the beginning. I knew there was something there like in my first relationship. It lasted 13 years until he died.

Bill, Jake’s partner, explains that he thought of Jake’s HIV disclosure as intimacy building at the outset of their relationship. Bill notes that he felt an early sense of trust between them because Jake was willing to disclose a potentially stigmatizing “secret:”

I knew [Jake’s HIV status] when I met him. Well, within 48 hours. He had the scope of everything; the problem. I didn’t walk right in the door where we met and knew he was. But yeah, you have to lay something like that on the table, you can’t hide something like that. I’m sure many people do. That’s why it’s spreading so much, you know. But if you’re open to somebody, and if you can tell that big a secret to somebody that you just met, I mean what in hell can you go and hide from somebody.

Another HIV-positive participant, Adam, was surprised by his HIV-negative partner’s pursuit of the relationship. Ultimately, Adam believes similarities in personality and a mutual desire for companionship were the basis for both wanting to pursue a relationship together. Adam explains:
The first date, or something like that, I did not tell him. But after a couple dates, I told him. And you know that didn’t really surprise him because he’d been in the same situation before, and he’s a very compassionate person. And so, it kind of drove him to try to continue a relationship with me because he thought that I was pulling away from it because I figured he wouldn’t want a relationship with me being HIV positive. But sex isn’t everything in a relationship. What kept us together is we liked to do the same things. We have similar personalities. It seems like we have different pasts, and there is a big age difference, at least I think there is, but we just respect each other, and we like to do the same things.

For other HIV-discordant couples, the process of disclosure was more difficult. Andrew was diagnosed with HIV during the first two weeks of dating Matt. Andrew describes how this was especially devastating because he not only had to face his own mortality, but also the possible termination of his new relationship. Andrew recalls the difficult process of coming to accept an HIV-positive diagnosis and telling Matt:

HIV was pretty much a part of our relationship from the beginning. We were just beginning the dating process when I tested positive. And at that time, we were dating, but not exclusively. I certainly was dating other people, he was too. I’m not sure, but it was clear that there wasn’t that commitment. Since it was just shortly after we started dating that I actually went through the testing, when I did test positive I thought that was going to be it. You know, he wouldn’t want to be involved with me. I was only 20 years old and I had no idea how he would take it. I told him right away. The day I found out, I called him. And we were supposed to go on a date that night to this buddy’s party. I told him I really didn’t want to go to the party, but asked if he was interested in coming over, and he did. He was very sad to hear. He said, “I’m sorry to hear that.” He doesn’t really know about it [HIV]. And we hadn’t even been intimate, truly we were just getting to know each other. So he came over that evening to my apartment. He just let me do the talking. And I just worked through all of the, all the questions that, you know, the litany of “This can’t be true. It had to be a false test.” You know, “It had to be a mistake. What am I going to do? How am I going to tell people?” He just sat there. He was very patient, and listened to that. He was very supportive. He let me cry, and he comforted me. I don’t know much of what he said other than I asked him if he knew
other people who were HIV positive besides me, he said, "yes." And I think it was at that time also that he told me he had dated an HIV-positive person. So in a way, that kind of reassured me that maybe he was still interested. The fact that he was there showed me that he was interested and he cared. He was pretty sad though.

Some found it more difficult to disclose because of a fear of rejection. Jerry had already moved in with his lover, Tom, without disclosing his HIV-positive status. Jerry explains:

Well, the HIV I don’t think is a problem now. Because I had it going into the relationship. We’ve been together eight and a half years. It was a problem about three or four months after we met. I knew we were going somewhere, I mean, especially since I moved in and stuff. So, I don’t remember too much about that except that it was a pretty emotional thing when I did tell him. I was going to try to commit suicide that night.

Despite the initial shock, Tom explained that his emotional involvement with Jerry was too strong to consider terminating the relationship. Daryl, another HIV-positive participant, was diagnosed further into his relationship. Daryl explains that his HIV-negative partner, Gary, seemed better able to deal with his diagnosis because Gary’s first partner of 12 years had died of AIDS. However, Daryl describes feeling guilt at putting Gary through the same trauma, and that the prospect of early death is emotionally difficult for both of them:

In the relationship it hasn’t been too bad because of the fact that Gary had a lover that had died before we had met. He passed away about five or six months before we even met. So when we got together, I wasn’t HIV positive then. I came to be HIV positive later in the relationship. But it had to have been before we was together. So I must’ve had it, and it just didn’t show up because I get tested through the VA all the time. But that, that didn’t bother him too much when he found out. It hurt his feelings, I mean, I know it hurt. It hurt both of us, you know. It hurt me worse I think because I always thought I was careful. I always thought I did the right thing. And I was careful. Tried to be real careful. And then you
know I get into a relationship and I thought I wasn’t, and then all of a sudden I come up positive. And I know how hard it was on him to lose his last lover and then to have him go through this again you know weighs a lot on me and him both, I know. But as far as the relationship, it’s been great, you know. I’m just dealing with it the best way I can and I know he’s trying his best.

For Martin, his diagnosis was devastating to his relationship. After 35 years together, the sexual relationship between he and his partner Fred had waned, but they were still affectionate with one another. However, upon learning of Martin’s HIV-positive status, Fred did not terminate the relationship, but detached emotionally largely due to a fear of contracting the virus. Martin explains that, with education about the means of HIV transmission, some affection has returned but their relationship has never been the same since his HIV-positive diagnosis. Martin explains:

We’ve been together for 35 years. He accepted the fact that I, you know, got AIDS or HIV. But he was insulting a lot of times and said, well, I got it for myself because I was very sexually active. We never had brought anybody home. We never discussed sex. Anything like that, we never discussed it. It was like it doesn’t exist. But I felt that I should tell him because I did live with him. And at that time nobody knew how you caught it, just living with someone or anything. And he said, “Well, we’ll just go on like we always have.” But his affection for me died. Not the sex part, the sex part was already over with, but the intimate hugging and sleeping together. We had just fooled around, but never really did anything, essentially. That just slowly died. But now, we never leave unless we kiss good-bye. After he learned you can’t catch it from kissing, he kisses me good night, kisses me good morning. Kisses me when he leaves to go out for the mail. That’s the extent of his affection, and I’m not allowed past that. I accept that.

Couples reported that the decision to enter into a relationship dealing with HIV involved attraction to similarities in values, interests, and personality
characteristics. In addition, for some the desire for an intimate companion was more important than the HIV status of that partner. HIV status was reported not to be central in the decision to enter an HIV-discordant or concordant relationship. However, two HIV-positive individuals did report seeking out a concordant relationship. For those couples already in a relationship prior to an HIV-positive diagnosis, the emotional commitment and companionship established in the relationship was a strong enough impetus for wanting to maintain the relationship, although it did create strain in some relationships. The actual strategies these couples use to maintain their relationships while dealing with the stress of the HIV disease will be examined in the following sections.

**Normalization of Illness: A Central Maintenance Strategy**

In addressing research question one, “What are the maintenance strategies and behaviors couples coping with HIV/AIDS use to maintain their relationship?,” analysis of the data in this study indicates that the primary strategy these couples utilize in maintaining their relationship is normalization of the illness. Strauss et al. (1984) recognized the need for persons living with chronic illness “not just to stay alive or keep their symptoms under control, but to live as normally as possible despite the symptoms and the disease” (p. 79). These researchers suggested that chronically-ill individuals engage in an ongoing process of seeking equilibrium between the abnormality of illness and the normalization of life. Strauss et al. (1984) proposed two primary normalizing tactics used by individuals living with chronic illness: concealing and “passing.”
Concealing involves attempts to hide illness symptoms or reduce their importance. "Passing" is an attempt to maintain poise during interactions in order to appear "normal." Miller and Zook (1997) also observed the occurrence of a "normalization rule" in couples coping with HIV/AIDS. They found that for HIV-positive individuals and their care partners "the existence of HIV infection was downplayed and life continued as before" (p. 65). However, it has yet to be fully determined how couples actually establish and maintain normalization in their lives.

Normalization through Acceptance

Underlying the drive for normalization in their lives, participants in this study described a process of coping through acceptance of HIV in their relationship. Many individuals suggested that through acceptance, HIV has taken on less and less centrality for both partners in their relationship. Within HIV-discordant relationships, in particular, there appeared to be even more importance placed on normalizing the health status of the HIV-positive partner because "illness" is not a direct experience in the HIV-negative partner's life. Thus, HIV-negative partners cannot directly identify with the illness experiences of their partners. Joe, an HIV-negative partner, suggests that the focus on HIV in his relationship is tied largely to the presence of symptoms. Currently, Alex, Joe's partner, has been asymptomatic for several months. As a result, Joe asserts that the disease has taken on less centrality in their lives:
The illness now is not central anymore. I mean, I think we’re both conscious of it, I’m conscious of it, but it’s, you know, on the back burner now. Which is a little scary sometimes. It’s easy to do that because he seems so well. He’s better which is wonderful. So it’s easy for me to go on like this, so that it’s not central.

Dave, another HIV-negative partner, comments, "You get, I mean you get accustomed to things. And you learn acceptance. And you learn some new levels of trust in yourself and your partner." Frank, who is in an HIV-concordant relationship and has full-blown AIDS with several opportunistic infections, explains in his relationship, "We just try to live our lives as normal. I really try not to think about AIDS." And yet Frank realizes his HIV cannot be ignored and is an integral part of his life and relationship. Frank relates, "All of the people I come into contact with are either infected or affected by HIV."

Several individuals explained that over time acceptance of HIV becomes routine, and thus, takes on a sense of normality. Couples begin to think of HIV as just another relational challenge. Bill, an HIV-negative partner, believes that all couples have problems, and HIV is only one form of relational challenge. Bill also explains that one way he and his partner, Jake, are able to deal with the stress of HIV is to move back and forth between normality and illness, largely depending on the presence of symptoms. Bill asserts:

I just think of it as normal. It’s been long enough, I’ve just gotten in the mind set that with a couple, there’s problems in every relationship. And if it’s not health, then it’s kids or ex-wives or ex-husbands, in laws. HIV is just another problem just like any other problem...maybe two weeks, three weeks go by and you know we’ll be watching TV and see a commercial on HIV or something, and sometimes I think “Oh yeah, he does have HIV.” It’s gotten just to a point where it’s not something we think about until something happens. Then we just get hit, "Oh, yeah, this is what this was all about. I
knew it was too good to be true.” And then something happens and he’s in
the hospital. It’s like, “Shit, time to get back in that mode with the roles and
power of attorney and all that.”

Bill goes on to make an interesting an analogy that compares the readiness to
deal with problems surrounding HIV to the readiness of rushing a pregnant wife
to the hospital. Bill explains:

It’s just, it’s gotten so routine that it’s just part of daily life, if that makes
sense. It just comes so natural now that unless you sit back and think, this
is what’s happening, it’s just like everybody else. They have problems,
too. I might be going bald in the back, I know it’s there, but I don’t think
about it unless I look in the mirror, and “Oh shit, it’s back there.” HIV is
always there, but unless it confronts you, then I don’t think about it. I try
not to. But it’s always there, just in case it gets thrown in my face. I go
into instant mode. It’s like having a pregnant wife. The suitcase is packed.
It’s in the corner. You can walk by it every day and you don’t notice it.
But as soon as her water breaks, you know exactly where that suitcase is,
you pick it up and you’re going to run to the hospital and off you go. It’s
the same thing with him. I don’t think, it’s there. I think it gets to a point
where I don’t even think about it that often. I mean sure, it comes up
every day, it’s hard not to. You know, it’s like if I was married to
somebody that was African-American, we’d have a normal life together.
But of course, every time I look at that person, sure they’re black, but it’s
not something I have to worry about every day. You know it’s there, but
you get used to it.

As part of acceptance, a commonly reported theme was being able to
normalize HIV to the point that a partner’s HIV-positive status is not a central
factor in the relationship. Taylor and Brown (1988; 1994) have theorized that
individuals need to engage in what they call “positive illusions.” Taylor and
Brown make a distinction between positive illusion and denial, or delusion,
claiming these are not the same forms of psychological coping. They assert that
creating positive illusions are a necessary aspect of maintaining mental health.
Based on clinical literature, Taylor and Brown (1988) suggest the criteria of good mental health include:

contentment, positive attitudes toward the self, the ability to care for and about others, openness to new ideas and people, creativity, the ability to perform creative and productive work, and the ability to grow, develop, and self-actualize, especially in response to stressful events. (p. 21)

These researchers propose that all individuals produce positive illusions to accomplish good mental health in three important domains:

(a) they view themselves in unrealistically positive terms; (b) they believe they have greater control over environmental events than is actually the case; and (c) they hold views of the future that are more rosy than base-rate data can justify. (1988, p. 21)

Taylor and Brown argue that positive illusions are a natural and important tool that help prevent individuals from being overcome by stress and distress. Specifically related to health, patients facing acute or chronic illness have been found to exhibit positive illusions in evaluating their conditions as better than others with the same disease (Helgeson & Taylor, 1993). In addition, chronically-ill individuals report feeling more control over their lives by switching their control-related beliefs from a survival and cure focus to controlling symptoms and life tasks (Buunk, Collins, Taylor, van Yperen, & Dakof, 1990). Helgeson and Taylor (1993) argue that switching the focus from illness cure to life tasks is not the dysfunctional coping strategy of denial, but rather is the necessary creation of positive illusion allowing individuals to function under the stress of terminal illness.
Participants in this study describe a process of coping with HIV that seems to incorporate positive illusion through a focus on life tasks rather than dwelling on the disease. The use of positive illusion appears to be central to the process of normalization. Most individuals asserted that while they are not in denial of the fact that one or both partners are infected with HIV, they intentionally choose not to focus on this fact on a daily basis. One HIV-negative participant, Peter, described creating the positive illusion not to think of his partner, Mark, as a "sick person," and yet he realizes that the HIV is always present:

I just don't really think of him that way [as sick]. I just think of him as my lover. And when it comes to a point where we do something that has something to do with it, yeah then it becomes a factor. And there are certain things we have to do. But other than that, it's like, it's not like, "Oh Mark, he has AIDS." It's like, I don't think about it, I guess. I don't see him as a sickly person. He doesn't look like a sickly person. He doesn't act like a sick person. And yeah, he's got a terminal disease, but I guess it's kind of hidden. I actually don't see him take his pills a lot. I mean, they're always sitting right there in the kitchen, and he's always got this little caddie with the pills that he has to carry. But I just don't think about it. I know that he does take them, and I know that they're helping him live. And that's all that matters to me.

Ken, who is HIV negative, explains how he and Adam try to maintain a positive attitude in their relationship:

My thought on it is really you just never know. It's just like anything else, I mean, I could walk out like they say and get hit by a bus tomorrow or whatever. And I really do feel that way. There's just so many things that can happen to you in life. I mean, you never know. And that's why, that's how I think you'd have to look at this. You don't, you can't really sit there and worry about it. I guess that I do worry a little, you know, it's on your mind. But for the most part, that's how I deal with it. I just think there's no guarantees either way.
Ronald, also HIV negative, indicates that he and Richard do not address HIV in their lives unless there is a problem related to it:

We don’t really, we don’t talk about it unless there’s a problem. It’s not, it’s, I don’t know how to put it. It’s there, you know, it’s staring you right in the face. But there’s a chalkboard over there on the wall and how often in this room as we’re sitting here, how often could I say I notice it. That’s all that needs to be said. Unless he starts shaking or something, and then, when it draws attention to itself, then we’ll discuss it. But otherwise, we just live pretty normal lives. When crisis happens, it happens. And when everything’s going smooth, it’s best not to rock the boat, and we take advantage of that time.

Despite the general feeling that normalizing the illness was a positive relational maintenance behavior, a few participants observed that normalizing can be taken too far. Alan’s HIV-negative partner, Dave, has normalized Alan’s HIV health status so much that he wanted Alan to join Weight Watchers with him, despite being aware that physical “wasting” is a common health problem for PLWHs. Alan describes:

He’s trying to lose weight, done a good job. I need gain weight because I’ve lost weight, and I need fat in my diet, he doesn’t. That’s been a friction area in our lives. He cooks all this low fat stuff. And I sit there, and I don’t want it. I don’t have any appetite to begin with. Food has a metallic taste, a taste aversion, and “you cook all this crap that you love and that you want to cook to make you thin, and I have AIDS.” And he went one time and said he wanted me to join Weight Watchers with him. And I said, “Oh, that’d be great. I’m going to be going to Weight Watchers and say, Hi, I have AIDS and I’m going to go to Weight Watchers.” Yes, I have my gut. But, I’m happy with that. Every once in awhile we get a cooking fiasco going though.

In sum, participants in this study report that one aspect of normalization of the illness in their relationships is accomplished through the coping strategies
of acceptance and the creation of positive illusions. These two forms of coping seem to directly impact the behaviors these couples enact in maintaining the relationship. Maintenance behaviors will be addressed next.

Normalization through Managing HIV communication: The Dialectic of Openness-Closedness

Within the context of couples coping with HIV/AIDS, one of the primary means of accomplishing normalization occurs through behavioral attempts to manage the dialectic between openness and closedness regarding HIV/AIDS communication. Baxter (1988; 1993b; 1994) describes the existence of dialectical tensions between polar opposites (e.g., openness-closedness, autonomy-connection, novelty-predictability) that exist in all relationships. One of the primary tensions she has observed is the need for relational partners to manage their level of self-disclosing openness versus closedness. Baxter has found that individuals must make decisions regarding complete openness and closedness as a means of maintaining equilibrium to minimize conflict and emotional stress in the relationship. Couples coping with HIV or AIDS in this study reported seeking a state of normalcy in their relationships by managing the amount of HIV/AIDS communication that occurs within their relationship.

The findings of this study indicate that managing the amount of HIV/AIDS communication in the relationship is a primary means for establishing and maintaining normalization. A common pattern of HIV communication aimed at normalizing illness among participants indicates that
individuals go through a period of heavy disclosure with select others in the period following initial diagnosis, and over time, decrease the amount of HIV communication in which they engage. Participants described the period after diagnosis as one of intense HIV-centered communication as they dealt with issues surrounding disease and their own mortality.

Coping during this post-diagnosis period often involves interactive coping strategies (Barbee, 1990) achieved through communication with intimate others. Research has found that relational partners and close friends are the primary source of emotional support and interactive coping for PLWHs (Catania et al., 1992; Freidland et al., 1996; Greif & Porembski, 1988; Hays et al., 1990; Johnston et al., 1995; Powell-Cope, 1995, 1996; Turner et al., 1994; Wrubel & Folkman, 1997). These sources of emotional support are particularly important in the period following diagnosis. In time, HIV-centered communication decreases as individuals begin to accept their diagnosis. Participants explained that a continued communication-focus on the disease is too emotionally distressing in that it keeps the issue of mortality constantly salient. Therefore, individuals described a process of normalizing their illness that involves managing communication regarding their HIV-positive status.

Alex, who is HIV positive, described an extended period of HIV communication in his relationship immediately following his diagnosis. He states, "Joe was with me when I was diagnosed and when we walked out, he said, 'We are in this together.' After that, we talked about it all the time." Mark, another HIV-positive participant, said he informed his partner Kevin of his HIV
status on their first date, and they discussed it in some detail at that time. Mark
explained that while the topic of HIV has come up after this initial conversation,
there has never been an occasion since when they sat down solely for the
purpose of discussing HIV:

We met kind of as a blind date. He didn’t know ahead of time then. We’d
gone out to dinner. We just spent the whole evening kind of talking.
Probably about three or four hours into the evening, when after we were
just sitting there talking and kind of going over each other like you know
“what’s your position in life?” type thing; “how do you feel about this?”
Or “what do you think of that?” I just went ahead and told him. I said
OK well everything’s so far so good. So it’s something to kind of throw at
you. And I didn’t really ask him at that point as far as how do you feel or
anything like that. Just from my own personal experience, I’ve seen every
reaction from one end of the spectrum to the other. So nothing surprises
me any more. Some things still do kind of hurt from time to time. But I
guess I was expecting anything as a response. And when I told him it was
kind of, it wasn’t so much like a shock or anything like that. It was more
just a, I caught him off guard. You know, he wasn’t expecting that. He
didn’t take it bad or anything. We just talked about it for a little while,
maybe about a half hour or so. And continued on with the rest of the
evening. Everything was fine.

Interviewer: Did it come up again later?
Not really so much like consciously coming up. There wasn’t ever a time,
“OK, well I need to ask you this” or “can you tell me that.” It wasn’t
anything like that. It was just more of like it came up in conversation a
couple of times probably like within the first couple weeks after we’d
known each other. But it wasn’t anything like a question and answer type
thing. I mean, he knows about it from other people or just general
knowledge of it and stuff. So it wasn’t anything that he had all these
questions about or anything like that. Actually, it went real smooth. But
as of now, it doesn’t really come up.

The maintenance strategy for these couples of managing the amount of open HIV
communication, and at the same time, with avoiding too much HIV
communication will be addressed in more detail in the next sections.
Engagement in HIV communication. Research question 2 inquired “Does the frequency of strategy and behavior use vary for couples based on the presence and severity of symptoms of the PLWH(s)?” The answer to RQ2 is that symptoms "implicitly" influence the enactment of many of the maintenance behaviors. For example, the dialectic of HIV communication engagement vs. avoidance often depended on the presence of symptoms (and sometimes the absence of symptoms), as did other maintenance behaviors. Thus, RQ2 on "presence of symptoms" was addressed as participants described using these dialectics and other maintenance behaviors to sustain their relationships. RQ2 was answered, but indirectly, and the answer was not a simply “yes/no,” but rather was more of "yes and no." RQ2 was addressed by participants as part of addressing RQ1. Therefore, the impact of RQ2 is largely it’s influence on RQ1. The issue of the presence or absence of symptoms was linked to the maintenance behaviors used by these couples.

When one or both partners are HIV positive, issues surrounding health routinely arise, often on a daily basis. In couples’ drive for normalization, they frequently utilize a combination of balance and cyclic alternation in managing the dialectic of openness and closedness of HIV communication. Baxter (1988) describes balance and cyclic alternation as the two primary strategies couples use in managing relational dialectics. Balance involves seeking a comfortable medium between the two extreme relational opposites within communicative interactions. Cyclic alternation, on the other hand, involves alternating back and forth from one extreme to the other at different points in time. Cyclic alternation
establishes equilibrium over time in relationships across interactions. Couples in this study reported utilizing both cyclic alternation and balance related to managing communication about HIV/AIDS. Cyclic alternation appears to be used more often because it allows couples to focus completely on HIV when symptoms arise, or attempt to downplay its influence when no symptoms are present. However, couples appear to lie on a continuum regarding the actual amount of engagement or avoidance of HIV communication overall.

Several respondents explain that HIV communication is frequent in their relationship. For instance, Alex, who is HIV positive, states, "We talk about my health almost every day. Probably every day. We don't ignore it." Jerry, another HIV-positive partner, described similar HIV communication patterns, he comments, "Daily we talk of HIV. Doesn't bring stress to either one of us. I keep asking. He says, "No, it doesn't bother me."

Tom, an HIV-negative partner, makes the interesting point in that it is not only the presence of symptoms that can engage he and his partner, Jerry, to talk about HIV, but also a lack of symptoms. Tom explains:

Lately it's been daily [talk of health] because he's been feeling so good, and he's so excited that he's feeling good and he can do stuff. When he wasn't feeling good, I guess we still talked about it every day because if he wouldn't be feeling good, he wouldn't be eating right. I'd nag at him, "you've got to eat better, you've got to eat more." He'd say, "I don't have an appetite. I can't eat." When things are just running smooth. I ask him every day how he's feeling. Probably at least twice. I think our relationship probably revolves around it. I think now because he's symptomatic. I'm more aware of it now, yeah. Because it's actually happened. Before, it was just something that, I mean he was HIV positive for so long and nothing's happened, so don't worry about it, forget it. Interviewer: OK, so you didn't talk about it as much then when he was asymptomatic.
Huh uh. Because he was just always feeling fine, he could do normal things.

Brian comments that, through his partner Steve’s attempts to keep him informed of his health status, his level of uncertainty surrounding the illness is reduced. Brian states:

He’s very free about offering up information. And that’s been from day one in the studies. He’ll say, “my viral load is this.” It’s undetectable, you know. I can remember the first T-cell count, you know, he had 20...And he’s got over 200 now. And I listen to this. So you keep getting those positive reinforcements you know over five years, and it does push that other stuff back. Viral loads, doctors’ comments. You know, he’ll say, “the doctor told me I was a boring patient. The doctor calls me a boring patient, so I’m like run, get out of there before they find something.” See, he’s been real good about that [informing me] and I think that keeps a lot of my fears at bay.

Concordant couples seem to have more communication about HIV and their health because both are dealing with health issues on a daily basis. There appears to be more openness about health concerns in relationships where both are sharing similar health experiences. Ted feels this a strength of a concordant relationship:

Probably we talk about at least some aspect every day, you know like, “Oh I can’t stand it, I just had a shitty day today,” or something like that. Or “I’ve got a headache, my allergies are bothering me.” And if there’s like something interesting, an article, like I have my AOL set up to receive anything that has like AIDS or something in the article. And if I get something interesting, I’ll either print it out, or I’ll send it to him [via e-mail]. Or if he sees something on TV or something, he’ll go like, “Oh, guess what I heard today.” The doctor tells him something before I go. Usually, he goes I think every month to the doctor, and I go like every three months right now. So usually he hears things before I do. And he was more involved with [an AIDS service organization]. I’ve started getting more involved with it since I met him. But he was just like really involved with it before.
Dennis explains that the HIV communication in his concordant relationship with Todd largely revolves around their doctor appointments. They engage in focused HIV communication about their health following appointments. Dennis notes:

When we come home from the doctor, we talk about it a lot that day. But then, the next day it's basically over. After I tell him what happened at the doctor, or he asks, it's basically over for me. And Todd will, you know, the next day he'll probably bring it up, like as if I had forgotten that he told me yesterday that you know his CD4 was X. His viral load, or if he's got something wrong with him, he'll tell me that.

Todd, his partner, agrees that because they are both HIV positive he feels they are more supportive than an HIV-negative partner would be:

Medical issues are real easy for us to talk about. We're real supportive, and we're not really naggish with it. It's a very comfortable part of our relationship. And we've mentioned before that we think it would be difficult to be in a relationship with someone who's not HIV positive. We don't talk about it much, though. We've had that conversation. Interviewer: Just because they wouldn't be able to relate to what you are going through? Or didn't want to relate or try to over-relate. We've both dealt with it. We can deal with it. But you know when to shut it off, and when not, and when to talk about it. HIV is not the centerpiece of our relationship. But it might be just in chit-chat at night. You know, if we're sitting around watching TV. I might say, 'I was an hour late taking my meds today, and I had to take it with CheezIts. Just, it's just chit-chat.

Avoidance of HIV communication. How couples manage HIV openness with the other end of the dialectic, HIV communication avoidance, is equally important. The participants in this study reported that there are times when they intentionally avoid communication about HIV/AIDS. Helgeson and Taylor
(1993) argue that individuals need to be able release themselves from the stress and worry of chronic illness. For example, William, who is HIV positive, describes attempts to inform his HIV-negative partner, Peter, but Peter does not always want to be informed because it is a reminder of William’s HIV-positive status. For discordant couples, there is a great tension to manage the dialectic of HIV openness and closedness because any HIV communication is a reminder of “abnormality” in their struggle to establish normality. William explained:

I try to talk to him, I would like to say I try to talk to him as much as possible. But I know that he doesn’t, lot of times he doesn’t want to hear it or he doesn’t quite understand what it all means. I know that he sees some of, he sees the struggles that I go through because he’s made those comments to me, “I see what you go through, and it just breaks my heart.” But as far as sitting down and being very specific, on a day to day basis, we don’t do that. When I was sick in the hospital or if I come home with, you know, some bad news. Recently it looked like I was going to go undetectable with my viral load and that changed and it started climbing again. And you know I told him and I could tell that, it’s almost like, he wants to say, “Well, what does that mean.” And you know, I explain it to him the best I can, but I don’t really think he, I’m not quite sure if he understands it all or wants to understand it all. And I don’t think that it’s that important. I mean, it’s important that he understands whatever he wants to understand, but if he doesn’t want to, for me, right now, that’s not vitally important. But I don’t think he’s, I mean, he’s certainly not up to date on all the ins and outs of it all. I don’t think any of us are.

Larry, an HIV-negative partner, asserts, "quite honestly, I'd say we try to not talk about it [HIV] more than we try to talk about it." Adam, who is HIV positive, thinks of avoiding HIV communication as a positive strategy for maintaining his relationship. He states, "a lot of times I just take a positive approach and if there's nothing new, you know, I don't even say anything. And so, luckily there
hasn't been a lot new lately." Ronald, an HIV-positive partner, echoes similar
sentiments:

Well, I just feel when things aren't going bad, then why bring up the
subject. I've been doing OK, my viral counts are down, well, my HIV is
contained, and so there's not a lot of reason to discuss it. Of course, I had
new blood taken today, maybe the counts will be different.

Several participants indicated that they tend to talk around the issue of
HIV rather than directly addressing it. Phil, an HIV-negative partner, describes
this pattern in his relationship:

We put it [HIV communication] off mostly. That is, not ignore it, but just
put it off until tomorrow or the day after that. . .Our conversations tend to
be a little bit round about. We have a great deal in common, so if it's
something like a television show, or the news, or a conversation like that,
we're pretty direct with each other. But then a lot of things we kind of
skirt and maybe bring it up the next day.

Matt, another HIV-negative partner, makes an important relational observation
stating that HIV is almost like having a third person in his relationship which
requires attention. He explains:

I think it's [HIV] very central to the relationship. It's hard for me not to
think about it. And not like all just constant conscious HIV thoughts, but
it's like always in the back of my mind. For a relationship, I don't think
we talk about it a lot, but we talk a lot about things around it. If that
makes sense. . .When we both get home at night, he has to return phone
calls from the machine from the day. It's like if there's five messages, four
of them will be HIV-related about speaking, or teaching, or a fund raiser,
or something like that. So in that way, it indirectly affects me
. . .Sometimes I feel it takes time away from us. It's like a third person in
our relationship that has to be tended to.

William, an HIV-positive partner, does not find avoiding HIV communication to
be problematic in his relationship:
I don’t think it’s [HIV] very central at all. . . I think it’s a good thing that we don’t talk about it. I don’t think it’s, let me rephrase that, I don’t think it’s a bad thing that we don’t talk about it. If we did talk about it more, I think that that would be fine. But I really don’t, I just don’t think that it’s that important.

As a way of relieving tension when discussions of HIV do arise, some individuals describe using humor to make the topic less serious. Ken, who is HIV negative, notes that he and his partner, Adam, frequently use humor to communicate about HIV:

Once in awhile, you know, he’ll make a joke or something, and we just pretty much laugh it off. Or I’ll even make a joke once in awhile. Just say something, and we just try and make light of it.

Adam, an HIV-positive partner, describes his use of humor this way:

We really don’t [talk about HIV]. And you know I’ll joke around that I’m not going to be here or whatever and you know at such and such time. And of course, you know it’s been much longer than what I ever expected. But no, he doesn’t want to talk about it. It’s not important.

On the other hand, avoiding communication about HIV/AIDS was problematic for some couples. Ed, an HIV-positive partner, explains that his partner’s avoidance of HIV communication has caused arguments in their relationship:

He’s there if it’s an emergency. Day to day he’s not real interested in it [HIV]. . . I keep my meds where I would use them. I know that’s the kind of stuff he doesn’t like to see very much. And if I’m complaining, it really bothers him. We’ve had arguments about it.

Andrew, an HIV-positive partner, talks about how he feels his partner, Matt, tries to protect him by not showing his concern and worry about his health. Andrew explains that, because of Matt’s avoidance of HIV-related
communication, he often feels that there are deeper relational issues Matt is not addressing:

I know how hard it is for him to talk about it [HIV]. And especially when he's really sad. I guess if there were anything that I wish were different, I wish it were easier for him to talk about it. I don't know if he's trying to protect me from his feelings or what's going on. I wish it was different, because I know it's so hard.

Rick, who is HIV positive, tries to protect his HIV-negative partner from unnecessary worry. He states:

If they would tell me something might happen, that hasn't happened, then I might not say anything, so he won't worry about it. Because he can't do anything about it. You know, they say "well you know your left leg could fall off if you take this medicine here, but it hasn't happened to a lot of people." I don't often times, you know, tell him everything they say because he'd be always watching to make sure it's not going to fall off. He just worries. It keeps him from getting aggravated, and then aggravating me.

Chris, who is now in a concordant relationship, describes how he left a discordant relationship because his partner would not discuss HIV and did not want anyone to know that he was HIV positive. Chris explains that he felt so stressed from hiding his HIV-positive status that after his break-up he wanted everyone to know:

I had just gotten out of a relationship that was, I don't know, there was a lot of stressors in it, and I just, I was like rebelling. I knew he didn't like people to know about it [his HIV positive status], So then [afterwards] everybody knew it.

Managing the dialectic of openness-closedness regarding HIV communication appears to be a central relationship maintenance strategy for the couples in this study. Perhaps more so for HIV-discordant couples than HIV-103
concordant couples, there is a trend for discordant couples to attempt to avoid HIV communication unless physical symptoms prompt discussion of the topic. Discussing HIV is a reminder for couples that at least one partner is dealing with a terminal illness, and that they must deal with issues that are not the norm for many couples. Thus, one important means of seeking normalization is to manage the intrusion of HIV communication in the relationship. That dialectics represent the tension between two opposite extremes underscores the fact that couples dealing with HIV/AIDS cannot completely avoid communication about HIV nor can they afford to become all consumed by it. How well these couples manage this tension appears to be an important means of relationship maintenance.

**Health Autonomy and Partner Involvement: Managing the Dialectic of Autonomy-Connection as Relationship Maintenance**

Baxter (1994) explains that the dialectic of autonomy and connection is also a primary tension in all personal relationships. She asserts that managing a balance between individual independence/self-control, while at the same time being connected to another and giving up some personal control, is at the heart of relationship maintenance. In every couple, there is a need to balance personal needs and desires with relational demands.

Many of the relational issues that must be negotiated seem rather mundane or unimportant, and yet, can cause relational difficulties if not addressed. Couples must negotiate a sense of interconnectedness while
maintaining a sense of an independent self. For example, Matt, an HIV-negative partner, argues that something as simple as personal control over the right to choose which shirt he wears can be an autonomy issue with his partner:

So what I would like to see changed about our relationship; I think I give Andrew total liberty and I don’t feel that I get that back. I mean, simple things like I put on a shirt. We’re going somewhere, I put on a shirt. He thinks it’s too wrinkled, so I have to change it. That’s taking away my liberty, just choosing what shirt I want to wear. And things like that shouldn’t be such a big deal. But if it happens a lot, then you don’t feel free. So I think that personal freedom, the personal liberty issue might be one of the big ones.

Another major area of the autonomy-connection dialectic that couples often must manage is the tension of needing to balance time together with personal time apart. Participants explained that because of the fear of early death of a partner with HIV infection, there is a tendency for partners to want to spend as much time together as possible. As a result, the lack of balance between the extremes of autonomy-connection is problematic for some couples. For example, Rick, an HIV-negative partner, comments on trying to integrate time together with his partner, John, while at the same time allowing each to retain separate interests:

We spend time, we watch TV, we work on bills, we do a lot of home improvements together. But he’s into different things, I’m into different things. I do a lot of home improvement and gardening. He’s trying. And we take his health into consideration. You know, he’s building a stone wall. You know, it’s about, probably about 50 feet long, couple feet high. It’s taken him a couple years, where I could’ve had it done in a couple weeks. But he’s, you know, he has little ailments, you know, shoulder, whatever. So he takes it slow, and we don’t have a time limit on it or anything. So he works on that. I do the bulbs in the fall and in the spring and all that stuff. We’re working on a fence together.
John, also explains his need to spend time apart from Rick:

I probably hang around like at our local bar. It’s very rare for him to stop in. And a lot of times, I’ll stop after work, and sit with the guys and stuff. And he won’t be there, you know, he won’t do that. It probably works out better that we don’t go together.

Daryl conveys that having autonomy helps instill trust between he and his partner Gary:

If I want to go to Bingo and stuff, he doesn’t mind if I go out by myself with my friends. He knows that where I go is where I’m going and I’m coming right back, you know. And that makes me feel good that he can trust me, you know. Because I trust him. He goes with his dad for a weekend or something, you know, that’s fine. I know where he’s at, what he’s doing.

Alan explains that during the work week he and his partner, Dave, spend a lot of time separately, however on weekends they balance that with time together:

We’ll eat at home most of the nights. And after dinner, we’ll just go our own ways pretty much. He’ll go read a book, or maybe talk to someone on the phone. I’ll go watch Crossfire on CNN and Larry King Live and all these controversial things that I like to keep in touch on. And about 10:00, we both end up in bed. And about 10:30, we’re both pretty much asleep. That’s a typical day. Weekends are meant for us.

Dave explains that he needed time away from Alan who needed to process through a lot of issues surrounding HIV. Alan lost his job and was constantly at home. As a result, Dave feels that he has lost all of his personal time to himself.

Dave states:

And then we had another argument, we continued to, we argued about that some more because he had lots of time during the day to work with himself, do all his processing. And I didn’t have any. When I’d come home it [HIV] was always there. So it wasn’t like I had a day off from work, or would work over-time, or be out of town on business - never any
time away like that. He was always there when I was there, and I wanted just to spend some time by myself. And that was a big issue, which I didn’t even realize for awhile. It took me awhile to catch on to that. And so when I did it was just like, “whah-laah.” But we worked that out. Now every Thursday night I work late, and I go out one other night. So I have space two nights a week. And that’s been a very healthy thing.

William, who is on disability, notes how difficult it was to balance autonomy and connection in his relationship because he would like to share all of his partner’s free time from work; and yet, he has learned that his partner also needs his personal space. William explains:

With him working, it’s hard for me because I have so much time on my hands, and then he comes home and then he wants his time, he wants some time to himself. It’s taken me awhile to learn, “OK just, you know, leave him alone.” It’s just a given now. I don’t think, you know, I think it just took a while to realize, you know, I mean he’ll get sort of quiet and sort of ignore me, and that’s sort of my cue that, you know, OK, come back later. What I’m trying to talk to him about is not that important that it has to be talked about right now. And you know, I’ll just put it off and talk to him about it later. Also, I’m very involved in computers. He’s not as involved with computers. He plays softball and volleyball. Things like that. He’s more athletically inclined than I am.

Health autonomy. One aspect of the autonomy-connection dialectic that is particularly problematic for couples coping with chronic illness is the desire for persons with an illness to maintain a sense of personal control over their own healthcare decision making and their lives in general, and at the same time, to deal with relational partners who want to be involved in their health care. Managing the dialectic of health autonomy versus partner involvement in care also influenced the ability of couples to normalize the illness. Participants
reported that the more autonomy the HIV-positive partner took on, the more
easily normalization occurred in the relationship.

Illness often can threaten a person’s sense of control as others attempt to
provide support and care. In a sample of nine gay male couples coping with
AIDS, Powell-Cope (1995) found that the issue of preserving the independence of
PLWHs as they deal with physical symptoms was an important factor in partner
caregiving. The findings in this study also indicate there is a delicate balance for
couples coping with chronic illness involving the dialectic of autonomy and
connection. Well partners are torn between wanting to show interest and
concern for their partners’ health, and yet, must maintain enough distance to
allow the ill partner to sustain a sense of personal control over their own health
care decision making. To David, an HIV-positive participant, autonomy was an
issue in his decision to stop taking medication due to severe side-effects. His
quality of life was more important than living in misery, and the decision to stop
his medications was based on a belief that he had control over his own body. He
so firmly believed he knew what is best for his body, that despite input from his
partner and mother, he decided to stop his medications. David explains:

I make all the decisions mostly, you know. Like stopping these pills. My
mom and them are all dead against it. People I talk to, “don’t do it, don’t
do it.” But it’s my health, it’s my body, you know. I was sick. Started
those things, and for the first six months, I was nothing but miserably sick.
Grouchy, you know, passing out in my house, going to the hospital. I had
to stay in the hospital for two weeks because of that. Coming back out
and then getting sicker on the Crixivan. And I said this is it. This is my
body, I’m the one dying here. They’re killing me with this stuff. I’m not
going out this way. And I just told the doctors, “look, I can’t take this
stuff.” And then they said, “OK, stop. We’ll find something you can
take.” But they didn’t tell me that at first. You know, I’m taking all this stuff thinking, “Oh God, I got to take this, it’s helping.”

And it was helping, you know, for some [persons CD4 counts are up] 400, and some up to 700, and some viral loads are zero. My viral load was some 20,000, and now it’s down to zero, it’s undetectable. You know that it [the drugs] must’ve been doing something. But it was just killing me. I couldn’t have no friends around, didn’t want to go out, didn’t even have a beer, or anything, you know. It would just make me sick. I said, “life ain’t worth living if you got to live it this way.” And then they said, “you got to stay with this all the time,” and I said, “No I can’t do it.” Because you have these other people try to tell you what to do.

And I know. I’ve talked to a lot of my friends that have died. You know, I’ve lost just about all my old friends, you know. Michael, my partner, I met six, seven years ago. His friends are my friends now. Most of the friends I had before I met Michael had already passed on. You know, most of them told me that the stuff the doctors would give them made them feel worse, and think they made them die faster. But you know, you never know. And I always tell myself that whatever I’m taking, or whatever I’m given, given from a doctor, if I don’t like it I’m not going to take it. You know, if he gives me something I can handle, or something that don’t bother me that much, I’ll do it. But, you know, Michael knows that too. Because he knows that I feel that it’s my body and who can take care of it better than myself. You know. He can tell me what to do, my mom can tell me what to do, but I know what I’m doing.

David’s partner, Michael, agrees, but also points out that they do discuss David’s medical decisions as a couple:

It’s his decision. It’s his body, so he has to make the decisions. I’ll give my input. But, I mean, the final decision is whatever he decides. If I disagree, we discuss it. I’d still back him up, but I’d make sure he knew I didn’t totally agree on it. But I would back him up.

Others describe a similar need to be in control of their health care decision making. Alan recalls that, although input from his partner, Dave, and his doctor was important to him, health autonomy was vital to make the decision to begin a
new protease inhibitor. Because of the unknown health risks of taking a new drug on the market, it was important for it to be his decision. Alan explains:

I'm in charge of my healthcare totally. The doctor is not and neither is Dave. But Dave has great input to it, and he's pretty wise, and he feels like I do. So I recently changed drugs a few months ago, and now I'm on protease inhibitors. And that decision, it was like, "Well, it's iffy," because protease inhibitors are new, and I went to the newest one. That was the big risk factor. But, I'm controlling it now with the other one. It changed my quality of life a lot. But I had to do a lot of thinking about that, and studying it, and talking with Dave in a manner of cross-examination: "Well if I'm vomiting with this one, I'm not getting all the drug, and then I'm doing this." And we decided that those are the negatives. But then the positives would be, of course, hopefully, those side effects will go away. But with the new one, the negatives are, "Well, it's new. So I'm going to have two heads growing on me next year by being the lab rat that I've become with the drugs. So would that make sense? What do you think?" And he'll tell me to the point what he thinks would be best. But, I have absolute domain, and that's more important than ever before with the risk I'm going to have now.

Partner involvement in healthcare. The contrasting dialectical tension to health autonomy experienced by couples coping with HIV/AIDS is a partner's desire to show concern and involvement in the other's health. Among the discordant couples in this study, the amount of partner involvement in the healthcare of the HIV positive partner ranged on a continuum from almost total noninvolvement (e.g., knowing nothing about what drugs one's partner is prescribed or what times he takes them) to complete involvement (e.g., monitoring his partner's adherence with his drug regimen). However, due to the drive for normalization, there was a predominant sentiment among HIV-negative partners that the HIV was the positive partner's primary domain and responsibility. As long as the positive partner is not manifesting symptoms that inhibit normal functioning, most HIV-negative partners preferred to let their
partner manage their own illness. This trend aided efforts for normalization by reducing the centrality of the illness for the couple and within their interactions. The following examples represent the range of partner involvement from low to high.

Alan, an HIV positive partner, addresses how his HIV-negative partner is not very involved in the daily management of his health. Alan reports feeling that his health care is his own responsibility. Alan explains that his health is:

... my ballpark. Again, since I'm not working at this point, that's a big part of those things I have to do myself for myself. So I have to manage them, and I take care of them. So as far as the pills and those regimens, he hasn't really done very much there, except for his concern once in a while that I'm not taking them appropriately.

Another example provided by Phil describes how his partner does not want to be involved in his care unless there is an emergency. Phil explains that as part of a normalizing strategy, his partner does not want HIV medications to sit out in plain view because they are a reminder that Phil has HIV:

He's there if it's an emergency. Day to day he's not real interested in it. I keep my meds where I would use them. I know that's the kind of stuff he doesn't like to see very much.

Interviewer: Because it reminds him?
I think. And if I'm real whiny, and just not real ill, but I'm complaining, it really bothers him. ...We've had arguments about it.

Medium-level involvement for one discordant couple involves driving together from a rural area to the metropolitan-located HIV/AIDS clinic. The couple makes an effort to accompany each other to all of the Rick's clinic appointments. Rick explains:
We kind of make an event out of it. We come up here and we'll do this today, and then on the way home we'll stop somewhere and shop. And go somewhere to eat. And so just make a day out of it. So we're kind of glad to do that, it's a lot easier than for me to just come up here by myself because it's a long drive. It's very tiresome and I'd rather have him with me.

While at the clinic, John, Rick's partner, does not sit in on the actual physician-patient interview. John explains:

I think it's my way of giving him space. But I know that when he went through, he just went through radiation for throat cancer. And I was active in that more. I was. It was through the hospital where I work. And I went in the doctor's office with him. I went to treatments with him. I think I was probably more involved. I think it made me realize that maybe I could go in with him here. I don't know why I haven't before this. Just giving space.

Several individuals also reported high involvement in their partner's health care. High involvement was an important means for these relational partners to emphasize their commitment and concern for the other. For example, Keith, who is HIV positive, explained his partner's high involvement in his health care this way:

When I was diagnosed, he was sitting there when the results were revealed.

Interviewer: Was he in the room with you?

Yeah. I asked him to go with me, and he, of course, wanted to be there. We had a good feeling that it was going to come out negative, I mean, positive, the way it did. I mean, HIV positive. But the results were as they turned out, and because the tests took so long, it took three weeks before I was able to get my results. It should've taken a couple of days. So I suspected that there must be trouble in store here, and I asked him to go with me, and he said, "No problem, I'm right there." The doctor said too, Dr. XXXX, that it was good because a lot of couples aren't that close and wouldn't have been there together. I was thankful that he was. After that, and now, he's quite an advocate of, against HIV, and for the people. And has really gone with me to see my infectious disease doctor. Up
front, he went to two or three visits, and things have slowly come to a
nice, almost a standstill, since my health has improved. And neither one
of us is quite as defensive about it, but he’s been very supportive, and
follows all the information, and subscribing to POZ Magazine and other
things to keep in touch with the disease.

Phil his HIV-negative partner states:

I read everything. I think I read more than he does. I always want to
know what this is about, or what this is going to do, or the side effects.
And try to keep on him about taking medicine regularly, without being
bitchy.

Interviewer: So you actually try to remind him?
Yes. Or just, you know, like buy him one of these little pill things that he
puts the pills in so he knows what he took. Yeah, I try to be active.

Rick, who is HIV positive, describes how his partner can be rather pushy
when it comes to involvement in his care. Rick explains that his partner’s
involvement is “overboard” at times:

Sometimes he’ll get, you know, a little overboard, like when I was real
sick. He’s calling my doctor, you know, “I’ve got to have some pain
medicine,” he asks if I’m in pain and everything. Yeah, well yeah, I’m in a
lot of pain. The doctor told me I was going to be in a lot of pain. But you
know you can’t tell him that because he works for the hospital and he
thinks, I’ll call Dr. XXXX. He’s real happy about that. Like I say, it’s just
extreme things like that. Normally it doesn’t bother me at all.

Another HIV-positive participant, Jerry, feels his partner also is too involved at
times to the point of being over protective. Jerry states:

Well, sometimes I think he carries it too far, he’s too protective. I mean,
like when I was in the hospital, he told me that he’d take my car keys so I
can’t go anywhere, and he did. He has done it before, and he says,
“you’re going to have to stay home.” He doesn’t want me to do this, he
doesn’t want me to do that, and sometimes he gets so over protective.
And that drives me a little nuts. But he’s very much with it, and he wants
to know T-cell counts, he wants to know blood counts and viral loads and
all that stuff. But it’s a daily thing. And you know he’s been there.
Of course, the highest level of partner health involvement occurs when caregiving is necessary. John, an HIV-negative partner, explains that he was quite frustrated when he had to care for his partner after surgery for throat cancer. Partners often are faced with the desire to provide good care, and yet, must deal with the stress of being so highly involved in their health care. John explains:

It's part of being in the relationship. It was a necessity. You know, our household is Rick, myself, and our dog. Well, the dog wasn't going to cook. Rick was on the couch, barely making it at one point. And, yeah, you know, it was very stressful. Oh my God, when he couldn't swallow, I tried everything. I tried every type of liquid consistency. Where I work we have speech therapy. We work with aphasia or dysphasia with swallowing problems, and sometimes we have to thicken a liquid for some of our patients when they drink. I tried everything with him, you know. Talk about frustrating, scary, and all that.

One relational dimension couples dealing with HIV/AIDS must manage is the dialectic of autonomy-connection, specifically as it relates to health autonomy and partner health involvement. As with the dialectic of openness-closedness, autonomy-connection is a dynamic relational continuum which couples must navigate and negotiate as they strive to maintain their relationship. As can be seen from the couples in this study, no one extreme of the continuum is relationally satisfying. Too little partner involvement may indicate disinterest and a lack of concern, whereas over involvement can be interpreted as being overbearing, smothering, and untrusting of the other's competence to care for
oneself. Yet, it seems clear that the behavioral manifestation of managing these tensions are both strategic and unintentional means of relationship maintenance for these couples coping with HIV/AIDS.

**Typological Maintenance Behaviors**

Canary and Stafford (1991; 1992) developed a typology of maintenance strategies and behaviors, subsequently expanded by Dainton and Stafford (1993), that couples use to maintain their intimate relationships (see Chapter 2 for a detailed description). This research primarily has involved investigating the maintenance behaviors reported by white middle-class heterosexual married or dating couples. There is continued interest among relational maintenance researchers to explore the generalizability of this typology to other types of couples. For example, Diggs and Stafford (1998) recently found evidence of the use of these behaviors in African-American married couples. In addition, Haas and Stafford (1998) found these behaviors to be reported by gay and lesbian couples in the maintenance of their relationships. To date, no research has explored the means of maintaining relationships in which one or both partners have been diagnosed with HIV or AIDS. One goal of this study, addressed in research question 3, was to investigate if gay male couples coping with HIV/AIDS utilize the same maintenance behaviors proposed by the Canary and Stafford (1991; 1992)/Dainton and Stafford (1993) typology.

The findings of this study indicate couples did report the use of several of these maintenance behaviors in their relationships. These findings provide initial
support for the use of this maintenance behavior typology within gay male
couples dealing with one or both partners being HIV positive or having AIDS,
and indicates additional support for the generalizability of this typology to other
populations. The specific maintenance behaviors participants reported in this
study were equity in shared tasks, openness, favors/positivity, assurances,
affection, sharing time together, social networks, talk of day, and use of
calls/letters/electronic mail. Evidence for the utilization of each of these
behaviors will be presented in the following sections.

**Equity in shared tasks.** Much of the previous research on relationship
maintenance has shown evidence of the importance of equity in intimate
relationships (see Canary & Stafford, 1994). One relational dimension where
couples often strive to establish relationship equity is in sharing tasks. Shared
tasks are duties and responsibilities which must be accomplished for the couple's
functioning, both day-to-day and long-term. Yet, each couple must negotiate a
distribution of tasks and responsibilities that are satisfactory to each partner.
Examples of shared tasks involve household duties (e.g., cooking, cleaning,
laundry, yard work, and the like), payment of bills, and decision making which
affects both partners. Canary and Stafford (1992) and Dainton and Stafford
(1993) have found that heterosexual dating and married couples attempt to
establish equity in their relationships. In these relationships, the division of
shared tasks largely have followed stereotypical sex-roles assignments, for
example, household duties have remained the stereotypical domain of the female
sex-role. Haas and Stafford (1998) and Kurdek (1993) found evidence that equity
is also a central feature of gay and lesbian couple relationships. However, this research suggests that gay and lesbian couples do not to adhere to stereotypical male-female sex-roles or sex-role task assignments (Kurdek, 1993). Equity in these same-sex relationships has been found to be established more through division and sharing of tasks across most all types of relationship duties.

For the same-sex couples in this study, evidence for equity across tasks was also found, despite the fact that at times HIV-negative partners reported taking on more tasks in the relationship because the PLWH was physically unable. Even in the face of occasional task imbalance due to HIV, couples overwhelmingly report feeling that their relationships are built on the principle of equity. For many of these couples, there is a tendency to capitalize on the interests of each partner. Tasks become the domain of one partner or the other based on personal interest and ability to perform the task. It is clear, however, that there is a great deal of overlap in who assumes shared relational tasks. For example, Daryl, an HIV-positive partner, explains that over time he and his partner negotiated the assignment of household tasks after moving in together:

Since we've been together, I've noticed he likes to do laundry, he notices I like to do dishes. I like to vacuum, you know, he likes to do like the bathroom, scrub the tub out and sink and stuff. So we just thought we'll just, you know, you do that and that, I'll do this and this, you know. The cat's mine, I'll take care of the box. Dog's yours, you walk him, you know. Just comes automatic when you do it. We lived together for two or three years, and we just thought, "well heck, let's just keep it this way." And it's just things that naturally get done without being said any more. Sometimes I won't do dishes for a day or so. He'll load the dishwasher and do it, no problem, you know. Sometimes I'll need a shirt or some clothes that he hasn't, he's got stacked up there and they ain't washed. I'll go down and wash them myself, you know.
Alan and Dave, an HIV-discordant couple, have a very similar rule regarding the assignment of dish-washing duties. Alan, the HIV-positive partner, notes:

Dave will come home and I used to be the person who was preparing all the meals. Dave has gotten into a weight watcher frenzy so he’s more fat conscious than I am so he likes to do more of the meals now. So that’s kind of a shared thing. I think it’s gotten almost 50/50 at this point. So he’ll come home, one of us will cook. I don’t like cleaning up. That’s boring. But we’ve always had the motto that whoever cooks does not clean up. And that’s always worked. And it almost always works that way. So when he cooks, I have to clean up, which I don’t like, but it’s just sharing the load.

Brian, who is HIV negative, describes a great deal of flexibility in assuming tasks in his relationship:

A lot of times, we just do it. I mean, I’ll see that a load of laundry needs to be done and I know that I’m getting up at 5:00 the next morning, so I’ll go ahead and do it then. Dishes, sometimes I’ll do them, sometimes he’ll do them. Unless we cook. If I cook, excuse me, whoever cooks does not clean. It’s only fair. That’s one of the few rules that we have. It basically gets done. He’s more apt to, if he sees that the kitchen floor is dirty, he’s more apt to sweep that. I’m more apt to do a load of laundry. There’s just so many ways you can do laundry. I figured that out early on.

Steve echoes his partner Brian’s feelings:

If he wants me to do something, then I’ll do it if it’s not too unreasonable. There’s a lot of give and take, we both compromise. I can’t really think of anything that he’s really in charge of. He takes care of laundry. He gets up early at 5, so he’ll do a load of laundry when he gets up in the morning, which takes about an hour and a half, and that gives him enough time to have his cappuccino, and do a load of laundry.
Gary, an HIV negative partner, comments on the importance of capitalizing on likes and dislikes in negotiating the assignment of tasks in his relationship:

Usually after I come home from work, because he is not working, you know, if I’m tired, he’ll cook. Or even I’ll cook, but we share, like I don’t mind doing laundry. That’s my thing, he hates it. I hate doing dishes. So he does the dishes and it works out good.

Ronald explains that, even though there are small tasks Phil cannot take on because of his HIV, they essentially have a great deal of task sharing in their relationship:

I always clean the cat box because, you know, he’s not supposed to do it. He does most of the grocery shopping now. We used to try to do it during the week because I never wanted to spend my weekend doing grocery shopping. . . . Gardening chores, we do a lot of that together, although I do most of it. I help him with tracking his medical spending. Most of the time he has to ask me to help him, and that’s fine. But just coordination of things. Little projects, we always do together. We make all of those decisions together, even though I could go sign the paper and put it on the credit card, we both go do this.

Finally, related to sharing financial responsibilities, Daryl describes how despite an imbalance in their financial contributions, they still very much strive for equity within their relationship. Daryl states:

All of our bills are paid, you know. He has to pay no bills. My VA, I’m a Vietnam Vet, and they pay all my bills until I get social security, or whatever. Gas, rent, electricity. You know, he works. All he has to come up with is just the phone and cable, which is fine. So you know I do my share, and he does his, and it just, it equals out. It really does. And I don’t think it’s because he wants to stay or anything. He cares a lot about me. He loves me, you know. And I just don’t worry about it.
Participants in this study report that equity in shared tasks is important in maintaining their relationships. This finding is consistent with previous research indicating that gay and lesbian couples value equity in their intimate romantic relationships (see Haas & Stafford, 1998; Kurdek, 1993).

Openness. Another maintenance behavior reported in this study was openness. Openness refers to the social exchange of self-disclosure and open communication which occurs within intimate relationships. Openness is a frequently-mentioned maintenance behavior by couples in the studies of Canary and Stafford (1991; 1992; Dainton & Stafford, 1993), and was also reported by the couples in this study. Alan, an HIV-positive partner, described the importance of openness in his relationship this way:

I think honesty has been a component that’s paramount. We’ve always told the truth to one another. We’ve never lied. Everybody tells white lies. But we, I think, have a very honest and open relationship all the way, a trusting relationship. And we have had open communication all the time. We’ve never closed the door on communication. So those are the things that were most concerned with and are most important today.

Bill, who is an HIV-negative partner, explained that he feels the threat of a shortened relationship because of HIV has led he and his partner to be much more open than they would normally be with one another. Bill states:

HIV makes you more aware, it would be like if you had a bad relationship with your parents, and you only had 24 hours, you knew they were going to die in 24 hours. All the things you could say to them in that 24 hour period. And say they died and you didn’t know you had 24 hours, then you’re screwed. Because they’re dead.

Interviewer: So has that had an effect on your relationship?
It’s very positive, because there’s no secrets, there’s no hiding feelings, there’s, everything is just open. If I don’t like something, I tell him, if he doesn’t like something he tells me. We’ll fight about it, but fights are over
in two minutes, then it’s just back to normal. There’s enough crap to deal with, you know. The stupid stuff just, you know, if I want to watch the Simpsons, and he wants to watch news, that’s stupid stuff. We just don’t fight about it, it’s no big deal.

One area of open self-disclosure that was considered vital to maintaining these couples’ relationships was openness regarding communication about sexual issues. For many couples in our society, sex is a difficult and often taboo topic for open discussion (Hatfield & Rapson, 1993; Lear, 1995). For the HIV discordant couples in this study, open sexual communication was considered very important to maintenance of the relationship because of an underlying fear of infecting the HIV-negative partner. Brian, an HIV-negative partner explains that he and his partner made a point to discuss sexual issues early on. Brian states:

It was a conversation. It had to be at first. I mean, with any normal relationship, you don’t wait until you’re into your relationship and say, “Oh, are you HIV positive?” You know, it’s safe sex, always. But our relationship is kind of to the point where sex really isn’t the major thing. When you get to the point in your relationship where just being next to somebody or you know, you don’t have to go through the act of sex. It’s not my fear of catching it or anything like that. It’s more I think on his part, it has to be because he doesn’t want something to happen to me. He’s cautious.

Another HIV-negative partner, Bill, explains that his partner has encouraged him to be more open about discussing sexual activities even though it has been hard for him to do so. He states:

He’s more of a talker about it [sex] than I am in that respect. He’s got me talking more about it, now. The kind of activities that we engage in, I am not, there are certain things I just don’t do well. And for that much, they are risky. And it kind of works out that I’m not that proficient on them
and he’s not too keen on me getting much expertise in that area, so in that respect, that behavior is eliminated. But we, we talk more about.

Discordant couples explained that the topic of sex not only requires communication, but also negotiation regarding sexual activities in which both partners are comfortable engaging. For example, Matt, who is HIV negative, explains:

Initially, it was a lot of negotiating, and a little bit of crying. Because there were only certain things I will and will not do. I don’t think that Dennis at that time fully understood my reasons. Like they have their safe sex list, safer sex list, and not safe list. And I’ve read all those. And then I also know of the experiences of people in my life who had turned positive and kind of judging by their behaviors what I would feel comfortable and not comfortable doing. And maybe not even, maybe it didn’t match up with the safe, safer and unsafe list, it’s just what I was going to be comfortable with. So we negotiated our way through that. We talked about it over several conversations.

Steve, who is HIV positive, describes the need to openly negotiate safe sex in the midst of sexual activity if certain behaviors are suddenly judged to be risky.

Steve states:

Yeah, there’s times that we’ve talked about it. And there’s been a couple times where you know it’s been close. It’s like wait, wait put a rubber on, put on condoms. When you’re around an area, you should be wearing a condom, you know, that kind of thing. I mean we kiss. Brian is not a real deep tongue kisser. So it’s usually just a lip kiss. Well, we just play it by ear. Whatever feels good and whatever’s safe. I mean he knew from the get go that I was positive and he knew that there were certain limitations and we have always abided by those limitations. I mean if there’s ever any illness, I always gloved [put on a condom] first and if there’s an open sore on my mouth or you know a cut or you know anything like that, take precautions or we won’t do it. It’s that simple.
Jake, who is HIV positive, explains that he is very adamant in discussing safe sex in his relationship. Jake echoes the need for couples to communicate which sexual behaviors they are both comfortable practicing. He explains:

We do practice safe sex. We have from day one. When we met, I said, "you will or there won’t be any." That was the conversation. A definite conversation about that. We discussed, you know, different aspects. Like I was comfortable with kissing, but you know you have to ask, and he was very comfortable with that. From all the data that I knew there was not a problem with it. And that was what he thought too. But it needed to be discussed. It will always be important, the safe sex aspect.

For concordant couples, open sexual communication is also prevalent, but most of these couples do not feel the need to practice safe sex. For example, Chris explains:

Well, even though they say we should still be practicing the safe sex and we both have discussed it, and we really don’t. I mean what more can we get in my opinion, and he pretty much feels the same way. I mean, the little that we do that could be unsafe, it’s rarely there. So I think that thing about being positive, it does, it eases the worries that I’m going to infect him. I mean, my last partner, every six months when he went [to get tested for HIV], I was taking a day off of work sick to my stomach.

Leon, who is also in a concordant relationship, explains that he and his HIV-positive partner stopped practicing safe sex over time:

Because we’ve been together so long, we used safe sex. Like when we first met, we used safe sex all the time. And then after like two or three years being together, living together and things, I decided that’s the person I want to be with, spend the rest of my life with. So now we don’t.

Openness is described as a salient maintenance behavior for the couples in this study. The exchange of open communication regarding issues such as sexual activity is reported to be particularly important in these relationships
dealing with HIV infection. Openly communicating about one’s feelings or
concerns regarding relational issues which arise in a relationship coping with
HIV is described by couples as useful in maintaining their relationships.

Favors/Positivity. One frequent strategy couples’ reported in prior
studies is being positive and doing favors for their partners. Favors also are
mentioned as a common way that couples in this study maintain their
relationship by openly showing care and concern for one another. Examples
here include Daryl, who is HIV positive, who explains of his partner Gary, “He
brought me flowers when I was sick at home.” Daryl goes on to explain that he
and Gary try to reciprocate favors for each other. Daryl details:

Like fold clothes. You know. He’d come up and pile them on the chair
and I know he’s getting ready to fold them but before he has a chance to
I’ll go over and fold them and he’ll come back up and they’re already
folded. He loves that, you know. He does the same for me. He’d be in
the refrigerator, “You want anything while I’m in here?” You know, he
didn’t have to ask. (right) It’s just, you know, like I said, you’ve got to
take care of each other because it’s a disease that affects everybody, you
know. Anybody that’s in a relationship.

Other examples of favors were offered by several participants. Ed, an
HIV-positive partner, explains, “Oh, as simple as, I usually wake him up in the
morning because he doesn’t wake up.” Or Larry, a negative partner describes,
“Making sure he’s always got orange juice and milk, and distilled water in the
refrigerator. And, you know, get him a glass of milk.” Ted, who is in a
concordant relationship, also details sharing favors in his relationship. He
explains:
I’ll come home and he’ll have dinner ready, if he goes to the post office, he’s like, “Oh, I had to get a book of stamps, you know. Here’s stamps for you too.” Or if he sees something that he thinks I would like, he’ll buy it for me. And I don’t pick up things like that all the time. I mean, I know he puts me ahead of him.

Another aspect of favors mentioned involves participating in activities the other partner likes. An example of this behavior is represented by Richard who describes going to plays and going ice skating with his partner, Andy, an activity Richard does not enjoy, but engages in anyway for his partner’s enjoyment.

Richard explains:

Like going to a play with him when he knows I hate the damned things. I hate them, I hate them. Once, he took me ice skating and I thought I was going to die. This kid’s throwing things and chasing them. I said, “I’ll never go again.” But I did it because he wanted to go, you know.

Assurances / Affection. In creating a positive relational environment, assurances which incorporate verbal expressions of love and caring, as well as intentions to continue in the relationship indefinitely also are exchanged. Examples of assurances used by these couples include Rick, who is HIV negative, who describes frequent verbal expressions of love in his relationship:

Like telling each other we love each other. Several times a day. And this is for 15 years, even through the bad times. We always in the morning say, “I love you.” At night, you know, these are the routines, you know, before we go to sleep. “Sweet dreams, I love you.” Every night it’s just something we do.

Ted, who is in a concordant relationship, explains:

I definitely make it a point every day to tell him I love him. I think usually before I go to work, I’ll say that. Or before I go to bed. And then, every so often, just so it’s not like, “Oh yeah, you say that every day,” I’ll
say it sometimes out of the blue. But then, like anytime he does anything for me, I always say, “Thanks, you know I appreciate it.”

Related to assurances is the display of physical affection. Several partners describe their relationship as being very affectionate. Steve, who is HIV positive, explains “If I come home from work, he’ll rub my feet for me if I ask him to give me a foot rub. And you know, I rub his head. We’re very affectionate towards one another.” Tom, an HIV-negative partner, states, “We hug each other, kiss each other, things like that.” Rick describes his HIV-discordant relationship with John as involving a lot of attention and affection. Rick explains:

We get along, I don’t know, I think, he’s just like my dog. The minute that I hit the door, my dog is ready for her hugs and kisses and everything, you know. And it’s like nothing else matters at the time, the attention that I give her. And the same thing when I come home, or if he comes home. You know, we’re more in love every day. Everyday we’re more, and I still think about it. I think, what a gift. . .When he comes in from work it’s like, John, you know, and it’s wonderful.

Ken, who is HIV negative, describes how he and his partner are quite affectionate:

We wake up every morning and we probably hold each other for about an hour, just like cuddle. And just hang on to each other for like an hour. And that’s just a really nice way to start my day, everyday. And it helps because I’m not overly happy about getting up for my job.

Sharing time together. Another important maintenance strategy for these couples is engaging in joint activities and increased time together. Participants explain that living with the knowledge that one or both partners is ill with a terminal illness makes both partners want to spend increased quality time with
each other. Alan, who is HIV positive, explains that HIV has brought he and his partner much closer together:

I think HIV has drawn us closer together. My mortality has brought his home, and therefore, I think he realizes the value of almost losing me and suddenly having me for awhile. And I think that has made a big difference in some of his emotions that he shows. He was never really closed, but he’s more of a romantic than he ever was. Almost like starting over. He’s more nurturing now I think than he ever was, and we don’t take our time together for granted. I think he has said many times, in his own way, that life together is very valuable to both of us. And the fact that we’ve been through so much, life is even more valuable.

Joe, who is HIV negative, explains that he feels also feels the need to divert attention from work to his relationship. Joe states:

I think, and I hope, that even though now he’s been better for a couple of months that the long term effect is that it has brought us closer, to not take each other for granted. I’m a very, I’m kind of a workaholic. I have a tendency to be very over obsessive about work. That’s not a good way to be. I’ve recognized that for years. But I’m more and more aware of wanting to spend time with him now. And in a good way, I’m thankful for that. It shouldn’t have to be something like HIV that causes that.

John, another HIV-negative partner, also states, “Other than our eight hours at work, we’re always together.” Ken, a negative partner, conveys a similar sentiment, “When we’re outside of work, we’re together, and we’re always doing things.”

Several partners explained that due to HIV, they make a conscious effort to spend as much free time together as possible. Peter, who is HIV negative, notes:

I’m with him everyday. I see him all the time. I tell him when something’s wrong, and we talk. I mean, when we’re together it’s
excellent. We’re often just sitting around watching TV, and we love to play jokes on each other. And we have a daughter now... a dog.

Tom, an HIV-negative partner, echoes the importance of sharing time:

When he was in the hospital it was scary. I was just really afraid I was going to lose him. I didn’t know what I was going to do if he was gone. We do so much together. We spend basically all our time together. When I’m not at work, we’re together.

Adam, an HIV-positive partner states:

We spend a lot of time together. We like to go out to the state park to hike, and we travel together. To me that is a big part of the relationship. Sex doesn’t necessarily hold things together.

Daryl, an HIV-positive partner, notes that he and his partner make an effort to spend time together every evening. As a result, they have even developed a shared hobby of video-taping television comedy shows. Daryl explains:

And at nights we make sure we have at least two or three hours to sit together, watch TV, like Seinfeld, comedy shows. We like sitting together and watching them, tapping them. We keep a collection of tapes, you know so we’ll have them, the series. Stuff like that.

Finally, Jake, who is HIV positive, explains that because he and his partner both are not working, they spend virtually all of their time together. Jake expresses concern that they could be too enmeshed in their spending all of their time together which was problematic in his last relationship:

He’s not working right now. He broke his leg back on St. Patrick’s Day, and he’s had problems with it. It didn’t heal right. So right now we spend a lot of time together. And I was concerned about that. I thought, “Well gosh, is this going to be too much?!” But for me it’s not, and it doesn’t seem like it for him. Because when I’m gone, he says, “Well, when are you coming back.” I don’t know if we’re getting too dependent here.
That happened with my last lover who I took care of. And we got to the place where it was really irritating. I couldn't go to the grocery store without knowing he would watch me, and say “When are you coming back.” I hope it doesn't get to that. It hasn't yet.

**Social networks.** In addition to spending time together, another maintenance strategy that was found to be important for these couples is the use of social networks for both social support and social validation of their relationship. Knapp (1984) asserts that, in the process of becoming a “couple,” individuals not only form an interpersonal commitment between partners, but also must seek social validation of couple status from others. Knapp has termed this social-coupling process “social bonding” (1984, p. 41). Formal public validation for heterosexual couples most often takes the form of legal or religious marriage. The marriage ceremony itself is public recognition and validation of couples. Validation by social networks continues to be an important factor affecting maintenance throughout couples' relationships.

Haas and Stafford (1998) found that, due to the inability of gay and lesbian couples to obtain legal recognition of their relationship, more informal means of social recognition and validation are sought out as an important component to maintaining these relationships. Increasingly, some gay and lesbian couples are engaging in “commitment ceremonies” as a more formal means of seeking social validation of their relationship. Within this sample, participants did report utilizing social networks for validation of the relationship. For example, Ed, an HIV-positive individual, explains that, in addition to support regarding HIV, he also wants family network support for his gay
relationship. He explains that he and his partner exchanged vows in a commitment ceremony. His partner’s family attendance was very important to him. Ed recalls:

Last summer Larry and I had a big wedding in the park. There were 20 people, Channel 6 and Channel 10 were there, I mean. It was really beautiful and wonderful and every member of his family showed up including his dad. Even though they came, they were constantly having to remind you that they accepted you. I’m not sure how they really feel about that. But at least they did it. So it was lovely to me.

Similarly, Jerry, who is HIV positive, recalled that his family also showed support of his gay relationship with an ex-partner by attending a commitment ceremony. Since then, they have supported his latest relationship as well. Jerry suggests that this type of social network support is important to him:

My other partner that I was telling you about, we had a wedding ceremony and they came to that and were very supportive. They’ve always been supportive through everything. Before that point I had nobody and my mother knew that I was HIV positive, she said if I ever got sick that I could come stay with them and she’d get me through it. And then I met Tom along the way. So, they’re very, very supportive. We were just up there again last weekend because my one foster brother lives in Michigan and his wife’s going to have a baby in June, so Mom threw them a shower and I hadn’t seen them in eight years, so we drove up again for that. So, they’re very supportive in everything.

For others, having a social network of friends was particularly important. Several participants explained that having a network of friends served both as social recognition of their relationship and as a connection to the support of a gay community. Social isolation is a frequent experience of PLWHs (Folkman & Wrubel, 1997) and having a network of gay friends was an important means of retaining social connection outside the relationship. Dave, an HIV-negative
partner, recounts that he and his partner made a conscious effort to increase their social networks to combat social isolation:

I didn’t have any access to the community. This was frightening, very frightening to me. And I certainly didn’t know how I would possibly access that alone at this point in time. And I don’t just mean necessarily sexually, although that too. But just socially. Companionship. Our main sources of companionship have been each other. So that was pretty frightening. And I think he was frightened for me about that. But also to get us off of our butts, just trying to get out. So that was kind of a plan I made. Now, we go out a lot. We have a whole series of new acquaintances and developing some really decent friendships out of it. And exploring other people and ourselves through other people, how we interact with others. So it’s like a whole new thing. So in that aspect, it’s been really good for me to. And us. So now I’m beginning to recognize there’s a lot more. Like, “God, life is short. Get going.”

Gary, an HIV-negative partner, explains that he and his partner have many single gay friends and that he feels they look up to his relationship as a role model. He feels this helps support his relationship. He states:

We have lots of single friends, not gay couples. I think they look up to us. If we can do it, then, you know, maybe they can. A lot of them have been together maybe six months, time-wise, and that’s it. It does take a lot of work.

In a similar way, Daryl, an HIV-positive partner, explains that many of their friends are also single. He describes how he and his partner make an effort to have parties and stay connected to this social network of friends, however, because many are single there is a tension related to being a couple in a group of single friends. He explains:

We have parties. Like his 40th birthday’s coming up. I’ve got something nicely planned. I just had my 40th the other day too. Real nice one for me. So we do a lot of things. We had a Super Bowl party. We have a Christmas party every year for our friends. Yeah, most of our friends are
single. Half of them are HIV positive. Half of them’s not. But they’re all single. And they’re all out at the bars five to seven days a week. And it’s kind of hard for us to get along with them being a couple like we are, you know. The way they party so much, it’s hard to get along with them. We see them when we want to.

Ed, an HIV-positive partner, points out that their network of friends has been seriously diminished due to AIDS-related deaths. Ed explains:

We have good times with several friends going and coming. We try to stop going out to bars. We have very good friends. I was thinking about this today. We really don’t have any AIDS friends anymore. They’ve died, which has been hard. We’ve had to go through together several people that we loved.

In general, participants described a fairly quiet home life spending much of their time watching TV and just being together. And yet ties to social networks also are important to them. Brian, an HIV-negative partner, explains:

Together, we sit at home and watch a lot of TV and movies. We’ll go out for the occasional meal. Have little parties for friends and that sort of thing. Last year or so, we’ve gotten into playing cards with another couple. Our landlord and his partner come up and we play various card games and dice and this sort of thing. So we’re together sometimes, and sometimes we’ll switch off partners and, you know, play against one another. Board games, that sort of thing. So we do that together. Occasionally go to some dance performances.

And William, an HIV-positive partner, says of he and his partner’s social network interaction with friends:

Our lives are pretty quiet. We do socialize a lot with friends and we go out occasionally. We do drink. Not, I don’t think we’re drunks, but we go out and party and have a good time, dancing. But mostly with friends, dinners, that sort of thing.
Talk of Day & Calls/Letters/E-mail. Finally, an area of routine maintenance behaviors which couples reported using regularly were more informal means of communication throughout the day. These behaviors involved talking of the day’s experiences, phone calls, notes/cards/letters, and use of electronic mail. These regular, more mundane forms of relationship maintenance also were reported by couples in Dainton and Stafford’s (1993) study. These maintenance behaviors revolve around the use of informal means of communication to stay in contact with one’s partner throughout the day. For instance, talk of day involves informally recapping daily experiences through face-to-face interactions so that partners feel they are informed of each other’s life experiences. In addition, couples report utilizing mediated forms of communication such as phone calls and written exchanges through notes/cards/letters or electronic mail to inform one another of information or feelings about each other.

Ted, who is in a concordant relationship, explains the frequent use of talk of day in his relationship, “first thing we do when we get home is we talk about what we did at work, and what’s going on, and what we’re mad about. Things like that. So we do communicate pretty well.” Ed, an HIV-positive partner also explains, “there is something we do every night, when he comes home we just kind of end up talking about personal events of the day.” Ed adds:

Larry really needs to talk about work for a good hour, and it really gets to a lot of people. I enjoy it. It doesn’t bother me. In fact, it helps me. I know what’s kind of going on. If I don’t keep up, sometimes I don’t understand what he’s angry about when he gets angry or something. Somehow I am the person who has to like...I mean, that’s how you know
people, by their trivia, not by their, the big stuff’s usually a lie or an accident.

And Brian, an HIV-negative partner, thinks an important connection with his partner is that he is more willing to listen to him about his day than past relationships. He states:

He listens to me which is a big plus. I work for an eye surgeon, and there’s a human side of that that I can’t help but bring home when shitty things happen to nice people. And that’s difficult at times and he’ll let me vent at the end of the day and listen to every little thing. And that’s therapeutic for me. That’s kind of purging the day and getting it behind me. He’s been more receptive to that than others I’ve dated.

Participants also spoke of the importance of mediated forms of communication to stay in touch, involved, and concerned about each other throughout the day. For example, Daryl, who is HIV positive, talked about how his partner calls periodically throughout the day to check on his adherence to his medication regimen. Daryl states, “He calls to make sure that I’m Ok or ain’t laying on the floor somewhere and that I’m taking my pills right.” Tom, an HIV-negative partner, explains that his partner calls him throughout the day to keep him informed of changes in his health status. This can be positive when the news is good, but also upsetting if the news is bad. As a result, he had to ask his partner not to call him at work with bad health news because it was making it difficult for him to perform his job. Tom explains:

I talk to him probably at least six times a day during the day at work. And he’ll call and say, “Oh my blood counts went from this to this, and my T-cell went from this to this.” I say, “Well, that’s good.” I don’t remember the numbers, but I remember that they’re good or bad. But when they were bad, I’d say, “You really could just wait until I come home to tell me
that stuff." Once I told him that he would have to tell me when I got home he couldn't call me at work with that. Sometimes he still would though. It's habit, you know.

Other informal means of mediated communication involve the use of notes, cards, and e-mail to stay in contact and express caring for one another. Daryl, an HIV-positive partner, explains, "He likes to leave me little love notes and stuff, and so I started leaving them back, and he appreciates stuff like that, just little teensy things." Dave, an HIV-negative partner describes how he and his partner started writing notes to each other in a journal:

There's rarely a morning that I don't leave a note at some point. In fact, he finally got a journal so I could just make my notes. It can be as simple as have a nice day. Don't forget we're having this tonight so take it out of the freezer, to our conversation about how he feels about sex. It kind of runs the gamut. It's whatever is happening. We've had some really interesting communications. We're able to make a connection. Also, we almost always call.

And finally, Ted, who is in a concordant relationship, describes a use of electronic mail and calls to stay in contact with his partner daily while they are at work. He explains:

Sometimes I'll send him e-mails. But I think he does more than I do. He's more of a romantic person than I am. I just don't think about it. Once he does something romantic, I'm like I should've done something like that. He'll like send me e-mails a lot. He makes it a point to call me almost every day. I don't call him because he's really not allowed to have phone calls at work. He doesn't have a phone at his desk. And I do.

Overall, couples in this study report the use of several maintenance behaviors found in prior research. These findings provide initial support for evidence of the Canary and Stafford/Dainton and Stafford maintenance behavior
typology in gay male couples dealing with one or both partners being HIV positive or having AIDS. This analysis adds to our understanding of the types of actual maintenance behaviors utilized in the daily life of these couples. The specific maintenance behaviors participants reported in this study were equity in shared tasks, openness, favors/positivity, assurances, affection, sharing time together, social networks, talk of day, and use of calls/letters and electronic mail. The reported use of these behaviors by gay male couples coping with HIV/AIDS provides additional support for the generalizability of this typology in more diverse populations.

The Effect of Stigma & Social Support on Relationship Maintenance

Stigma

Research question four addressed, “What social or relational issues affect maintenance behavior enactment for these couples?” One of the major relationship maintenance challenges couples coping with chronic illness face is social stigma. Goffman (1963) argues that stigma is rooted in issues of a “spoiled identity.” Goffman suggests that the stigmatized person is seen as tainted, discredited, and abnormal. Stigma can be based in three types of abnormality: (a) physical irregularities, such as illness or disease; (b) psychological abnormalities viewed as unnatural, (e.g., mental disorders, addiction, homosexuality); and (c) group stigma rooted in differences of race, ethnicity, nationality, or religion (Goffman, 1963). Persons living with HIV/AIDS report being subjected to a double stigma of physical and psychological abnormality.
due to the AIDS disease and its association with homosexuality and IV drug use. In addition, ethnic minorities report facing a triple stigma (Jackson & Yep, 1996). Stigma is manifest through direct communication that condemns the stigmatized individual’s identity as abnormal, or through communication avoidance which often results in the social isolation of stigmatized individuals (Biordi, 1995). Alonzo and Reynolds (1995) suggest that the degree of stigma experienced by PLWHs varies based on the stage of the illness; as symptoms become more visible the amount of stigmatizing “abnormality” increases. Powell-Cope and Brown (1992) found that stigma is not only experienced by PLWHs, but also their family members and significant others due to guilt by association.

To maintain their relationship, couples coping with HIV infection must manage the effect of stigma and social isolation in their lives. Several participants in this study reported experiencing as much stigma associated with homosexuality, as is tied to the AIDS disease itself. As a result, participants are very careful not to reveal their homosexuality or HIV-positive status to persons who were not close to them. Corbin and Strauss (1984) have referred to this strategy as “passing.” When symptoms are not observable to others, PLWHs may choose not to disclose their HIV status in order to avoid stigma. For example, John, an HIV-positive partner, explains that he would rather hang out at the local bar without his partner because he fears gay stigma will be assigned. John states:

It’s better that we don’t go together because I would get weird feelings. It’s like I say when we’ll walk in a straight bar, “Everybody knows, but they don’t want to see it.” That type of thing. There are friends of mine
that come to our house and stuff like that, but you get different stuff with different people.

Steve, another HIV-positive person, explains that he experienced gay stigma at an auto mechanic's shop receiving sub-standard service. Steve states:

I was in a car accident last St. Patrick's Day, and took my car to the XYZ body shop. They screwed me over, and I was pretty sure it was just because I was gay. I had a rainbow sticker on my car and I think they hassled me about it. It took 9 months to resolve the issue. I had to go through the state attorney general's office.

Ed, an HIV-positive partner, explains that he does not necessarily experience stigma related to having AIDS as much as stigma related to being homosexual and the fact that homosexuality is identified so closely with HIV/AIDS:

I don't see the issue of having AIDS as more special than being straight and having a wife with cancer.

Interviewer: What I'm interested in is if you think people treat people with AIDS differently than they treat say someone with cancer.

Yes, but that's because even before they had AIDS, they treated them differently because they were queer. I mean, that stigma keeps going.

Several participants commented on feeling the need to engage in "passing" strategies to avoid being stigmatized by family members and co-workers. Phil explains how he and his partner, Keith, purposely avoid disclosing Phil's HIV-positive status to Keith's family for fear of rejection and stigma:

Keith’s parents don’t know my situation [an HIV-positive status]. I just, I don't want them to know. Because I'm afraid that they would think ill of me. You know, “What are you doing dating my son? Are you trying to give him this disease? I don’t want him with you.” You know. And they like me. They’ve always been very kind to me. But I just don’t want them to know. And I don’t think he does either. But he would tell them you know if he was positive. We already discussed that.
In a similar way, Ken, an HIV-negative partner, explains that he also does not disclose his partner Adam’s HIV-positive status for fear of stigma from others in his interactions with them:

Just because as open as people think they are or try to be or whatever, I think there’s just still such a stigma for a lot of people, a huge stigma. And I don’t want to have to see that and I don’t want to have to sit there and think are you doing this because you know and are acting differently, and I don’t want it to start. I think it could cause me to be very paranoid. I’d start examining everything a person did or said.

Interviewer: OK, so you don’t want it, the HIV, to become a focus of your interactions with others.
Right. I don’t want him to be looked at as a victim. You know. I don’t want any of that. I want us to just live normal lives.

Still other participants describe blatant stigmatizing treatment by others.

Chris, an HIV-positive partner, describes being kicked out of his family’s home upon their discovering he was gay. Chris’ mother initially had difficulty accepting his homosexuality and HIV-positive status. Chris explains that over time she has become more accepting:

My mom, she’s a typical mom. She is better with it [HIV] now. But she wasn’t so well with it at first. She wasn’t so well with it when I told her I was gay either, you know. But when I came out, I came out. Told all my friends. I didn’t tell my parents. They found out quite by accident. But everything I suspected would happen did happen. Dad kicked me out of the house. I didn’t talk to him for a year. That was another story. But mom was always supportive, you know. There was times I needed things, I’d call her. She would help me. I needed a winter coat, she’d buy me a winter coat, you know. She’d say, “Don’t let your father know.” You know, that kind of thing. When I told her, when I discovered I was HIV positive, she wasn’t so nice, “That’s what you get for messing around with them damned boys.” You know, not the kind of support I needed to hear, or wanted to hear. I was very hurt. I didn’t talk to her for a long time. But things have changed, we’re very close now.
Daryl, who is HIV positive, describes going to dinner at his brother’s house and feeling stigmatized when his sister-in-law kept his plates and silverware separate after dinner so she could specially sanitize them. Daryl explains:

I went to my little brother’s house once, and his wife had made dinner for us and stuff. And she had just, it was two weeks after I was out of the hospital and I was still on antibiotics. I went over there with my mom and my little brother. Well he was already there. And his kids and his wife. And then when we got done with eating, I noticed she took everybody’s dishes away except for mine. And then mine was the last one she took away and she put it over to the side of the sink. And I thought why’d she do that. And silverware I was eating off too. So I didn’t pay no attention to it and then about 10 minutes later I went back to the kitchen to get a glass of water and I seen my plate sitting in a bunch of Clorox with the silverware. And I thought, well she thinks she’s going to catch something just off my plate. And it upset me a little bit. And I never said nothing to it, other than my mom when we left. Lord knows she probably said something the next day, but my sister in law never did it again. I mean, she’s been real different.

In the African-American community, there is believed to be even more cultural stigma surrounding homosexuality and AIDS. In one concordant couple, Reggie explains how his partner, Leon, struggled with accepting his own homosexuality, and his family’s attempts to convince him he was not gay.

Leon’s family actively encouraged him to engage in sexual activity with women. Leon, who was already HIV positive, followed his family’s advice, unfortunately without practicing safe sex. Reggie explains:

Leon was still questioning his sexuality. I said, “You cannot be with me and then try to be with the girl down the street because you don’t know what you got.” And unfortunately, he went and stayed with his family and they tried to tell him he was not gay. And they, of course, threw some girls on him. And I know for a fact Leon didn’t use protection with those two girls. But right now, it’s just like signing a death warrant to go and try to tell them that he has AIDS, you know, sick, he’s sick. To go tell
these women who have babies, not his, but have little children that look, “Leon is sick.” That’s just signing their death sentence.

In addition, several participants report experiencing stigma in the workplace. Leon, who is HIV positive, describes experiencing open harassment on the job:

What really bugs me are people at work. Like a lot of them know I’m gay and there are some that don’t because I really don’t talk about it. I mean, that’s none of their business. And I hear, “faggot this, and faggot that.” I’m like, “Man, if you had any common sense you would just treat people the way they want to be treated.” You know what I mean? You don’t go around calling people this and this and this. I just treat everybody like I want to be treated. Regardless if they’re gay or not. You know, I’m not after any of them. I got who I want to be with. But they just don’t understand that, and that’s the biggest thing that really makes me mad because they don’t really understand gay people.

Brian, who is HIV negative, explains that he is not comfortable telling people at work that his partner is HIV positive even though he works in the medical field.

Brian states:

I avoid telling people I work with at the hospital because he’s at all the functions. I mean he has been from day six. Five days into dating and I’ve got an office party to go to, so what the hell, I’m like, “This is my date,” you know. So yeah, even though they’re medical people, you still get narrow minds.

In general, participants in this study reported commonly experiencing or fearing the assignment of stigma in their lives. Stigma surrounding HIV/AIDS and homosexuality were interconnected for these individuals. Couples report this double stigma manifesting as an additional stressor in maintaining their relationships. One important means of coping with stigma is achieved through
seeking out social support. The impact and importance of social support in these couples lives will be addressed in the following section.

Social support

Research question five asked, “What are the predominant sources of social support for couples coping with HIV/AIDS?” Consistent with previous studies (Catania et al., 1992; Freidland et al., 1996; Hays et al., 1990; Johnston et al., 1995; Katz, 1996; Powell-Cope, 1995, 1996; Turner et al., 1994; Wrubel & Folkman, 1997), in this sample relational partners and very close friends were the predominant source of social support for PLWHs. In addition, evidence of families, especially mothers, providing support was found. Past researchers found little evidence for family support largely due to AIDS stigma, thus, these findings may indicate a slow shift towards greater acceptance of family members living with HIV or AIDS.

Partner support. Regarding the support provided by relational partners, PLWHs in this study repeatedly underscore the importance of their partner’s support as they dealt with HIV or AIDS. Relational partners are a source for all forms of social support proposed by Cutrona and Suhr (1994): emotional, informational, tangible, esteem, and network support. Importantly, for many of the PLWHs in this study, relational partners serve the crucial role of confidant and companion that they feel helps them cope with the stressors of HIV/AIDS, and life in general. One HIV-positive person, Adam, states of his HIV-negative partner Ken, “He definitely provides me with support. Just by being there and not running from me. He’s very concerned about my health and that I stay
healthy. If he weren't he wouldn't be there, he would be gone.” Ted, who is in a concordant relationship, explains, “Chris is my primary support. If something was stressing me out, he's the first person I'd talk to.” Chris, Ted's partner, echoes this sentiment stating that Ted is his primary confidant, and his mother is second, “If I was worried about my health, I would talk to Ted first. But I would then call my mom. There's two other people I'd call too, but first I would talk to Ted.” William, who is HIV-positive, describes how important his HIV-negative partner Peter's companionship is in his life:

With Peter, things are so easy. I've had other relationships. I've been HIV positive for 10 years. And I've had two other relationships in that time. And with him, nothing ever seems to bother him. He's always there, he's always attentive, he's always compassionate and loving. I mean, I would be hard pressed to say that things could be much better or worse than they are now. He's just, he's just always there which sometimes amazes me even now being together for over a year and a half, and I'm just amazed sometimes that he deals with things as well as he does.

Jake, an HIV-positive individual, explains how his HIV-negative partner, Bill, showed him support by visiting him in the hospital despite the fact that Bill was wheelchair bound at home with a broken leg:

I was amazed with him. You know, I knew how much he cared, but I was hospitalized and he was still in his wheelchair at the time. He wheeled himself down to the hospital which is about a mile. That said so much, and showed his concern.

Daryl, who is HIV positive, detailed several of the forms of support his HIV-negative partner Gary provides. Daryl also underscores the importance of reciprocating support within his relationship:
Usually Gary first, and then my mother. He's always first. He works, keeps a good job. He brings in money. You know, like I said, the VA pays all my bills. I don't get no money. If I need money, I just ask Gary for it, you know. I pay the gas, rent and electric. He don't, I don't ask him for half of everything. I just, when I want money, I say, "I need twenty dollars for this" or "I need thirty dollars for that," you know. He gives it to me, no questions asked. That's supportive, you know. He does my laundry. We share household duties. I do dishes, he does laundry. The cat box is mine, because the cat's mine. The dog's his. He's got to let it out. Share, you know, divide, makes me feel supported that way because he's supporting me in what I'm doing and I support him at his job and what he's doing.

Other PLWHs explain that their partner's support was important in combination with the support of others. For example, Andrew, who is HIV positive, states:

There's really no one per se. It's, with me it's a combination, several pieces of the whole. Matt certainly is a major part. A really good friend of mine, Janet who helped me get my life back together and has adopted Matt too. And my therapist who is also a part of it. They're the ones who have really helped me keep together.

Jerry, an HIV-positive partner, describes a similar matrix of individuals making up his support system in addition to his HIV-negative partner Tom. Jerry states:

Tom's the most supportive, you know. But my disability is a dual diagnosis because I have AIDS and severe depression and high anxiety. So I go to XXXX [a clinic] and I get my drugs through them for that. And I have a counselor down there, so I get it there and then I have XXXX [a social worker] who is with XXXX [an AIDS service organization]. And he's my case worker and everything, and he helps me through it. He needs a push to get things done and you know Tom calls and talks to him.

**Friend support.** Close friends also served as a main source of support for the PLWHs in this study. Jerry, who is HIV positive, explains how his close
friend prevented him from committing suicide when he was diagnosed HIV positive:

I wanted to commit suicide that night when I found out. But I had a friend that I went over to and we got drunk til we passed out. She helped me through that. It's so funny, I mean, looking back at it now all this thing. Now I'm fighting for my life now that I have AIDS and stuff, and there I wanted to end it.

Jerry goes on to explain that when he was hospitalized with an opportunistic infection and feared he was near death, he turned to his friends for support.

Jerry says:

Well, I've got friends. That's why my one friend flew here from Louisiana, she didn't really have the money to come up here but I just told her on the phone because I'd probably never see her again, you know. And I was pretty depressed when I was in the hospital. So I called people and talked to them.

Dennis, a partner in a concordant relationship, addresses the fact that his partner Todd still relies on his best friend who lives out-of-town for support. Thus, proximity was not a requirement for this person to be considered part of Todd's support network. Dennis explains:

He has a friend in I think she's in Indiana or something like that. Well that's where he's from, Indiana, so she lives in Indiana, that he goes to visit sometimes. I think he's going to be able to visit her next weekend when he visits his dad. But other than that, it's basically just the two of us.

Similarly, Steve, who is HIV positive, feels he has access to several close friends who are sources of social support. Steve states:

Scott, or my two friends Tom and Jim, my landlord and his partner that come out and drink with us a lot, I've got a lot of friends, all my friends have always been very supportive. Always.
Interviewer: You say a lot. Like, how many? I mean are there people that you would call up if you had a problem?
Close, close friends, well I can count them for you a lot of my friends if I had to. I would say there's probably at least off the top of my head three or four close friends that I could contact if I had any problems or I needed anything. One of them, my best friend, she lives out of state. But if I ever needed her, all I have to do is call.

Andrew, an HIV-positive individual, explains how his friends pitched in to provide tangible support to himself and his partner Matt during a hospitalization. Andrew reports feeling that his friends are supportive to he and Matt as a couple, not just as individuals. Andrew states:

We both have, as I said, a number of friends who have been wonderful with us. And friends who I've made who have sort of adopted Matt too, and they're always looking out for him. They step in and try to pick up some slack if there's really something big going on. Even if it's just to make dinner and bring it over. In fact, I remember there was one time last year when I had surgery and I was in the hospital for couple days. It was supposed to be outpatient and things went bad in the operating room, so they went ahead and admitted me. A couple of our friends called to see if there was anything they could do. And I said, "Yeah, there is. You could help me and Matt by bringing us dinner so that he doesn't have to cook." They did every night I was in the hospital. And just things like that have been a great support to both of us.

George, who is HIV-positive, discusses how helpful it can be to have a network of friends, especially other HIV-positive friends, with whom one can talk. He underscores the importance of feeling connected to others as he deals with HIV:

There's several friends, some are couples and some are not, that are close to us.
Interviewer: And is that important for your relationship, do you think? Yeah I think so. Keeps you from killing yourself. No, you know, it's nice to have people around. You know, it's hard to talk to other people. And I don't know, it just feels better having people around every day. They're like me and him, and you can talk to them.
Interviewer: Are any of your friends HIV positive?
Yeah. Well, yeah, a couple of them. You know we kind of keep check on each other. You know how you call them, they’ll call me. Like when I was sick with cancer and stuff, they called me a lot, wanted to make sure I was getting along all right and everything. And if one of the others, if somebody will flare up I’d do the same thing. I think it makes you feel like, you know, somebody’s around and cares.

Family support. Several individuals report that their friends provided support that was lacking from family members. This finding that family members can be hesitant to provide support to PLWHs is consistent with previous studies of PLWHs (Turner et al., 1994; Wrubel & Folkman, 1997). For example, Powell-Cope and Brown (1992) found that family members often take on the stigma associated with HIV/AIDS once they become involved in the support and caregiving of PLWHs. They also found that family members may have difficulty providing adequate support due to fear of infection or lack of education. Biordi (1995) suggests that family members may resist the stress of becoming too closely involved in the lives of the chronically ill, often resulting in the social isolation of the ill person. In this study, the support of families was mixed, some family members were quite supportive, and others quite avoidant. For example, Alan, who is also HIV positive, describes how his partner and best friend have become his primary sources of support because his family remains uninvolved:

I have a very small circle of support. Dave is number one. The second person is my best friend John. And he’s been the best friend that you can imagine, very supportive and understanding and compassionate. He’s full of really good things. He’s a really good man. My family has been absent through my life. My father due to my sexuality has chosen his own route, to go his own way. I finally saw the light and was able to have the
courage to divorce him because he was just a very negative person in my life.

Adam, another HIV-positive individual, details the fact that his family is in denial about his disease, and seem to believe it has gone into remission. As a result, he relies on his HIV-positive friends for support. He notes:

I’ve told quite a few friends. My family, they don’t really discuss it. They act like they were very interested in knowing, and that they offered to help, but they really haven’t, I guess they feel that I’m in remission more or less. They haven’t really offered that much. Occasionally friends that are HIV positive will ask me how, you know, how are my results, what’s going on with it and things like that. So as far as a support group, I do have some friends that you know would support me and that are in a similar predicament. Well, in recent months, I haven’t been seeking a lot of information, but prior to that when things were going bad as far as a skin condition and things like that, you know, there is a couple friends that I would call and we’d talk about it. I’m really kind of a private person and so I’m not constantly calling them, you know, calling friends to ask for support.

The sentiment of a lack of social support from family members was a recurrent theme. Dennis, who is in an HIV-concordant relationship with Todd, explains that Todd does not have much support from his family due to the double stigma of AIDS and homosexuality, possibly combined with a fear of infection:

They know that he’s gay, and that he’s positive. They kind of accept it, but they don’t want to, you know, they don’t really talk about it or want other gay people in their house. I don’t know maybe they think they’ll catch it or something, I don’t know. But so his family’s kind of weird. He doesn’t talk to them.

Several of the families of HIV-negative partners seemed to also avoid the issue of HIV or AIDS. Joe, an HIV-negative partner, states, “His family is somewhat
supportive. My own family’s a little different. They’ve been OK. But I think they’ve, it’s easiest for them if they don’t think about it. So they don’t think about it.” Similarly, Ed, who is HIV positive, explains that his partner Larry’s family is pleasant to him, but uninvolved. Ed asserts:

I think Larry’s family is very big on not saying a lot. They’re very, they’re very nice. I mean if he gets a card or something, it’s always to both of us now. But I don’t know how much they know related to AIDS. We really don’t have much contact with them.

Two study participants explained that the lack of family support experienced was tied to peculiarities within their families. For example, Martin, an HIV-positive participant, explained:

My mother, she calls me once in awhile and says, “Are you still alive?” I say, “yes.” She says, “I do love you.” I say, “yes.” And then she says, “I’ll call you again.” I say, “I still love you too, bye.” That’s it. I have a very strange family.

Bill, an HIV-negative partner, suggests that his HIV-positive partner’s family has a history of suicide in the family, and therefore, avoid taking on excessive stress. Bill explains, however, that his own family is supportive:

His family doesn’t come up much at all. I think he’s the youngest. I think he’s had a lot of trauma in his family. His family if I remember right, is suicidal and all, a family trait. I have a real close family, they all stick together. His family is not. My family’s really supportive to both of us. His family, I don’t know if they’re supportive at all.

In addition, although some participants described a lack of family support, an important finding in this study was an overall increase in family support compared to past research findings. Several participants reported that
their family and their partner's family do provide support for them as they cope with HIV/AIDS. This finding may reflect an increase in HIV/AIDS education regarding transmission risks and a decrease in family-imposed HIV/AIDS stigma. For example, Joe, who is HIV negative, explains that his partner Alex was quite hesitant to disclose his HIV status to his family for fear of rejection. Joe details that despite lacking a complete understanding of HIV/AIDS, Alex's family has turned out to be generally supportive. Joe explains:

Yeah. His family is very, very close. Has been. And he was afraid to tell them at first primarily because his mother, his mother's a worrier. We knew that she would worry about it. I understood that. She's way out in the country, this whole gay thing and this whole AIDS thing, the AIDS thing would be really scary. I understood that, although I felt like he needed her support. So I didn't press him on telling her, although he was kind of getting my message. But he finally did tell them. He wasn't going to tell them til he got real sick, but he did. He told his mother first. And she was very supportive. Immediately. I was not in the room actually when he told her. But no there was never a, as we've seen with other people, a drawing back and a disowning, or "I'm disappointed in you" kind of situation. It was basically "you're sick, and we need to pitch in and do what we can do to help you get better."

Peter, who is HIV negative, describes a similar response from his partner's family. Peter states:

He's got a great family. They're pretty much in denial about the whole thing, but they're very close. We were just down there for Easter. And his cousin was there, his aunts were there, his sister with her little family, and mom and dad. Family had dinner there. His family is great to me. They all know about the sickness and his mom calls a lot, once, twice every week to see how he's doing. And, I mean, he'll tell her when something happens also. He's pretty open with her about it. He has some of his medicine delivered down to her house. When he knows he's not going to be at our house, the one that has to be frozen.
Gary, an HIV-negative partner echoes this in the support of his family. He explains that their support is important because many of his friends have died from AIDS. Gary states:

My parents are a lot of help. Some friends. We talk about it. They, they’re open, we do talk about it. They’re always there if I need to talk. Most of my friends that I would talk to are dead.

Leon, who is in an HIV-concordant relationship, asserted that his partner Reggie’s family originally tried to blame him for Reggie’s HIV status. Leon explains that Reggie’s family became more and more supportive with time, although they still are not comfortable with their gay relationship:

Reggie’s family? Everybody, everybody’s supportive. They come, they ask me questions because Reggie won’t talk to them sometimes. And they’re like, “Is he doing this?” And I’m like, “Yeah, he’s doing this and this and this.” And they go, “OK. Just as long as you’re watching.” I think that’s really, really important for the person that has HIV to have people in their lives like their family that come together, things like that. Because there’s no sense in just trying to put blame. You can blame and blame and blame all you want, but you’ll never know exactly where you got it from.

Dennis, who also is in a concordant relationship, asserts that his family is emotionally supportive in times of crisis, and yet on a day-to-day basis his partner provides him most of his social support. Dennis states:

My grandmother, my father, my sister and my cousins, my aunt, my two nieces, they’re all real supportive, you know. I don’t pick up the phone and say, “Oh God, you know what.” But, like when I was in the hospital, everybody was worried. I called them at home and said, “It’s really nothing serious.” You know, I really didn’t think it had that much to do with AIDS. It just was one of those things that happen. And so yeah, they’re all supportive. But Todd on a day-to-day basis, he’s real supportive. He’s normally, he’ll ask, you know, are you feeling OK? How was work? And things like that. So he is supportive.
Andrew, another HIV-positive individual, recalls that he was hesitant to disclose his HIV status to his partner’s family for fear of stigma. He recounts that his partner’s family has turned out to be quite supportive in times of crisis. Andrew explains:

I didn’t really want to worry his parents, that kind of thing. And so now that they know I’m positive, you know, they’ve been really wonderful. They helped out different times whenever we needed it. Someone to bring the food for us. His dad came and picked me up from my doctor visit. They were really good about it.

HIV-positive individuals and their significant others may encounter stigma in their interactions with others if their HIV-positive status in known or revealed. PLWHs must endure the double stigma related to HIV/AIDS and homosexuality or IV drug use, and HIV/AIDS is still viewed by many in society as a disease of the “socially-undesirable.” To deal with social stigma, PLWHs often seek support from significant others who will help them cope with this stigma. Similar to past research, this study found that PLWHs consider a romantic partner or very close friends to be the most supportive. However, contrary to past studies which found families most often rejected family members with HIV/AIDS, with some exceptions, participants in this study report feeling their family members are reasonably supportive. This finding may indicate a slow shift toward increased HIV education and acceptance of family members with HIV or AIDS in our society. Further research is needed to investigate the possible scope of this trend in contemporary society.
Comparing Relational Maintenance Issues in HIV Discordant Versus Concordant Couples

Research question six addresses the issue of whether or not there are relational differences between discordant and concordant couples as they deal with HIV or AIDS. Differences were found in this study for several relational issues when comparing discordant and concordant couples. The most obvious difference between these two types of couples is a fear of infecting one’s partner for HIV-discordant couples which is not an issue for concordant couples. Fear of infection, particularly related to sexual activity, brings an elevated degree of stress to discordant couples that appears not to be present for concordant couples. Several partners in HIV-discordant relationships in this study indicated that a fear of HIV infection was a major issue for them in their relationship. For example, Andrew, who is an HIV-positive partner in a discordant relationship, explains that sex in his relationship is not fulfilling for him because his HIV-negative partner will not perform certain sexual activities. At the same time he understands the need for concern about possible infection, Andrew reports feeling a lack of emotional connection to his partner because of an unfulfilling sex-life. As a result, Andrew explains that sex has become much less of a focus of his relationship:

It’s affected our sex life. A lot of times it was a matter of being in the middle of something and saying, “Hey, I’m not comfortable. This isn’t cool.” And there were a lot of hurt feelings. And to be perfectly honest, I don’t think our sex life has ever been completely satisfying for me. Because of these barrier issues. There are things that we just, he will not do. And that’s been real hard for me. I feel like there’s a part of him that I’ll never know. And there’s a part of him obviously that I can’t be close
to physically, and because physically, I assume emotionally and spiritually. And it's, I don't know, it's so frustrating sometimes, but I know that's how things have to be. And of course after you've been together for eight years, sex just does not play a major role in your relationship. You know. We even joke about that, once a week obligatory sex. And it's like, OK, you know, all right, "So it's your birthday, OK. I guess I have to do this." We laugh about it, but at the same time it's like we're close in so many other ways.

Adam, another HIV-positive partner, explains that he gave the option for his partner to leave the relationship upon his HIV diagnosis. His partner has chosen to stay, but the fear of infection has affected the amount of sex in which they engage. Adam explains:

I just told him you know how it affected me and you know and I just explained to him that you know he being not positive, that maybe this isn't the best relationship or whatever. And him being very compassionate it didn't really matter. He, he loves me for what I am, who I am...I worry about infecting him. And also sex is not a main component of a relationship. Also, we just aren't as close as we should be in sexual desires. I want sex more much more often, and that's been a issue.

For these discordant couples, multiple issues can arise due to the fact that only one partner is infected with HIV. Other issues expressed by participants include imbalance in relational decision-making power, the stress of uncertainty regarding the life expectancy of the HIV-positive partner, differences in physical health experiences, and anger toward the HIV-negative partner because he is not infected. The couples in this study indicate that the fact that only one partner has a terminal illness can upset the balance of equity in decision making within the relationship. Several HIV-negative participants describe a habit of deferring to their HIV-positive partner's wishes because their life expectancy is shortened.
Bill, an HIV-negative individual, expresses feeling frustrated at times by allowing his partner more decision making power in their relationship because of his HIV disease:

The only thing that I would like to change is sometimes have my opinion voiced a little bit more than his. I find myself bowing down from a fight or let him have his way because he's sick. But he's no sicker than I am. He'll run to the store more than I will. He's so alive, and I'm just sitting here dragging. But he's cautious. A fear of infecting me, which I would feel the same way.

Brian, an HIV-negative partner, addresses the difficulty of not experiencing the same physical difficulties as his HIV-positive partner. These differences affect their daily life, such as not being able to eat meals together. Bill explains:

He gets sick to his stomach, this sort of thing, I feel real bad when he goes, four mornings out of the week stuck with his face in the toilet. The Crixivan is rather restrictive in it's schedule, so we're not able to be, we can't eat at exactly the same time. Maybe I'm famished. I didn't eat lunch that particular day and he can't eat for another hour and a half, two hours. I'll have lunch around 4 at that point, so that won't work. So he, that's disruptive. I eat, he eats. You know, we don't do a cooked meal or if we do we do it in stages. But, or maybe I'll just eat a sandwich or you know. Sometimes, it's good to eat together and other times we just have to eat separately. It's in the same place with each other, but just at different times.

Dave, an HIV-negative partner, explains there is an overall feeling of uncertainty for the future that pervades his relationship. Uncertainty about the longevity of his partner is salient for him. Dave describes the uneasy feeling of never knowing how long one's partner will live:

But I wonder if it's [his partner's death] going to be tomorrow too. It's like driving blind. I mean it's wonderful, but we don't know, we just don't know what these drugs will do. And it's so weird because you just can't put it in perspective, "yeah, but I didn't know I was going to get run
over by a truck.” But you never go back. Just can’t go back. And I’m very glad the drugs are working and that his health’s gotten better, and of course the depression that goes along with the disease. But I’m not sure which one’s worse, knowing or not knowing. It’s just, a weird box to be in. And neither one of us knowing that this disease is going to kill you. But I’m not sure that I could say that that’s a bad box right now. Is there another box? I’m not sure. And because you’re not sure, it’s such a weird feeling. We’re not used to that. You know, if we’re all human beings, we’re used to spending our years thinking that we’re all invincible, we’re going to live forever. You know. It’s a tradeoff. I perceive it as a tradeoff. That’ll probably change too. As time goes on I’m sure that will change. Again, it’s just that it changes. How is he going to feel when his time’s up. How is he going to handle the long term life times goals that he’s had for so many years. And now he just can’t make any decisions. How is he going to handle that. Are we never going to have sex again?

Andrew, an HIV-positive participant, expresses the feeling that his HIV-negative partner will never be able to understand what he is experiencing. These feelings originally manifested as anger toward his partner, but the anger has since subsided. Andrew explains:

As much as he is affected by all this, I don’t think he really truly understands what goes on in my mind. And no matter how much he loves me or cares about me, you know, he’s just never really going to know what this has been like. I guess that is a source of anger. Interviewer: Do you still feel that anger? No. No, I thank God that he doesn’t know and I pray he never does. I hope he stays negative forever.

Alan, another HIV-positive partner, notes that despite never having practiced safe sex with his partner, only he has been diagnosed as HIV positive. Both partners agree that they are in their relationship by free choice and that either partner is free to leave the relationship at anytime. Alan explains that he feels this freedom is what has kept them together:

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I thought if I ever get diagnosed or Dave, I think it would be best if it would be up to each of us to decide whether to go on or not as a couple. And unfortunately, or I guess there’s no unfortunate to it, but I was diagnosed. When Dave took the test and he turned out negative which was a shock because we had unprotected sex all those years, and he’s the passive partner, it just didn’t make any sense at all. Neither one of us still today would have thought about that. I was thrilled that he was negative, but in his own way he said he really felt that he would want to be positive too. I think a lot of that had to do with the care giver aspect I mentioned earlier. So I felt, and part of our relationship that’s worked is the honesty and the fact that at any time if either one of us want to end the relationship, there’s no stopping us. And if that would be another person, or this disease, or for whatever reason, we never had shackles around ourselves. We’ve always kept it that way. And I think that that reaction we had there was in direct answer to your question, was what kept it together, was the fact that we spoke openly about our feelings as much as we could while in a state of shock. There was I guess a little bit of a change for a period there where I felt like maybe that would be a good thing to do. And especially back to the care giver where I was thinking I would be a burden and I didn’t want to be a burden. I thought well maybe I should end it. But I didn’t want to.

In addition, several discordant couples expressed that sexual activity is not the basis of their relationship. Therefore, HIV status is not a central focus of the relationship. For example, Bill who is HIV positive, explains:

We, we have a very good bond and it’s not what you read about as you know lots of romance and all. I mean we’re totally casual about things. Not very sexual.

Daryl, who is HIV positive, explains that physical symptoms often interfere with sexual activity in his relationship, but that they try to deal with it:

There’s, there have been some times where it’s hard to do stuff because I get sores in my mouth and stuff. And I just am not good, you know. And I have to use mouth washes and stuff for two or three weeks at a time. And I know that’s bothersome to him and me both. Because you know the sex isn’t the same or you know somebody’s not getting what they want and it interrupts the, but you know, he learns to deal with it because he knows it’s part of it.
Concordant couples, deal with the stress of both partners being HIV positive, yet they report feeling tremendously freed from the fear and potential guilt of infecting their partner. Todd, who is HIV positive, explains that he had dated HIV-negative individuals but could not deal with the fear of infecting them:

I dated a couple of people in that two year period who were HIV negative. Hey, I couldn't deal with it. Maybe they were OK with it, but it's just too much of an issue for me. Way too stressful on all fronts. All fronts, my God, any sort of references to the future. My future, automatically my life seemed different than theirs. Sex was a nightmare. Because I felt incredibly responsible for my virus. And sexuality, psychologically, just a big old void from here to here. And God that would make it even worse. Even intimacy, non-sexual intimacy was a problem for me. Kissing. This person's kissing me too deeply. What if I cut their tongue with my teeth. They're pushing their tongue down. I started worrying a lot about that stuff. So that was all I could take. I don't have that with him.

Ted addresses the relief of being in a relationship with another HIV-positive person:

Knowing that Jeff was positive already, just relieved everything. I'm like OK. He's positive so there's nothing to worry about. You know. I mean, there's stuff to worry about, but that feeling of rejection. That wasn't one of the reasons why I wanted to get in a relationship. I, it was one, it wasn't, it wasn't a bad aspect, it was just, it was a better aspect, I guess. I mean, I wanted to get in a relationship because I'd always liked him

Several participants describe relational benefits to having a partner who is also HIV positive because they can understand each other's health experiences. For instance, Todd asserts:

We're real supportive and we don't, we're not really naggish with it. It's a very comfortable part of our relationship. And we've mentioned before
that we think it would be difficult to be in a relationship with someone who’s not HIV positive. We don’t talk about it much, though. But we’ve had that conversation.

Todd’s HIV-positive partner, Dennis, explains that both he and Todd being HIV positive is a special bond between them:

We’re both positive. But it’s kind of like there’s comfort in that in some strange way. If it just happens both people being positive. Kind of like a bond. Kind of like that whole thing because you know you deal with so many people like that say oh my God you know. You get so much, well from our community that once people have found out your positive, it’s just like, “Oh yeah, he’s dying.” You know. Yeah, and I come from a small town. When they hear the words, you might as well just buy caskets. But we just get up and live with it, you know, the pills and you know, of course I’ve been the one that’s been sick lately. Todd’s hardly ever sick. So and it just, you know I get mad a lot. I get mad at myself for being sick and I get mad at him for like, like this morning, he forgets his pills and we have to go back. And I do the same thing. And it brings a lot of worries, but I think at the same time it’s a lot easier for me being with him when he is positive rather than if he wasn’t. I think there’s a huge, there’s a huge comfort in knowing we’re both positive.

Also, medical researchers theorize that PLWHs may become infected by other mutated strains of HIV. These HIV cross-strains also may have developed resistancy to some HIV medications. Despite knowing the theories concerning potential HIV cross-strain infection, Chris describes accepting these risks and appreciating the sexual freedom of not practicing safe sex in his concordant relationship:

They say we should still be practicing the safe sex and we both have discussed it, and we really don’t. I mean what more can we get in my opinion, and he pretty much feels the same way. I mean, and the little that we do that could be unsafe, I mean it’s rarely there. So I think that thing about both being positive, it does, it eases the worries that I’m going to infect him. I mean, my last partner, every six months when he went, I know I was taking a day off of work, sick to my stomach. Because usually
he didn’t tell me until the day his results were due. So it was, “Oh shit.” But I mean, I don’t need to worry about it now. It’s like I said, we can’t give each other anything else that we don’t already have. And I mean there’s always worry on my part thinking, “Well, I’ve done almost every HIV drug in the gambit. If my resistant drugs or whatever could carry over to him?” But it’s more of a worry on my part than on his. So I mean it’s just easier. I mean that’s not something you’re always worrying about.

One important relational difference found between discordant and concordant couples revolved around how involved the couples are in the HIV community. There is evidence in this sample that concordant couples are much more likely to participate in the services of HIV/AIDS service organizations and community HIV/AIDS programs. For the HIV-discordant couples in this study, the need to normalize the illness was heavily influenced by the fact that one partner did not have HIV. As a result, there was a tendency for discordant couples to avoid HIV/AIDS services and community programs as a means of making the relationship appear more “normal.” For the concordant couples, HIV/AIDS services and programs (e.g., weekend HIV/AIDS retreats) were important relational functions to attend together. In this way, attending these functions may serve as an additional relationship maintenance strategy for HIV concordant couples that HIV discordant couples are not accessing. Chris, who is in a concordant relationship, explains he and his partner’s involvement in the HIV/AIDS community this way:

We go to do forums together. I mean, we go anywhere I want and do what interests us. I’ve taught him a lot of things. I got him to go to my doctor and he was happy there. I’ve got him involved with the clinical trials. I was very active before I went back to work. And he usually comes and helps on the local community AIDS newsletters and stuff. He’s
gotten involved. We don't really do much of like volunteering. But we do what we can together.

In another concordant couple, Ted and his partner, together, have become more involved with a local AIDS service organization and attend HIV/AIDS retreats. Ted states:

He was more involved with XXXX [an AIDS service organization]. I've started getting more involved with it since I met him. We go to their Healing Weekends together. But he was just like really involved with it before, now I am too.

Finally, one challenge participants report for concordant couples is the temptation to compare each other's health status. This can create a competitive atmosphere in the relationship which couples acknowledged can be problematic. For example, Ted explains:

I always want to know his results and I think he always wants to know mine. I don't know if he's always asking. I always just tell him. And then sometimes I think though, like since mine are better than his, I don't know if that upsets him or not. So I tell him but I don't actually, I just, you know, like nonchalantly, "Oh guess what." And with him, I always, I ask what his results were and test results. And I think it bothers him sometimes if mine are better.

In general, there appears to be a greater need for HIV discordant couples to engage in normalization of the illness than in concordant couples. In other words, there was a trend for discordant couples to be more removed from the HIV/AIDS community as part of the normalization process. For the concordant couples, both being HIV positive made HIV much more prevalent in their relationships. This may indicate that HIV discordant couples are failing to access
social support which is available to them as they cope with HIV/AIDS.

However, there appeared to be no difference in the length of relationships between these two groups, and therefore, it is unclear that access to the HIV community is a necessary relationship maintenance strategy. Future research is necessary to further investigate these findings.
CHAPTER 5

SUMMARY & THEORETICAL IMPLICATIONS

Summary of Findings and Recommendations for Future Research

To date, the few studies which have examined gay couples coping with HIV/AIDS primarily have focused on describing transitional issues involving loss and dying (Powell-Cope, 1995), and the impact of caregiver burden within gay couple relationships in the late-stages of the AIDS trajectory (Folkman, Chesney, Cooke, Boccellari, & Collette, 1994; Powell-Cope, 1996; Wrubel & Folkman, 1997). Because PLWHs are living longer through the use of protease inhibitors in combination with other HIV antiretroviral medications (Kelly et al., 1998), and prophylaxis for opportunistic infections, there is an increasing need for studies focusing on the psychosocial and relational issues facing PLWHs (see Greene & Serovich, 1998). Powell-Cope (1995) found that the primary concerns of PLWHs in her study were couple/relational concerns, yet most of HIV counseling has been focused on the individual. The purpose of this study was to begin to explore the communicative maintenance behaviors gay male couples report utilizing to sustain their partner relationships over time.
Several important findings emerged from this analysis. First, possessing the view of HIV as a manageable health risk may be an important precursor influencing individuals’ willingness to enter and maintain an HIV-discordant or concordant relationship. The participants in this study indicated that early disclosure of an HIV-positive status in the dating process was an important part of establishing relational trust. PLWHs have been found to be quite selective in disclosing their HIV-positive status (Greene & Serovich, 1996). Participants in this study reported feeling that disclosure of a positive status was intimacy building in their relationship when it did occur. Participants also felt that HIV status was not a central factor in the decision whether or not to pursue a relationship. Instead, traditional attraction factors such as personality, similarity in values, and companionship were reported as motivations for relationship initiation. For a few couples, a partner’s HIV-positive status was diagnosed further into the relationship. In these cases, partners explained that the established emotional attachment was strong enough to encourage maintaining the relationship (for a general discussion of emotional attachment and relationship maintenance see Rusbult, Drigotas, & Verette, 1994).

In general, the ability to cope with the fear of infection in discordant couples was important. Also, discordant and concordant couples both reported that being able to accept the presence of HIV in the relationship positively impacted relationship maintenance. These findings suggest that those individuals who are unable to view HIV as a “manageable” relational issue may be less likely to maintain an HIV-discordant or concordant relationship. The fact
that many of the individuals in this study had knowledge of the HIV-positive status of one or both partners early on in the relationship also may have an important impact on these couples’ ability to maintain these relationships over time. Future studies are needed to further explore the impact of individuals’ orientation toward HIV infection as “manageable” in the maintenance of relationships dealing with HIV/AIDS.

Findings indicate the primary maintenance strategy utilized by these couples was a drive for normalization of the illness. This analysis revealed that couples achieved normalization through several means: (a) psychological coping through acceptance, (b) managing the dialectic of HIV-communication engagement or avoidance, and (c) managing the dialectic of health autonomy with partner involvement. The theoretical implications of normalizing illness through communication as a primary maintenance strategy will be addressed in detail in the next section.

In addition, evidence for the use of the maintenance behavior typology proposed by Canary and Stafford (1991;1992) and Dainton and Stafford (1993) was found. The specific maintenance behaviors participants reported in this study were equity in shared tasks, openness, favors/positivity, assurances, affection, sharing time together, social networks, talk of day, and use of calls/letters/electronic mail. Evidence of these behaviors in this sample indicates additional support for further applicability of the typology in more diverse populations than previous studies have investigated. These findings increase our understanding of the types of behaviors utilized in the maintenance
of gay male relationships coping with HIV infection, and add to our understanding of relationship maintenance, in general, across relationship types.

Recently, relational communication researchers have begun to theorize about interconnections between a dialectic and social exchange approach to understanding relationship maintenance (see Canary & Zelley, 1998; Canary & Zelley, in press). In past research, these approaches have been applied to studying relational maintenance independently. This study offers an initial empirical exploration of how these two theoretical approaches may be applied simultaneously in examining relational maintenance behaviors. Future studies are needed to further explore these types of theoretical connections.

In general, the predominant social/relational issue found to affect relationship maintenance in these couples coping with HIV/AIDS was social stigma. Participants consistently reported feeling a double stigma associated with HIV/AIDS and homosexuality. Stigma often negatively impacted the social network behaviors of couples in maintaining their relationship. Consistent with other studies (Greene & Serovich, 1996), participants described the tendency to be very guarded concerning disclosure of an HIV-positive status due to a fear of stigma assigned by co-workers, family members, and some friends. Some family members, particularly elderly parents, frequently were not informed of a son’s HIV-positive status because of a combination of fear of rejection and a desire to protect parents from distress. The result of a failure to disclose an HIV-positive status involved enacting “passing” behaviors in which references or indications
of HIV were avoided by partners. Over time, these passing behaviors served as a source of relational stress for both PLWHs and HIV-negative partners.

One of the primary means of enduring stigma for the couples in this study was seeking out the social support of those that are thought to be accepting of an HIV-positive status. Similar to past research (Freidland et al., 1996; Hays et al., 1990; Johnston et al., 1995; Turner et al., 1994; Wrubel & Folkman, 1997), the HIV-positive participants in this study described relational partners and very close friends as most supportive in their lives. However, contrary to past studies, the couples in this study also reported moderate to high levels of social support from family members. This finding may indicate a gradual shift toward increased understanding of HIV/AIDS in the general public and reduced stigma imposed on HIV-infected family members. Future research is needed to further explore the replicability of this finding.

Past research on couples dealing with HIV/AIDS primarily has focused on the caregiver/receiver relationship involving provision of social support to PLWHs (Folkman, Chesney, Cooke, Boccellari, & Collette, 1994; Powell-Cope, 1996; Wrubel & Folkman, 1997). As PLWHs are living for longer periods of time, these roles may be less useful in describing the relationships of gay male couples coping with HIV infection. Similar to McCann and Wadsworth’s (1992) findings, none of the participants in this study described their relationship in terms of “caregiving,” and rejected the implication that care inequity might exist in their relationship. An effort to maintain equity of care in the relationship was clearly a priority despite the presence of HIV infection.
One implication of this finding is a need for additional research on the reciprocity of social supportive communication. Pearlin (1989) and Rook and Pietromonaco (1987) asserted that each relationship can enhance or constrain the effect of social support. Hays et al. (1990) found that PLWHs reported their intimate, romantic relationships to be more supportive when they are able to reciprocate support in some way (i.e., caring, concern, affection, information, and the like). They found that PLWHs were much less satisfied with relationships in which they were unable to reciprocate care or support (Hays et al., 1990). The findings of the present study underscore the importance of reciprocal support within couples dealing with HIV infection and call for further examination.

Reciprocated support behaviors also appear to serve as forms of relationship maintenance. In fact, for couples coping with illness, the same behaviors likely accomplish social supportive and relational maintenance functions. Participants in this study commonly conceptualized HIV as a joint-relationship challenge, not simply as one partner’s health problem. Future studies need to explore the relational communication behaviors enacted which meet reciprocal support needs and also function to maintain the relationship. Reciprocity of support, however, may be difficult to study. Applying the work of Duck et al. (1991), Cutrona et al. (1990) asserted that social support is a transactional communication process which often is enacted through everyday, routine talk. Researchers need to develop means for accessing and studying these forms of relational communication interactions in future research.
Finally, findings indicate there are several differences reflected in the maintenance of HIV-discordant and concordant couples. The most distinct difference between these two types of couples is a fear of infecting one's partner for HIV-discordant couples which is a not an issue for concordant couples. Fear of infection brings an elevated level of stress to discordant couples, particularly related to sexual activity, that appears not to be present for concordant couples. Several partners in HIV-discordant relationships in this study indicated that a fear of HIV infection was a major stressor in their relationship.

Several other maintenance issues expressed by HIV-discordant couples included imbalance in relational decision-making power, the stress of uncertainty regarding the life expectancy of the HIV-positive partner, differences in physical health experiences, and anger toward the HIV-negative partner because they are not infected. The discordant couples in this study also indicated that when only one partner has a terminal illness it can upset the balance of equity in decision making within the relationship. For example, several HIV-negative partners described deferring to their HIV-positive partner's wishes because their life expectancy is shortened. In addition, even with safe sex practices, discordant couples reported that sexual activity was reduced and not a major focus of their relationship (see also Tewksbury, 1995). Reduced sexual activity was a point of relational dissatisfaction for some partners in HIV-discordant relationships, and may lead to a fear of abandonment (Cranson & Caron, 1998).
While dealing with the stress of both partners being HIV positive, concordant couples reported feeling tremendously freed from the fear and guilt of possibly infecting their partner. Sexual activity was freely practiced by these couples, often without engaging in safe sex practices. Thus, much of the relational tensions surrounding sexual activity experienced by the HIV-discordant couples were not an issue in the HIV-concordant relationships. HIV-concordant partners also reported feeling a close bond with one another rooted in sharing a similar illness experience. Being able to understand each other’s health experience is an important point of connection for these couples. Finally, concordant couples appear to utilize AIDS organization support services for both personal coping and relationship support purposes more than the HIV-discordant couples in this study. Concordant couples described attending HIV retreats and HIV/AIDS functions as a useful form of social support for themselves and their relationship.

HIV-discordant couples did not report utilizing these forms of social support. In general, there was a trend for discordant couples to be more removed from the HIV/AIDS community as part of the normalization process. For the concordant couples, both being HIV positive made HIV much more prevalent in their relationships. This may indicate that HIV-discordant couples are failing to access social support which is available to them as they cope with HIV/AIDS. However, it is unclear that access to HIV community services is a necessary relationship maintenance strategy. Future research is needed to further explore these findings.
Theoretical Implications

The findings of this study support the emergence of a grounded theory involving a drive for normalizing illness through communication as a means of maintaining long-term couple relationships coping with chronic illness. Family systems theorists (Bavelas & Segal, 1982; Bochner & Eisenberg, 1987; Minuchin, 1974, 1984; Olson, Russell, & Sprenkle, 1979; Whitchurch & Constantine, 1993) have proposed that when internal or external feedback indicates a family system is out of balance, the system will re-calibrate in order to re-establish homeostasis (balance). The grounded theory proposed here delineates a relationship maintenance process of establishing a sense of normalcy in a couple relationship where the ongoing stressor of chronic illness is present.

Select researchers have touched on the importance of normalizing illness for relationships dealing with chronic illness (e.g., Strauss et al., 1984; Miller & Zook, 1997), and yet these researchers have not fully delineated how couples actually achieve normalization. For example, Strauss and Corbin (1984) discussed normalization of illness as enacted through "passing" strategies used in public interactions to hide illness. Based on the data from the current study, "passing" appears to be only one manifestation of normalizing illness. Couples reported accomplishing normalization through managing the communicative predominance of illness foci both in their public and private interactions; with very different goals in mind for the two contexts.

This study contributes to the body of literature on couples coping with HIV/AIDS by exploring in more detail the communicative and behavioral means
of accomplishing normalization of illness in relationships. The grounded theory of normalization of illness through communication proposed here involves three primary components: (a) coping through acceptance of the illness, (b) the management of the dialectic of engagement versus avoidance of illness-related communication, and (c) managing the dialectic of health autonomy with partner involvement in communicative interactions.

Researchers have suggested that one means of dealing with stress is for individuals to learn to cope by reframing the meaning of life stressors (Pearlin, 1989). Lazarus and Folkman (1988) have proposed that realistic acceptance (accepting a situation while emphasizing aspects that can be positively influenced through action) and positive reappraisal (re-examining a situation highlighting positive aspects) are two important forms of coping that help reframe stressors with a problem-solving emphasis. The couples in this study provided additional evidence for the use of these two coping strategies. Couples in this study indicated that, in time, realistic acceptance of HIV in their lives was an important psychological aspect of normalizing the illness.

Investigating coping strategies, researchers have suggested that problem-focused coping (e.g., planful problem solving and confrontive coping) is more effective than emotion-focused coping (e.g., escape-avoidance and distancing from the stressor) (Aldwin & Revenson, 1987; Felton & Revenson, 1984; Mitchell, Cronkite, & Moos, 1983). The underlying assumption is that emotion-focused strategies are less useful and should be avoided. The findings of this study suggest that this advice may be too simplistic in helping couples to cope with
illness. Those who argue that problem-solving strategies are always the most effective approach to coping have failed to recognize that coping is a dynamic process. For example, couples in this study reported effectively utilizing emotion-focused strategies (e.g., topic avoidance, distancing) to avoid constant attention on the illness which may lead to an illness situation becoming overwhelming.

In addition, couples indicated that the use of positive illusions (Taylor & Brown, 1988; 1994) and emotion-focused coping strategies may be effective coping mechanisms depending on the stage of crisis. Scholars have proposed coping with life crises (e.g., divorce, incurable illness, death) involves moving through four primary stages: (a) shock; (b) recoil - denial, disbelief, anger; (c) depression; and (d) reorganization - emotional recovery/acceptance (Kubler-Ross, 1970; Parkes, 1972; Feifel, 1977).

In this study, it would appear that most of the participants had reached a level of acceptance of HIV in their lives. One important factor likely influencing the ability of these couples to achieve acceptance is time since diagnosis. For these couples, the mean time since HIV diagnosis of 6 1/2 years likely allowed sufficient time for individuals to have reached a psychological/emotional stage of acceptance. Conversely, it is likely unrealistic for couples having recently experienced a partner’s HIV diagnosis to expect to achieve a level of acceptance without sufficient time to process the life crisis.

The management of the dialectic of HIV communication engagement and avoidance appears to be central throughout this process. A theoretical trajectory
model delineating the relationship of illness-related communication engagement-avoidance with stage of emotional crisis is presented in Figure 5.1. Participants

Figure 5.1 Emotional Crisis and Illness-related Communication Trajectories

in this study, in concordance with past research (Greene & Serovich, 1996), indicated that the need for PLWHs to engage in HIV-related communication with select, trusted individuals increases sharply upon an HIV-positive diagnosis. Over time, it appears that the desire for intense HIV-focused communication gradually decreases. The need to engage in HIV communication likely increases again during stages of depression which may be accomplished through informal talk with a partner, friends, or family, or through seeking
formal counseling/support group interaction. Once relational partners have reached a level of acceptance of HIV, they reach a point where the management of the illness-related communication engagement-avoidance dialectic must continue to be negotiated in maintaining the relationship over time.

Thus, blanket recommendations advocating constant illness-related communication openness do not appear to be useful. The participants in this study indicated that HIV-related communication must be balanced between engagement and avoidance to keep the partners from being completely overwhelmed by the health condition. When HIV-communication is necessary, then partners should not avoid open and honest illness-related communication. However, a constant focus on HIV-related communication may cause heightened relational distress.

In addition, throughout this process the dialectic of health autonomy versus partner involvement also must be managed through communication. Many researchers studying HIV have highlighted the need for the HIV-positive individual to maintain a sense of autonomy and independence over their own health care (Corbin & Strauss, 1988; Powell-Cope, 1995, 1996; Rolland, 1994). In a couple relationship, partners often are quick to interject their own beliefs and opinions without considering the perspective of their partner. Couples in this study indicated that partners must be conscious of managing the amount of involvement in one another’s health. Health autonomy must continue to be negotiated through communication to reach a relational agreement concerning partner involvement appropriate to the present health circumstances.
One factor that may influence the management of relational dialectics is illness symptoms. Participants explained that not only the presence, but also the absence, of symptoms influenced the management of relational dialectics. For instance, the presence of symptoms often served as an impetus for engaging in HIV-related communication, and also increased partner involvement in healthcare. However, participants explained that an absence of symptoms also may encourage HIV-related communication; emphasizing how good the PLWH feels and discussion of how long the asymptomatic period might last.

On the other hand, an absence of symptoms also enabled partners to avoid HIV-related communication and increased the PLWH’s health autonomy. Participants explained that avoiding HIV-related communication was not viewed as denial of the disease, rather these couples found it unproductive and stressful to place constant focus on the illness within their relationship. This finding appears consistent with recent research which has found that positivity and optimism may be important coping mechanisms for PLWHs and their partners (Folkman, 1997; Folkman et al., 1994; Wrubel & Folkman, 1997).

The grounded theory of normalization of illness through communication proposed here may have important implications for developing interventions to help couples coping with HIV or AIDS. Results from this analysis indicate the importance of avoiding advice-giving to couples dealing with HIV/AIDS that promotes one extreme or the other of these relational dialectics (e.g., complete partner involvement or withdraw from care) as the most effective means of maintaining these relationships. For the gay male couples in this study,
balancing the dialectics of engagement-avoidance of HIV communication and autonomy-connection regarding health autonomy was reported to be an effective communicative means for accomplishing normalization. Neither extreme of these dialectics was reported to be more effective than the other. Rather couples utilized both balance (compromising on a mid-point) and cyclic alternation (alternating between extremes over time) to effectively manage these relational dialectic tensions. Interventions which increase couples' awareness of these dialectical tensions, and the need to continue to negotiate and manage these relational issues over time could be very useful in assisting couples coping with HIV/AIDS in maintaining their relationships.

In addition, the stage of emotional crisis must be considered in developing interventions for couples. Couples facing a recent HIV diagnosis are likely to have different needs than those couples which have had time to cope with the diagnosis. The model of illness-related communication proposed in this study is a step toward conceptualizing the divergent needs of couples based on a crisis trajectory. Future research is needed to develop and test the effectiveness of interventions using this model.

**Limitations**

Several limitations of this study should be recognized. First, the method of a qualitative grounded approach limits the generalizability of the findings of this study. In utilizing an interview methodology, large numbers of study participants are impractical for detailed transcript analysis. The 40 hours of
interviews in this study resulted in 459 single-spaced pages of transcription. To further explore the generalizability of these findings in a larger sample, the development of quantitative measures could be useful.

Second, the method of convenience sampling through AIDS Clinical Trials Units may also influence the generalizability of these findings. Recent research (see Brashers, Haas & Neidig, 1996) suggests that PLWHs who are willing to participate in clinical drug trials may hold a more self-advocating, problem-focused orientation. This orientation—reflecting a tendency toward increased assertiveness—may carry over into approaches to managing participant’s personal lives, thus, influencing the types of maintenance strategies and behaviors they employ in their relationships. Therefore, it would be useful to explore similarities or differences which may exist in non-clinical samples.

Third, with a few exceptions, the majority of the HIV-positive individuals in this study were aware of their HIV-positive status upon initiation of their current relationship and revealed this status to their potential partner early on in the dating process. Thus, the findings of this study may be unique to gay couples matching these characteristics, and may not apply to couples who discover a partner’s HIV-positive diagnosis further into the relationship. Theoretically, individuals with more time since diagnosis have had longer to process through the life crisis trajectory; whereas, couples discovering an HIV-positive status of a partner later in a relationship must move through all of the stages of crisis together (i.e., shock, recoil, depression, reorganization; see figure 5.1) which may cause extreme relational stress. Thus, it is likely that the couples
in this study had already reached a stage of emotional stability as they maintain their relationships. Future research is necessary to investigate if similar maintenance behaviors are utilized by couples facing an HIV diagnosis at later stages in the relationship.

Finally, differences related to demographic characteristics such as age, race or ethnicity, length of relationship, and the like, were not systematically analyzed in this study. The small sample size did not allow for substantial comparisons based on these types of characteristics which may have an impact on the forms of relationship maintenance behaviors partners enact. For example, McWhirter and Mattison (1984, 1988) have proposed that gay male couples move through relationship stages over time. It is possible that effective maintenance strategies may differ based on the stage of relational development. Future studies are needed to explore these types of demographic dimensions.

Conclusion

The number of heterosexuals infected by HIV is on the rise (CDC, 1998). Three recent studies have begun to assess the impact of HIV/AIDS on heterosexual couples. Van der Straten, Vernon, Knight, Gomez, and Padian (1998) have found similar issues of stigma impacting heterosexual discordant couples as found for the gay male couples in this study. HIV-negative heterosexual partners frequently reported feeling stigmatized themselves through "guilt by association" (Brown & Powell-Cope, 1992), and did not feel the health care system responded to their needs. These couples also reported
decreased sexual activity in their relationship. VanDevanter, Stuart Thacker, Bass, and Arnold (1999) also found reduced sexual activity and emotional connection to be important relational issues. In addition, they found that issues of reproduction, future care of children and spouse, and HIV-status disclosure to others were relational stressors for heterosexual discordant couples.

Moore et al. (1998) found that an HIV diagnosis negatively impacted relational intimacy in male-infected heterosexual discordant couples when symptoms were present, but found no difference between female-infected and male-infected discordant couples when partners were asymptomatic. Also, measuring perceived willingness to communicate about HIV, males reported more comfort in addressing the topic of HIV regardless of whether or not they were HIV infected. Moore et al. hypothesize this comfort level is in response to males' perceptions of female openness to discussing difficult topics. Importantly, regarding coping strategies, avoidant coping was found to increase relational intimacy when used by women, but decreased intimacy when utilized by males. These contradictions requires future research to further explore the effects of sex-based coping styles on relational quality.

The goal of this study was to explore the means of maintaining gay male relationships coping with HIV/AIDS. By expanding the populations studied, broader insight into relational communication and relationship maintenance across relationship types can be increased. Specifically regarding same-sex couples, Peplau (1982) argues that:
Studies of homosexual couples... provide an opportunity to test the generalizability of social science theories of "human behavior" which have been derived almost exclusively from heterosexual models and tested on heterosexual samples. In this way, research on lesbian and gay male couples contributes not only to our knowledge about homosexuality but also to our more general knowledge about close human relationships. (p. 7)

Even as the numbers of HIV-infected heterosexuals increase, HIV or AIDS continues to deeply impact the daily lives of many gay men and lesbian women and the relationships they establish. One HIV-positive partner in this study, Andrew, summarized the impact of HIV on his discordant relationship this way:

Yeah, it's taught me to appreciate the time we have. Especially when we're both feeling really well. Everything's just so much more precious. And even though we both can get stressed out, me especially, and I can lose sight of what's really important. HIV really brings you right back to what's important. It's been a very powerful, sometimes unforgiving teacher. But it's taught me some really good lessons. And I think it has impressed our relationship in a positive way. I think we're closer, you know. I guess I can say that. When I think about my parents' relationship, I don't have anything that even comes close to that, and I thank God, you know. I don't think they have a good relationship. They don't communicate with one another. They don't lay together and watch TV holding hands. They don't do the things that we do together. My dad doesn't come home from work and say to my mom, "let's go get Chinese take out and go watch the sunset." You know? But he does, Matt does those kinds of things for me. And you know, I really do attribute a large extent of those things to HIV. It has taught us both that time is so precious and so valuable. And we want to do things together that are meaningful and that make us both happy.

Reflecting on his relationship, Joe, an HIV-negative partner, observed:

We've been together for a long time, and we have sort of become part of each other in many ways. We don't have a perfect relationship. Neither of us are perfect. But we've learned to get along, you know. And with the things that we have to deal with, the positive things are more important than the things that are difficult.
Finally, Steve, an HIV-positive partner described his discordant relationship this way:

We talk a lot. We compromise a lot. We practice safe sex. Basically that's, you know, it's pretty much just like any other [gay] relationship or any other heterosexual relationship. We just try to both do what's right and try not to inflict harm on anyone else.

Despite the social and legal barriers that still exist, gay men and lesbians are establishing and maintaining long-term relational commitments.

Understanding the communicative behaviors that gays and lesbians use to create and maintain relationships in the face of social barriers and relational stressors enlightens our overall understanding of relational communication. Continued study of gay and lesbian relationships will help to increase our understanding of the minority relationships and communities that co-exist within our society. This study has explored the strategies and behaviors gay male couples coping with HIV/AIDS use to maintain their relationships. As life expectancy for persons living with HIV infection continues to increase, the development and testing of interventions and counseling developed from empirically-based maintenance behavior research has important implications for increasing the quality of life of couples coping with HIV/AIDS, and other forms of chronic illness as well.
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Maintaining Relationships:
Gay Couples Coping with HIV

Earn $60 per Couple

This study is interested in exploring the ways that gay couples dealing with either one or both partners being HIV positive maintain their relationships. The study will investigate the strategies and communication behaviors that couples use to maintain their relationship over time. The study will involve a separate one-hour interview with each partner. Interviews will be tape recorded, however, names and identifying information will not be used in the study. Each partner will be reimbursed $30 for their one-time participation in the study. Interviews will be conducted at the OSU AIDS Clinical Trials Unit or the College of Social and Behavioral Sciences at The Ohio State University.

Interested participants, please contact Stephen Haas, M.A., Doctoral Candidate in Communication, College of Social and Behavioral Sciences, The Ohio State University at 292-5943 (e-mail: haas.76@OSU.edu), or Jane Russell, R.N., OSU AIDS Clinical Trials Unit at 293-8112.
APPENDIX B

HIV/AIDS Relationship Maintenance Interview Schedule

Introductory statement: When people are diagnosed with an illness their lives and their relationships often undergo change. After being diagnosed as HIV+, people's relationship with their significant other can vary in any number of different ways. I'd like to ask you some questions about your relationship with your significant other.

1. While I understand that HIV is not the only aspect of your relationship, could you describe, in general, how you feel (you or your partner) being HIV+ has affected your relationship?

2. What do you feel has kept your relationship together since discovering (you or your partner) are/is HIV+?

3. What do you do in order to keep your relationship together? In other words, what actual things do you do to maintain your relationship? One way to help you think of things you do is to tell me about a typical day in your lives. What do you do on weekends?

4. Who does what in your home as far as household tasks? Has (you or your partner) being HIV+ affected who does what in your relationship? If so, could you explain?

5. How involved are/is (you/your partner) in (your/your partner's) health care? Does this change depending on how well (you or your partner) feel(s)? How does this involvement impact your relationship? Are there routine things specifically related to the illness that your partner does?

6. Who do you go to for support in dealing with HIV? Does your partner provide support to you? If so, how do they show their support? How does this affect your relationship (positive and/or negative)?

What role do both of your families play in dealing with HIV?
7. If you sense that your partner is not receiving the kind of support they desire, what, if anything, do you do or say to them to attempt to acknowledge their needs?

8. Often times we do things on a routine basis that help maintain our relationships, but because they seem trivial we may not pay much attention to them. a.) If you focus on routine things for a minute, are there things you do routinely which you see as serving to maintain your relationship? b.) Do you think your partner also sees these as a means of maintaining your relationship?

9. Sometimes people who are close to us may say or do things that make us upset. They may have had the best intentions, or maybe they just weren't thinking at the time. Are there behaviors related to dealing with HIV that would be more helpful from your partner or you wish they would change?

10. Unfortunately, many people in our society still do not fully understand about HIV/AIDS and may treat people with HIV negatively. Are there things you and your partner do or say to help each other deal with this?

11. How has HIV affected your sex life? Do you practice safe sex in your relationship? How did you negotiate safe sex practices?

12. Is there anything important about your relationship that I have not asked you about? Do you feel you have described your relationship fully to me?