"THE FULL HAS NEVER BEEN TOLD": BUILDING A THEORY OF SEXUAL HEALTH

FOR HETEROSEXUAL BLACK MEN OF CARIBBEAN DESCENT

by

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(Under the Direction of Edward Delgado-Romero)

ABSTRACT

Black sexual health studies have failed to represent the heterogeneity of ethnic groups identifying as Black. For people of Caribbean descent in the United States, ethnicity may be a salient cultural factor that influences the way they define and experience sexual health. Second to sub-Saharan Africa, the Caribbean has the highest prevalence of HIV/AIDS in the world, and immigrants from Caribbean countries in the US have higher prevalence than their peers from other ethnic groups. Sexual health is defined more broadly than STI prevalence by world organizations, so psychological and emotional indicators are important to consider when exploring the sexual health of a culture. However, despite comprehensive definitions, most sexual health research focuses on behavior and biological indices. Few studies utilize the voice of participants to define sexual health for themselves. For a marginalized group such as heterosexual Black men of Caribbean descent, failing to understand their definitions of sexual health and their sexual health experiences ignores the cultural differences that inform their sexual lives.

The purpose of this grounded theory study was to qualitatively co-create a theory of sexual health for heterosexual Black men of Caribbean descent (HBMCD). Eleven men who

self-identified as Black, Caribbean, and heterosexual participated in three focus groups where they were asked to define sexual health, critique the SEICUS List of behaviors of a sexually healthy person, and address what they see as encouragers and discouragers to sexual health in their lives. Because the methodology was grounded theory, the researcher withheld hypotheses to allow the data to direct the results.

The result of the study was the Be a Man model, a working theory of sexual health for HBMCD, which showed that, for them, sexual health is: heterosexually privileged, protective, contextual, interpersonal, cultured, and pleasurable. These themes were found to have overlap, and they aligned with aspects of Sexual Scripting Theory (Simon & Gagnon, 1984, 1986, 2003). There were some departures from the expert definition of sexual health that were notable. Recommendations based on the theory were provided, as this study contributed to the literature on sexual health, Black masculinity, Caribbean sexuality, and heterosexuality.

INDEX WORDS: Sexual health, male, Black, African American, heterosexual, sex, Caribbean

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For Farrah Simone Brown.

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I am grateful for the support of my committee through this process and every other experience, personal and professional. Their unwavering encouragement made the difference. I am grateful to the gentlemen who participated for opening up to me and sharing intimate details of their lives so graciously. I am grateful to my loved ones who have cheered me on along the way. I am grateful to God for being my source for all, including fortitude and motivation.

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Chapter I

Introduction

"I could go on and on. The full has never been told"

Untold Stories (Banton, 1995)

Sexual health research often paints a grim picture of Black men in the United States. The research is predominantly focused on pathology and disease (McGruder, 2009). Statistics are reported about the infection rates of Black women in a way that tends to place the blame for sexually transmitted diseases on heterosexual Black men, while their vulnerabilities and strengths are minimized or ignored. Yet, their vulnerability is represented in the Center for Disease Control's (CDC, 2011) estimate that in 2009 nearly 20% of Black men with human immunodeficiency virus (HIV) contracted it through heterosexual sex. And, in 2008, 18.8% of Black men diagnosed with acquired immunodeficiency syndrome (AIDS) reported that it was contracted from heterosexual sex (Avert, 2011). Although these numbers do not represent the highest percentages of HIV contraction among Black people, they do represent a demographic that has been under-represented in sexual health literature, programming, and HIV/AIDS prevention efforts (Charnigo, Crosby, & Troutman, 2010).

In addition to the dearth of published studies focused on heterosexual Black men, the body of sexual health research that does focus on this demographic often fails to capture their heterogeneity, with an overrepresentation of men from lower socioeconomic status groups, younger age cohorts, and little break down by ethnicity (Lewis & Kertzner, 2003). Black men of Caribbean descent in the US may experience sexual health differently than their US Black

counterparts and their Caribbean counterparts who remain on their respective islands, and yet few studies have examined Caribbean sexual health (Akin, Fernandez, Bowen, & Warren, 2008) or focused on heterosexual men of Caribbean descent (Saint-Jean, Devieux, Malow, Tammara, & Carney, 2011). The scarcity of research presents a gap that must be filled.

Context of Caribbean Culture, Immigration, and Acculturation in the United States

This section describes the cultural context that surrounds the Caribbean experience in the United States. It begins with a brief overview of Caribbean culture, situating the location and culture of the Caribbean islands. Next, an account of the immigration statistics related to Caribbean and Black Caribbean people in the US, Georgia, and Atlanta are detailed. It concludes with a description of the acculturation experience of Black people of Caribbean descent. This context is provided to offer insight into the uniqueness of the demographic, in relation to the larger Black US demographic, with which they are often grouped. Sue and Sue (2008) noted that within-group differences must be explored (rather than assumed) for culturally competent research with ethnic minority populations.

Caribbean Culture

The Caribbean is a general description for 21 islands, each with their own unique history and cultures. Although people in the Caribbean are not culturally homogenous, for the purposes of research and some sociocultural political markers, the countries are often linked together (Avert, 2013). Countries included in this group are Antigua and Barbuda, Aruba, Bahamas, Barbados, Cayman Islands, Cuba, Dominica, Dominican Republic, Grenada, Guadeloupe, Haiti, Jamaica, Martinique, Puerto Rico, Saint Barthélemy, St. Kitts & Nevis, St. Lucia, St. Vincent and the Grenadines, Trinidad & Tobago, Turks & Caicos Islands, and Virgin Islands (Latin American Network Information Center [LANIC], 2013). Across the individual island countries

and territories one finds diversity of ancestry, including people of East Indian, Chinese, African, Native American, and European origins (Atlanta Regional Commission, 2009). Many people of Caribbean descent often have mixed heritage because of the historical interracial relationships across groups, especially during the trans-Atlantic slave trade of the 15th to 19th centuries. Caribbean cultures have varying degrees of similarities in the foods, music, architecture, and languages found across islands. While some islands are predominantly English speaking (i.e., Trinidad and Tobago), with patois dialects in use, others islands are francophone (i.e., Haiti) or Spanish-speaking (i.e., Dominican Republic), with creole dialects in use (Atlanta Regional Commission, 2009).

Unfortunately, Caribbean culture has long been synonymous with overt sexual expression because of colonial associations with sexual deviance and the tourism industry's emphasis on the sexual aspects of the culture, so much so that many tourists use vacations in the Caribbean to explore their sexual desire and pursue sexual experiences with the citizens of the various countries throughout the Caribbean (Kempadoo, 2009; Weichselbaumer, 2012). The sexual tourism industry is just one space where sexuality is manifested. Caribbean cultures also embrace music and celebratory festivals (i.e. Carnivals) that promote erotic dancing and open displays of sexual desire and engagement (Perkins, 2011; Weichselbaumer, 2012). Carnivals are festivals that celebrate life through dance, music, food and festivities with historical ties to slavery, where enslaved people would dress up and mock slavers who held balls during certain times of the year. The festivals have a history that extends beyond the sexual, but the time does mark an abandon of otherwise relatively conservative values (Carpenter, 2011). Carpenter notes, "These celebrations are largely gaudy and noisy displays of drinking, music and revelry, which fly in the face of traditional ''good behavior''. In fact, patrons are openly encouraged to ''get on bad'' or

''behave badly'' in the lyrics of the songs and the mood of the festivals" (p. 314). Thus, people of Caribbean descent are often raised in environments that allow for open expression of one's sexuality in heterosexual contexts. Some stereotypes about Caribbean men are that they are homophobic, misogynist, womanizing, and sexually promiscuous (Kempadoo, 2009). These stereotypes prevail in the US upon immigration.

According to the UNAIDS World AIDS Report (2012), the regional HIV prevalence in the Caribbean is second only to sub-Saharan Africa. Given that Caribbean people represent 9.3% of the immigrant population in the US (Acosta and de la Cruz, 2011), their sexual health in the US deserves attention. Despite this health disparity, few studies exclusively examine sexual health among people of Caribbean descent in the US (Akin, Fernandez, Bowen, & Warren, 2008; Saint-Jean et al., 2011). With traditional gender dynamics typically espoused in Caribbean culture (Erving, 2011), and unprotected sex standing as the leading means of transmission of HIV within Caribbean countries (UNAIDS, 2012), exploring definitions and influences of sexual health in heterosexual men may uncover the ways in which those who hold more power in sexual relationships understand and promote or forego sexual health and therefore impact their partners and children.

Immigration

According to Acosta and de la Cruz (2011), 9.3% of the foreign-born population in the United States in 2010 was Caribbean. This percentage amounts to approximately 3.7 million people. Among this group, most migrated from Cuba, the Dominican Republic, Haiti, Trinidad and Tobago, and Jamaica, and they are most likely to live in California, Florida, and New York upon arrival (Migration Policy Institute [MPI], 2011). Thomas (2012) notes that there are 1.7 million Black Caribbean immigrants in the United States. He states,

The share of immigrants who are Black varies across Caribbean-origin countries: they are the vast majority (90 percent or more) of immigrants from Haiti and most English-speaking countries, 14 percent of immigrants from the Dominican Republic, and just 3 percent from Cuba. (p. 1)

Caribbean immigrants often enter the United States with higher levels of English proficiency than other immigrants, and they tend to gain citizenship at faster rates (MPI, 2011). Black Caribbean immigrants are more likely to have documented status than other Black immigrants. Sixteen percent of Black Caribbeans are undocumented, compared to 21% of Black Africans and 29% of other Black immigrants from other regions (Thomas, 2012). Nearly half of people of Caribbean descent living in the United States were naturalized citizens between 2006-08. Many entered through family reunification programs, and approximately seven percent are refugees or people who sought asylum. In recent years, the Black Caribbean immigrants that have entered the US have had lower levels of education than previous immigrants; however, their percentage of participation in the work force and median earnings exceed all immigrant groups combined, as well as US natives (Thomas, 2012).

Black Caribbean men constitute 45% of the Black Caribbean immigrant population. Age groups most represented are 45-54 (22%), 35-44 (21%), and 25-34 (17%). The most common family/household structure is single with no children under 18. Eighteen percent of their households are married with children, and seventeen percent are single with children. The extended family household structure represents 10% of Black Caribbean immigrant family types (Thomas, 2012).

Georgia is home to three percent of the total Black Caribbean population in the US (Thomas, 2012). At the 2010 census, the foreign born Caribbean population in Georgia was

estimated to be approximately 90,000. Men represented 44.8% of that number, and those identifying their race as Black represented 76.4%. An estimated 22% held a bachelor's degree and 10.5% held a professional or graduate degree. The median earning for males was $42,003 (U.S. Census Bureau, 2012 American Community Survey). In the Atlanta metropolitan area, where this study took place, 3,463 people reported having West Indian ancestry, but these figures did not include the Hispanic Caribbean groups (U.S. Census Bureau, 2008-2012 American Community Survey). There were approximately 24,000 people of Caribbean descent in the Atlanta metropolitan area at the 2000 census (Atlanta Regional Commission, 2009). Of English-speaking Caribbean people, those from Barbados, Jamaica, Trinidad and Tobago, and Guyana, most (n = 10,210) lived in Dekalb County. Other counties with relatively high concentrations of English-speaking Caribbean people are Cobb (n = 2,729), Fulton (n = 2,630), Gwinnett (n = 2,299), and Clayton (n = 1,222). Atlanta's Caribbean community holds an annual Carnival, is home to cultural organizations such as the Atlanta Jamaican Association, and sporting events familiar to Caribbean islands, such as cricket and soccer. Caribbean restaurants abound, and other opportunities for economic advancement often lure Caribbean people from larger meccas such as NYC, making the metropolitan Atlanta area a likely location to find a purposive sample of HBMCD (T, 2014).

Acculturation

While people of Caribbean descent in the United States may begin to endorse some of the values of US culture, their Caribbean identities are typically firm. Guy (2001) stated, "Black Caribbean immigrants do not arrive in the US as empty cultural containers waiting to be Americanized" (p. 19). Caribbean values are passed down through generations in a way that affirms the importance of attitudes and beliefs meant to maintain pride in Caribbean culture and

separation from African Americans, whom may be perceived as less respectable (Lorick-Wilmot, n.d.). The race-based social hierarchy complicates assimilating into US culture as a Black immigrant, yet Black Caribbean people from English speaking countries tend to do better economically than their Black US counterparts (Guy, 2001). Guy (2001) states that in their acculturation process, Black immigrants from Caribbean countries "…*de-emphasize their black identity* in favor of their national identity as black Caribbean immigrants. Finally, the learners tend to *idealize their home culture*, even while expressing satisfaction with having emigrated to America" (p. 19).

The Migration Policy Institute (2011) found that in 2009, while there were 3.5 million Caribbean immigrants reported in the United States, 6 million people self-identified as Caribbean. This discrepancy may indicate that if you ask a Caribbean American man about his racial/ethnic identity, his answer will most likely reference his Caribbean country of origin, rather than US or Africa, regardless of birthplace (Guy, 2001; MPI, 2011). Guy (2001) echoed this sentiment, stating that his participants "were careful to say that they do not see themselves as American blacks" (p. 19). He described this phenomenon as *hybridity*, which psychologically and socially aligns Caribbean immigrants with their national identity, while simultaneously acknowledging their different US acculturation experiences, all the while maintaining psychological and social distance from African Americans. Given this experience of hybridity, many Caribbean people resist acculturation by segregating into their own communities (Guy, 2001). Saint-Jean et al. (2011) suggest that this phenomenon of self-segregation into cultural enclaves may be connected with the high rates of HIV among Caribbean immigrants in the US. Information about how acculturation and immigration affects other non-pathological aspects of sexual health within this demographic is minimal and requires exploration.

Problem Statement

It is important to understand the way Caribbean men make sense of the paradox of how a culture that embraces sex so widely can also suffer so greatly as it relates to several other markers of sexual health, including respect of sexual diversity, rates of sexually transmitted infections (STIs), and honest communication in romantic and sexual relationships (Avert, 2013; Caribbean360, 2012). Traditional Caribbean culture maintains gender roles that position heterosexual men on the top of the power hierarchy, suggesting that their decisions and values are more likely to guide the direction of relationships (van Veen et al., 2011). Because the Caribbean culture is one in which traditional gender roles and values are reflected in romantic relationships, an important place to begin the study of Caribbean sexual health is with heterosexual men. Black men of Caribbean descent in the US are likely to embrace the values of their culture of origin (Saint-Jean et al., 2011). Sexual health disparities exist within the Black community in the United States, yet few studies have focused on specific ethnicities within the larger group. For example, Black men who sleep with men (MSM) are more likely to contract HIV and AIDS than Black women or Black men who sleep with women (Clarke-Tasker, Wutoh, & Mohammed, 2005), but there is no breakdown by ethnicity in that study. Therefore interventions that fail to attend to cultural, ethnic and national norms and strengths may be doomed to fail.

Additionally, to prevent negative sexual health outcomes, a theory that explains how sexual health is defined and experienced among each ethnic group within the Black population in the United States is important. With existing stereotypes and lack of information about

Caribbean Black men, researchers and practitioners risk mistakenly treating Caribbean men as if they were African Americans. Thus, with few studies examining sexual health among Caribbean immigrants and consistent sexual health foci on behavior and disease among Black populations, exploring sexual health in HBMCD in the US is a first step in building a theory of their sexual health that acknowledges factors that influence a comprehensive definition of sexual health.

<div align="center">Statement of Purpose</div>

The purpose of this study is to develop a theory of sexual health among HBMCD to identify the way they define and experience sexual health. As HIV/AIDS and other STIs have been found in higher concentrations in Black communities, much research has attended to sexual health using Black samples. Many of the studies conducted have focused on women, teens, and men who sleep with men (MSM), in response to higher STI contraction rates among these populations (Myers, Javanbakht, Martinez, & Obediah, 2003; Radcliffe et al., 2010; Stephens & Phillips, 2005; Washington, Wang, & Browne, 2009). However, this research literature has resulted in relatively limited attention to heterosexual Black male sexuality, despite statistics that indicate that STIs remain higher than in this group (Bowleg, 2004; Centers for Disease Control [CDC], 2011). The lone study found that examined sexual health among heterosexual Caribbean immigrants (Saint-Jean et al., 2011) was a quantitative study and it did not allow the participants to define sexual health for themselves or indicate the factors that encourage and discourage sexual health.

In addition to behavioral aspects of sexual health, this study uncovered social, psychological, and cultural underpinnings of sexual health among HBMCD. Given the absence of theoretical work in this area, Sexual Scripting Theory (Simon & Gagnon, 2003) served as a theoretical foundation on which the group-specific theory was built. Furthermore, non-disease

related aspects of sexual health received attention, based on this study's line of questioning developed from the World Health Organization's (2006) definition and Sexuality Information and Education Council of the United States (SEICUS) list of healthy sexual behaviors (Pan American Health Organization, World Health Organization, & World Association of Sexology [PAHO, WHO, & WAS], 2001), contributing a more comprehensive understanding of sexual heath in HBMCD than is currently available in the literature. The researcher looked at how the individual defines sexual health, rather than how others define it for them historically or in US society. This exploration of sexual health has implications for the health of Caribbean men, as well as their partners and children.

Definitions

Sexual health has been defined in a number of ways, depending on the intent of research studies. This research uses the World Health Organization's (WHO, 2006) definition, which states that sexual health is:

A state of physical, emotional, mental and social well being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (p. 5)

Heterosexual was self-identified for the purposes of this research, allowing the men autonomy to label their sexual orientation according to their concepts of their behaviors and

attitudes about sex. One can assume that the definition of heterosexual will include the concept of identifying with the idea of a man who primarily engages in sexual behavior with women.

Black was a self-identified identity for the purposes of this research, allowing men the autonomy to label their racial identity according to their affiliation and historical connection to their concept of Black as a socio-political category and a racial designation. The researcher uses Black as an all-encompassing term of people who self-identify as Black throughout the diaspora. It is used in the way it is used in research, specifically to say that Black should be broken down by ethnicity, but it often isn't.

Caribbean descent was self-identified as having a heritage in one of the following island countries: Antigua & Barbuda, Aruba, Bahamas, Barbados, Cayman Islands, Cuba, Dominica, Dominican Republic, Grenada, Guadeloupe, Haiti, Jamaica, Martinique, Puerto Rico, Saint Barthélemy, St. Kitts & Nevis, St. Lucia, St. Vincent and the Grenadines, Trinidad & Tobago, Turks & Caicos Islands, or Virgin Islands (Latin American Network Information Center [LANIC], 2013).

<div align="center">Research Questions</div>

This research answered the following questions to develop a theory of sexual health for HBMCD: How do HBMCD define sexual health? Do their definitions align with or depart from the established sexual health behaviors as outlined in the SIECUS List? What do HBMCD believe influences their sexual health?

Chapter II

Review of Related Research

Caribbean Black men in the United States see themselves as psychologically and socially different than their Black US peers (Guy, 2001). Yet, US research on Black men often fails to differentiate ethnic group identity, regardless of topic. Ethnic distinctions can be relevant to sexual health research, as the historical and cultural nuances of Caribbean sexuality present considerations outside the borders, literally and figuratively, of US sexual health statistics and norms (Smith, 2011). The following review of literature explores definitions of sexual health, Sexual Scripting Theory, and the relevance to the sexual lives of Caribbean Black men.

Sexual Health

No consensus exists on the definition of sexual health. Edwards and Coleman (2004) reviewed the various ways sexologists and health care providers have conceptualized sexual health since 1975, when the World Health Organization (WHO) published the first international definition. They noted that the original definition, based on the WHO definition of health, provided a solid framework on which expansion has taken place over several decades, as the need for more comprehensive definitions emerged to fully attend to the many facets of sexual health. They added, however, that the broader definitions of sexual health may actually make research more difficult and overwhelming, due to the sheer number of factors that must be considered (Edwards & Coleman, 2004).

WHO's (2006) latest working definition of sexual health included some of those additions. They describe sexual health as:

A state of physical, emotional, mental and social well-being in relation to

sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual

health requires a positive and respectful approach to sexuality and sexual

relationships, as well as the possibility of having pleasurable and safe sexual

experiences, free of coercion, discrimination and violence. For sexual health to be

attained and maintained, the sexual rights of all persons must be respected,

protected and fulfilled. (p. 5)

The Sexuality Information and Education Council of the United States (SIECUS) List of Life

Behaviors of a Sexually Health Adult (Pan American Health Organization, World Health

Organization, & World Association of Sexology [PAHO, WHO, & WAS], 2001) behaviorally

operationalizes this definition by providing statements that specify how an adult with high sexual

health would act. It says:

A sexually healthy adult would:

- Appreciate one's own body.

- Seek further information about reproduction as needed.

- Affirm that human development includes sexual development that may or
  may not include reproduction or genital sexual experience.

- Interact with both genders in respectful and appropriate ways.

- Affirm one's own sexual orientation and respect the sexual orientation of
  others.

- Express love and intimacy in appropriate ways.

- Develop and maintain meaningful relationships.

- Avoid exploitative or manipulative relationships.

- Make informed choices about family options and lifestyles.

- Exhibit skills that enhance personal relationships.

- Identify and live according to one's values.

- Take responsibility for one's own behavior.

- Practice effective decision-making.

- Communicate effectively with family, peers, and partners.

- Enjoy and express one's sexuality throughout life.

- Express one's sexuality in ways congruent with one's values.

- Discriminate between life-enhancing sexual behaviors and those that are harmful to self and/or others.

- Express one's sexuality while respecting the rights of others.

- Seek new information to enhance one's sexuality.

- Use contraception effectively to avoid unintended pregnancy.

- Prevent sexual abuse.

- Seek early prenatal care.

- Avoid contracting or transmitting a sexually transmitted disease, including HIV.

- Practice health-promoting behaviors, such as regular check-ups, breast and testicular self-exam, and early identification of potential problems.

- Demonstrate tolerance for people with different sexual values and lifestyles.

- Exercise democratic responsibility to influence legislation dealing with sexual issues.

- Assess the impact of family, cultural, religious, media, and societal messages on one's thoughts, feelings, values, and behaviors related to sexuality.

- Promote the rights of all people to accurate sexuality information.

- Avoid behaviors that exhibit prejudice and bigotry.

- Reject stereotypes about the sexuality of diverse populations. (p. 12)

This list specifically articulates 30 sexual health behaviors related to the WHO definition, based on expertise of sexologists worldwide.

As with much of social science and health research, experts tend to define variables in general and universal terms. Often the perspective of lay people, and in particular lay people of color is absent from such expertise. For example how does a heterosexual Black man of Caribbean descent (who has traditionally been excluded from research) define sexual health? Is it a process or a goal? What is his level of dedication to sexual health, given the complexity of its attainment? These questions surfaced while reviewing the current definitions, keeping the context of this demographic and personal experience with them in mind. The SEICUS definition informed one aspect of this study, which considered how heterosexual Black men of Caribbean descent (HBMCD) define sexual health and how their conceptualization aligns with and departs from the above list.

Given the complexity of studying sexual health, many researchers have opted to select limited aspects of sexual health for investigation. Behavioral indices tend to receive the most research attention, including onset of sexual intercourse, condom use, sex under the influence of drugs and alcohol, and number of partners (El-Bassel et al., 2003; McGruder, 2009; Scholly, Katz, Gascoigne, & Holck, 2005). In a study of the efficacy of a couples sexual health

intervention, El-Bassel et al. (2003) measured condom use and number of partners in the past 90 days as the baseline and follow up variables for sexual health. This study left out the social dynamics that might be at work within couples, a variable that could have impacted the efficacy of the intervention and the sexual health of the individuals involved. Scholly, Katz, Gascoigne, and Holck (2005) studied college students' sexual behaviors and the impact of an intervention based on social norms theory. They discovered that no changes in behavior occurred after nine months; yet, without a deeper look into the psychological underpinnings of the students' sexual behaviors, they may have missed an important aspect of sexual health and change. McGruder (2009) conducted an in-depth literature review on studies of Black sexuality and sexual health, confirming the overuse of behavior indices and disease-oriented studies on the Black populations. He reported, "Most of the articles from the two databases and from the Journal of Sex Research focused on topics related to sexually transmitted infections, primarily HIV and AIDS" (p. 253).

Studies that explore the psychological and social aspects of sexual health exist (Boyle & O'Sullivan, 2010; Byers, 2011; Thompson-Robinson et al., 2005), but they are often not under the search terms *sexual health*, leaving the impression that they are separate from, rather than related to, the sexual health behaviors. Studies on sexual decision-making and sexual communication, for example, relate to the SIECUS List (PAHO, WHO, & WAS, 2001) items "practice effective decision-making" and "communicate effectively with family, peers, and partners," (p. 12) yet they are not found when using *sexual health* as search terms. Still, these studies provide important insight into the factors that influence sexual health, both quantitatively and qualitatively.

Otto-Salaj et al. (2010) concluded that having the ability to communicate with one's partner about sexual health issues is an important factor in prevention of HIV, and Sheeran and Orbell (1999) confirmed this assertion through their meta-analysis, which found a strong link between sexual communication with partners about condoms and actual use. Additionally, Juhasz and Sonnenshein-Schneider (1979), stated that sexual decisions include: "to have or not to have intercourse; to have or not to have children; to use or not to use birth control; (if pregnant) to deliver the child or to seek an abortion; to keep the child or give it up for adoption; and to marry or to remain single" (p. 181). Effective decision-making in these areas influences and is influenced by various other aspects of sexual health. Cultural, interpersonal, and intrapsychic components of sexual health tend to be overlooked due to inconsistency in sexual health definitions (Lewis, 2004).

Another overlooked aspect of one's sexual health is to "demonstrate tolerance for people with different sexual values and lifestyles" (PAHO, WHO, & WAS, 2001, p. 13). Research on prejudice, homophobia, and intolerance often exists outside of the literature on sexual health, presenting this concept as one that has little effect on the sexual lives of those with intolerant beliefs. However, some studies have found that men may endorse homophobic beliefs and also engage in secretive homosexual behavior, embodying an internalized homophobia that limits their psychosexual wellbeing and the wellbeing of others (Myers, Javanbakht, Martinez, & Obediah, 2003). For men who identify as heterosexual, inability to tolerate diverse sexualities may also impact the full range of their sexual expression with their female partners (hook, 2004). In Caribbean culture, where systemic oppression of LGBT populations is evident in all aspects of society, it could be deduced that this aspect of sexual health may not align with the definitions of people in that culture.

Because of the complexity involved in studying a comprehensive definition of sexual health in an underserved demographic, HBMCD, finding a culturally appropriate theory proved important. Sexual Scripting Theory (Simon & Gagnon, 1984; 1986; 2003) offered a sound theoretical framework with which to frame this study. A few authors have suggested that Sexual Scripting Theory fits well with explorations of sexuality among Black people, and yet only studies with Black women have attempted to utilize this theory to discuss specific outcomes or explain sexual health experiences (Bowleg, Lucas, & Tschann, 2004; Lewis & Kertzner, 2003; Stephens & Phillips, 2005). An explication of Sexual Scripting Theory follows.

<center>Sexual Scripting Theory</center>

Simon and Gagnon (1984) developed Sexual Scripting Theory (SST) as a conceptual framework to "examine development and experience of the sexual" (p. 60). This social constructionist theory emerged out of resistance and response to Ericksonian and biological theories about sex, with the intention of questioning how the sexual is represented in one's behaviors (Simon & Gagnon, 2003). They recognized that biology and drive only explain one part of sexuality in the context of cultural norms and interpersonal dynamics. Thus, the authors suggested that three intersecting levels must be considered when examining what influences sexuality: cultural scenarios, interpersonal scripts, and intrapsychic scripts. Congruence of cultural scenarios and intrapsychic scripts holds weight in what sex represents. When cultural scenarios and intrapsychic scripts are incongruent, as they might be among HBMCD, given the stereotypical nature of certain cultural scripts around their sexuality, as well as limited access to the full range of hegemonic masculinity-based cultural scenarios, sex becomes metaphoric (Simon & Gagnon, 1986). Metaphoric sexuality implies that the meaning of a man's sexual health choices may represent something outside of simply a desire for sexual pleasure.

Cultural Scenarios

Cultural scenarios guide roles through collective societal norms and social institutions, such as media and government (Simon & Gagnon, 1986). Using an acting metaphor, the authors state that cultural scenarios "provide for the understandings that make role entry, performance, and/or exit plausible for both self and others" (p. 98). What the media, government, and other cultural institutions demarcate as appropriate informs the way sexuality is expressed (performed), suppressed, and/or hidden. Cultural scenarios intersect and instruct citizens on which sexual health experiences, roles, and performances are acceptable and for whom (Bowleg, Lucas, & Tschann, 2004). According to Simon and Gagnon (1986), cultural scenarios communicate which objects are sexual, what the aims of our sexual experiences should be, who desirable sexual partners are and how one should relate to them, in addition to when, where, and how one should act sexually. They also tell what one should feel, which differs from intrapsychic scripts that relate to how one actually feels. Some cultural scenarios relevant to HBMCD's sexual health are global stereotypes and national values about Caribbean identity and sexuality, media and policy related to heterosexual identity, and the various countries' sexually transmitted infections (STI) histories and current prevalence.

Interpersonal Scripts

Whereas cultural scenarios reflect relatively abstract concepts, interpersonal scripts are defined as the concrete application of culturally guided and psychologically influenced roles (Simon & Gagnon, 1986). This level is the most visible, in relation to the others. The authors acknowledge that cultural scenarios may not be congruent with the specific situation a man encounters. They state, "This is a process that transforms the social actor from being exclusively an actor to being a partial scriptwriter or adapter shaping the materials of relevant cultural

scenarios into scripts for behavior in particular contexts" (Simon & Gagnon, 1984, p. 53). One's understanding and application of cultural scenarios happens through interactions with other actors, including partners and peers, as well as family. Several studies have articulated the role of peers in sexual health, with one's perception of his peers' sexual health often serving as a comparative marker of his own sexual health (Bowleg, 2004; Thompson-Robinson et al., 2005). The interpersonal level includes the man's awareness of the context surrounding the behaviors, which may encourage him to deviate from or remain consistent with cultural norms or intrapsychic desires, as "the sexual also shares the burden of demonstrating social, gender, and moral competence" (Simon & Gagnon, 1986, p. 116). Thus, if one's peers tend to be deviating from the known cultural scenarios, one is likely to do the same. The interpersonal script level also holds implications for contexts such as age and setting, with certain actions being acceptable amongst peers groups depending on the developmental level and environment.

Partners present an interesting dynamic, given the power differential typically inherent in heterosexual relationships. Bowleg, Lucas, and Tschann (2004) found that US Black women tend to negotiate gender roles in a way that allows Black men to express their power within relationships, in healthy and unhealthy ways, because they understand that Black men may not have access to other avenues of power (afforded White men) outside of the home. Kempadoo (2009) found the same behavior in Caribbean relationships. Thus, the way HBMCD act out interpersonal scripts may be related, in large part, to whether their partners acquiesce or challenge their behaviors. Gender roles that establish relatively strict and separate, but ostensibly complementary, male and female performances function in Caribbean culture, with the masculine role of being a protector emphasized. These gendered performances overlap with cultural scenarios about heterosexual identity.

How relationships were modeled in one's family of origin may also inform sexual health at the interpersonal level (Stephens & Phillips, 2005). When a man's parents exhibit a loving, healthy relationship, he is more likely to apply that interpersonal script, regardless of what the cultural scripts about Black men might suggest. Interpersonal scripts that affect sexual health in HBMCD include gender roles, specifically the role of protector, interpersonal dynamics with female partners, and other contextual factors related to age and setting. The interpersonal scripting level reflects the ability to challenge or accept and depict stereotypes and cultural norms, as well as one's response to drives, emotions, and desires, while intrapsychic scripts often influence a man's willingness or desire to do so.

Intrapsychic Scripts

Intrapsychic scripts describe the "wishes and desires that are experienced as originating in the deepest recesses of the self" (Simon & Gagnon, 1986, p. 100). They also include various aspects of psychological functioning that influence one's ability to act at the interpersonal level. Stephens and Phillips (2005) note, "knowledge about sexual risks does not translate into behavior change" (p. 38), which speaks to the necessity of understanding the intrapsychic level that may guide behaviors that attend to desires, even when they are not congruent with knowledge about what is sexually healthy. In addition, while norms about who one should be as a member of certain cultural groups happen at the cultural scenario level, one's level of identification with those identities, or the salience of those identities, can be found at the intrapsychic script level. Pleasure, desire, trust, and confidence are some intrapsychic scripts that shape the sexual health of HBMCD, and these factors are often situated in the salience of their heterosexual identity development status, further representing the overlap of levels.

Intersectionality of Scripts

SST emphasizes that cultural scenarios, interpersonal scripts, and intrapsychic scripts overlap (Simon & Gagnon, 2003). This overlap fits with the counseling psychology literature on multiculturalism and intersectionality, which details the ways in which one's many identities are connected and varied in salience (Novotney, 2010). Simon and Gagnon (1984) shared that while the levels have some distinct features, there are some intersections as well. For example, it may be difficult to separate the cultural influence of hegemonic masculinity from the behaviors that indicate conformity to masculine norms at the interpersonal level. Furthermore, there may be some aspects of one's interpersonal interactions with peers or partners that influence the way he feels about himself as a sexual being on the intrapsychic level. Thus, one must be mindful when assigning levels to the variables in the review of literature, as well as data analysis. Other critiques of SST include difficulty operationalizing its levels and being too individualistic (Frith & Kitzinger, 2001; Lewis & Kertzner, 2003). Additional examples of this intersectionality will be acknowledged within sections of the literature review, resulting in the examination of some studies in more than one script level.

<center>Sexual Scripting Theory and Black Sexuality</center>

Lewis and Kertzner (2003) were first to cite the value of using Sexual Scripting Theory (SST) to examine Black sexuality. They asserted that a social constructionist perspective informs their premise that Black male sexualities are not essentially similar, but that they become comparable as a result of similar socialization. This assertion suggests that given cultural scenarios that impose sexual stereotypes onto Black men, similar themes in their sexual behaviors may emerge. The authors reviewed three theories that may be useful in grounding research on Black male sexuality (social exchange theory, symbolic interactionism, and SST)

and concluded that SST was the outstanding lens based on its inclusion of multiple intersecting layers: cultural scenarios, interpersonal scripts, and intrapsychic scripts.

Stephens and Phillips (2005) furthered the assertion that SST has relevance for Black people, although they offered it to frame the sexual experiences of Black female adolescents. Both sets of authors discussed how the various levels of scripting are informed by media, peer and family interactions, as well as racial and gender identity; however, Lewis and Kertzner (2003) added that cultural scenarios related to Black masculine norms, such as the *cool pose*, also have importance. These authors did not speak specifically about some of the variables found in other sexual health research, such as conformity to masculine norms and acceptance of male stereotypes, but they did provide some grounding for examining how ethnic identity and endorsements of beliefs about Black male sexuality influence sexual health for heterosexual Black men.

Hussen, Bowleg, Sangaramoorthy, and Malebranche (2012) were first to apply Sexual Scripting Theory to the study of heterosexual Black men. While they did not distinguish their 90 participants by ethnicity, they discovered that cultural scenarios were promoted by peers, parents, pornography, television, and sexual education were relevant for this group. Interpersonal scripts included early sex play, older female partners, and childhood sexual abuse. The intrapsychic scripts they found were limited, as the authors noted that the applied the Sexual Scripting Theory framework post-hoc and had not included questions in their interview to extricate those scripts. This study's participants were largely men from low socioeconomic backgrounds, which is the case with most Black sexual health research.

For HBMCD in particular, the first author's research (Crowell, 2013) found that while a cultural scenario related to Caribbean sexual norms insisted that a participant despise gay men,

his subsequent interaction with gay peers at an all men's college allowed him to adopt an interpersonal script that increased his acceptance of people who had different sexual orientations than his, thus increasing his sexual health according to SEICUS's list. Simon and Gagnon (1984) suggest that in industrialized, or postparadigmatic, societies the lack of congruence between the levels creates anomie, out of which complicated sexual experiences emerge in an effort to restore a cohesive sense of self. US society would likely create anomie for HBMCD, based on their description and the relationship between the migration and acculturation process.

Simon and Gagnon (2003) suggest that the sexual is not intrinsically important, but it is metaphoric, as it helps sexual actors convey meaning. How HBMCD make meaning of their sexual health has received minimal attention in the vast body of sexual health literature. Therefore, SST is useful in explaining what factors contribute to the definition and meaning of the sexual for HBMCD. The use of SST frames how, at each of these levels, HBMCD must negotiate the meanings of their sexual lives, both imposed and internalized, as well as those they create out of their own needs. Next, I will present a review of relevant literature that addresses elements of sexual health at the cultural, interpersonal, and intrapsychic levels, as it relates to HBMCD.

<center>Sexual Scripting Theory and HBMCD</center>

Below I frame the literature germane to HBMCD using Sexual Scripting Theory's three levels (cultural scenarios, interpersonal scripts, and intrapsychic scripts) to categorize research (Simon & Gagnon, 2003). Some overlap is expected, given the intersectionality of identities and scripts; therefore, some studies may be analyzed in more than one section, as it relates to that level's meaning.

Cultural Scenarios

Cultural scenarios pertinent to HBMCD's sexual health include global stereotypes and national values about Caribbean identity and sexuality, media and policy related to heterosexual identity, and the various countries' sexually transmitted infection (STI) histories and current prevalence. These scenarios serve as a backdrop guiding the representation of Caribbean men in the West Indies, as well as those who now live in the US, but retain close ties to their Caribbean heritage.

Caribbean identity and sexuality. Smith (2011) prefaces her edited volume *Sex and the Citizen* with commentary about the depiction of Caribbean identity and sexuality as linked and intersecting, such that they are seen as one in the same. She states, "the Caribbean – as part of the so-called New World or in its own right – has been regarded by the rest of the world as the very epitome of excessive sexuality" (p. 6). Kempadoo (2004) appraises the relationship of the Caribbean's colonization and its sexuality, asserting that hypersexuality is both an historical imposition and a reality of the lived experiences of Caribbean people. In an attempt to counteract some of the global stereotypes about Caribbean sexuality, a conservative system of values around sexuality competes with events like the region's cultural celebration of the sexual through Carnival. Carnival has now become a tourist attraction for travelers around the globe, and Kempadoo (2004) argues that a part of the appeal is the sexual possibilities. Yet O'Callaghan (2011) highlights the inherent conflict by addressing "the deeply conservative nature of Caribbean sexual morality, its intolerant and repressive attitudes toward inappropriate desire and sexual difference" (p. 130). Caribbean identity carries unique tensions in the interstices of its intersections.

To be a Caribbean, one must be born in or to parents or grandparents who were born in any of 21 islands on the Caribbean Sea (LANIC, 2013). Though the diversity of the Caribbean is

evident in language, culture, and socioeconomic status, sexual health research tends to aggregate the countries for purposes of research, given historical similarities and geographic proximity (Avert, 2013). Supporting this point, Livingston, Neita, Thompson, Warren, and Livingston (2006) noted that they found no significant differences among Black Caribbean immigrants in acculturative stress and health, which may suggest that discussing the groups as one culture will be acceptable for the purposes of this study.

As part of a Caribbean sexual identity, cultural scenarios suggest one must embrace "patriarchal heteronormativity yet includes bisexual and same-sex relations. It is powerful or violent, frequently acts as an economic resource, sustains polygamy, multiple partnering and polyamory, and is mediated by constructions of race, ethnicity and racism" (Kempadoo, 2009). For Caribbean women and men, sexuality holds the potential for pleasure, power, and danger, although the degree to which they perceive these three variables differs based on culturally sanctioned stringent gender roles more than their US peers.

Lorick-Wilmot (n.d.) suggested that people of Caribbean descent in the US may occupy a position different from non-Caribbean Blacks from the US, because they immigrated from countries where they were the majority. This difference, she posited, may translate into fewer encounters with overt prejudice and increased self-esteem. The exception seems to be related to those who were connected with the hospitality and tourism industries before immigration. In the hospitality industry, Caribbean people are exoticized and exploited for sexual consumption by others (Saunders, 2011; Weichselbaumer, 2012). A cultural scenario that might emerge from this perspective is that HBMCD are more exotic and sexual than US Black men. Therefore, while Caribbean people in the US are often aggregated along with African Americans in research it is important to study Caribbean men as a distinct group rather than assuming homogeneity.

Heterosexual identity. Indicators of sexual health, such as respecting the sexual diversity of others (PAHO, WHO, & WAS, 2001) have been at conflict with Caribbean cultural scenarios that promote heteronormativity (Cowell & Saunders, 2011). From music that deals with assaulting and killing gay men, to public policy that polices sexual practices outside of heterosexual intercourse, homosexuality has not received widespread acceptance, or even tolerance, among many people of Caribbean descent (Smith, 2011). The cultural script that HBMCD must hate homosexuals and anything gay prevails. Everything from Caribbean governmental policy to music defines masculinity by not being homosexual or feminine (Gillespie, 2011; O'Callaghan, 2011; Tambiah, 2011). On the other hand, sexual health behaviors related to respecting and appreciating one's body tend to align with cultural beliefs, especially within celebrations like Carnival, where bodies receive prominence and adornment for display and dance (Perkins, 2011). These cultural scenarios suggests that HBMCD are sensual and tuned in to their bodies, but only appropriately so when said bodies are engaged in heterosexual sexual encounters.

Heterosexual identity development research articulates the process through which one comes to understand himself as heterosexual (Worthington et al., 2002; Worthington & Mohr, 2002; Frankel, 2004; Morgan, 2012). While White cultural norms around heterosexual identity may represent entitlement to power, for men of color, heterosexual identity may represent an opportunity for power not afforded to them in the way they perceive White men to have access (Smith, 2011). Smith writes, "To agree with 'the West' that the region is violently homophobic, or even that homophobia is reprehensible, is to risk yielding the hard-won sovereignty of a region historically subject to the whims of colonizers…It is to concede the spectacular and exceptional nature of the region's violence and its not quite modern character" (p. 10). The

tension, then, is that holding the Caribbean to US standards on sexual health and critiquing the homophobia may be pathologizing, and hypocritical, given the United States' history with oppression (Worthington et al., 2002). Still, Smith (2011) states, "Repudiating these ideas about the Caribbean, on the other hand, also means denying that homophobia exists, or that it is a plausible cause for concern in the region, or that the discussion of homosexual desire is appropriate" (p. 11). Heterosexual identity, like racial identity, is not a static aspect of self (Worthington & Mohr, 2002). Worthington et al. (2002) highlight that because identities intersect, "For example, cultural contexts of family, community, cultural norms, and oppression can potentially magnify or inhibit an individual's affectional preferences and sexual behaviors, thereby affecting his or her sexual identity development. Adherence to one's cultural identity may require acceptance of heterosexist and homonegative attitudes" (p. 507), which has likely been the case for most HBMCD.

In general, the sexual health literature has focused on females as the subject of investigation, promoting the association of women and girls with sexual vulnerability. Higgins, Hoffman, and Dworkin (2010) coined the term *vulnerability paradigm*, to highlight this popular assumption that men are the perpetrators of sexual risk and disease, rather than acknowledging how aspects of their masculinity actually put them at risk as well. The vulnerability paradigm represents a cultural scenario in which heterosexual men across race and class are encouraged to act as if they are invulnerable, and others are expected to view them that way. Studies on heterosexual male sexual health contribute an important contrasting concept of how masculinity functions in sexuality and sexual health. Masculine norms have been cited in some studies as influencing male sexual health and increasing sexual risk (Elder, Brooks, & Morrow, 2012; Snell, Belk, & Hawkins, 1990).

Elder, Brooks, and Morrow (2012) evaluate *The Centerfold Syndrome*, claiming that the components of this syndrome evolve from cultural scenarios that men should be "sexually experienced, with a high frequency of sexual relationships, some of which occur without commitment" (p. 167). As is the nature of the sexual, the authors assert that The Centerfold Syndrome are cognitive aspects of men's sexual self-schema that work in response to cultural norms that suggest what a man *should* be. Thus, the findings of this study will be explored in the section of this chapter that addresses intrapsychic scripts, while the overarching societal messages must be referenced in this section on cultural scenarios. This study articulates what culture tells men about who they should be, but stereotypes related to heterosexual male sexuality have also been explored as it relates to their impact on clinicians and what they think a sexually healthy male should look like (Snell, Belk, & Hawkins, 1990). These authors note that both men and women believe some of these stereotypes, which include: "(1) Inexpressiveness; (2) Sex Equals Performance; (3) Males Orchestrate Sex; (4) Always Ready for Sex; (5) Touching Leads to Sex; (6) Sex Equals Intercourse; (7) Sex requires Erection; (8) Sex Requires Orgasm; (9) Spontaneous Sex; and (10) Sexually Aware Men" (p. 252).

What Snell and colleagues (1990) describe as cognitions must first present at the cultural level, as a way to set the script for what to think about oneself. For example, at the cultural level, inexpressiveness suggests that men should be stoic and lack expression of affect or emotion, in sexual relationships and in other relationships. Additional directives state men must orchestrate the sexual experience while the sex must be spontaneous. For example, consider the movie *American Pie* (Weitz & Weitz, 1999), where Kevin, the White male lead, attempts to orchestrate a sexual experience with Nadia, the object of his desire, in a way that doesn't seem pre-

determined, although he exerts considerable energy to do so. Thus cultural scripts can cause considerable conflict and confusion.

Cultural scenarios have implications for sexual health related to performance and emotional connect for heterosexual men. The more men internalize cultural scenarios, the greater difficulty they may experience in their sexual performance and ability to express emotional intimacy with partners, often depersonalizing them. Furthermore, when partners and clinicians endorse similar assumptions, they could possibly prevent men from working against these norms at the interpersonal level (Snell, Belk, & Hawkins, 1990).

Forrest (2001) identified several ways in which men's sexual health, particularly college men, can be addressed. She emphasized aspects of the WHO (2006) definition that require attention in this population, including physical and emotional factors in sexual health. She also noted that communication with partners is an important area of sexual health that can be developed in a college setting. Forrest addressed common stereotypes and norms that may interfere with the health promotion or help-seeking around sexual health concerns for heterosexual men on college campuses, such as gender roles that position men as risk takers and less likely to seek help for STIs or other sexual issues to hide their vulnerability. She addressed another under studied aspect of sexual health: sexual violence. This issue relates to the SIECUS List item "discriminate between life-enhancing sexual behaviors and those that are harmful to self and/or others" (PAHO & WHO, 2001, p. 13).

Some of Forrest's (2001) suggestions to address issues of masculinity in sexual health promotion on college campuses are to host "focus groups in which men reflect on the ways their behavior and sexual practices are determined by culture, history, religion, and gender; how these traditional practices might interfere with the practice of safer sex; and how they might prevent

STI/HIV in their own lives" (p. 261). This suggestion proves especially important for heterosexual Black men, who have limited opportunities to explore how race intersects with masculinity and contributes to their sexual health.

Much of the heterosexual male sexual health literature examines masculinity and masculine norms in White populations, therefore parceling out the separate experiences of heterosexual Black men is necessary to capture an additional level of culture and associated stereotypes and experiences. Studies examining sexual health among heterosexual Black men are relatively few in the large canon of sexual health literature (Bowleg, 2004; Charnigo, Crosby, & Troutman, 2010; Higgins, Hoffman, & Dworkin, 2010; Lewis & Kertzner, 2003; Oparanozie, Sales, DiClimente, & Braxton, 2012). Among those that do focus on this demographic, there are various methods used to determine what influences the way this demographic experiences sexuality in the US.

Poulson-Bryant's (2005) book *Hung* offered a narrative exploration of perceptions of Black male sexuality in the US and addressed the ways in which historical and current stereotypes about Black men as hung (i.e., having larger penises than White men), have influenced how Black men negotiate their identities. He asserted that the cultural stereotype of Black male sexual endowment, which is often promoted as fact, has been internalized by a number of men, who then act out of a stereotypical, and often unhealthy, sense of pride and anxiety in one's perceived prowess (Poulson-Bryant, 2005). This notion, coupled with hooks' (2004) discussion of how endorsing hegemonic masculine ideals compromises Black men's ability to communicate their need for intimacy and make healthy sexual decisions, adds to the ways this research views sexual health. For example, with attitudes that sometimes dehumanize partners, one cannot become intimate if there is *otherness*.

The marginalization and discrimination faced by Black men makes them vulnerable to a number of health-related stressors (Parham & McDavis, 1987; Wester, Vogel, Wei, & McLain, 2006). Sexual health is an area where Black men are affected at disproportionate and alarming rates. The CDC (2011) estimated that in 2009, nearly 20% of Black men with HIV contracted it through heterosexual sex. In 2008, 18.8% of Black men diagnosed with AIDS reported that it was contracted from heterosexual sex (Avert, 2011). There are socially and culturally imposed stereotypes that have kept heterosexual Black men out of the literature. For example, they are not perceived as vulnerable by researchers, society, or themselves, despite the statistics that suggest otherwise (Higgins, Hoffman, & Dworkin, 2010; Lewis & Kertzner, 2003). This phenomenon can be traced to the "demonizing of Black male sexuality," (Nagel, 2000; p. 122) that originated in the White male depiction of Black men as sexual predators during slavery. It may also be traced to stereotypes such as the *player* and the *tough guy* (Crook, Thomas, & Cobia, 2009). When Black men internalize these stereotypes, it impacts their sexual health. Additionally, other cultural scenarios associated with masculinity (Crook, Thomas, & Cobia, 2009) and traditional male sexual stereotypes have been found to influence sexual health among this group (Bowleg, 2004).

Bowleg (2004) asserted, "Empirical studies with African American men, although scant, have indicated that factors such as age (Cazenave, 1984; Hunter & Davis, 1994), socioeconomic class (Hunter & Davis, 1992), racial and ethnic identity (Abreu et al., 2000; Wade, 1996), and geographic residence (Levant & Majors, 1997; Levant, Majors, and Kelley, 1998) influence masculine ideologies" (p. 170), whereas other studies have looked at demographic factors and sexual health, finding no difference in consistent and inconsistent condom users (Charnigo, Crosby, & Troutman, 2010; Corneille et al., 2008). Simon & Gagnon (1984) declared, "few

cultural scenarios are without implications for age or life-cycle stage" (p. 57), implying that while the stereotypes and norms prevail, they are not expected to be applied equally across age groups, although each actor has some degree of autonomy in deciding whether he will follow the norm. The same can be assumed for other demographic markers, such as class and geographic region. These conflicting findings warrant additional exploration.

Sexual health history and STI prevalence. According to Avert (2013) the primary route of contraction of HIV in Caribbean countries is through heterosexual sex. Approximately one percent of the Caribbean population is infected with HIV, making it the region with the second highest prevalence in the world. These rates of infection differ by country, with the Bahamas representing the highest rate at 3.1% and Cuba representing the lowest at 0.1% (Avert, 2013). Caribbean immigrants in the US have higher prevalence rates of STIs than most immigrants (St. Jean et al, 2011). Stereotypes about Caribbean infectiousness have prevailed since the late 1980's, when there was a popular belief that HIV/AIDS originated in the Caribbean, specifically Haiti (Farmer & Kim, 1991).

Farmer and Kim (1991) explored the theory of the origination of HIV in Haiti and offered some insight into how Caribbean sexual health has been approached in US culture. In the opening narrative, the authors quoted a document in which a White teacher told her Haitian students that AIDS originated in Haiti because Haitians have sex with monkeys. Farmer and Kim (1991) noted that this teacher's remark was emblematic of the larger US culture's perception of Haitian Americans as voodoo practicing deviants who were placing the US at risk for AIDS. While there have since been corrections to these perceptions about Haitians in the media, the history of these depictions and related discrimination represents another cultural legacy of how people of Caribbean descent are viewed by the mainstream US.

In a secondary data analysis of HIV and substance abuse among Caribbean immigrants in the US, St. Jean et al. (2011) found that "in New York City…the largest number of people living with HIV are from Haiti, the Dominican Republic, Cuba, and other Caribbean countries" (p. 329). The authors assert that concurrent partnering, poor health practices, stigma related to HIV, lack of condom use, and presumed anonymity in the US may contribute to high prevalence among Caribbean Americans (St. Jean et al., 2011). Interestingly, HIV prevalence in the Caribbean has actually declined in the past decade (Figueroa, 2014). Imprisonment, sex work, drug use, and men who sleep with men were cited as contributors to the high prevalence of HIV, but heterosexual sex, often with a primary partner, remained the main route of transmission (Figueroa, 2014; Garcia, Bayer, & Carcoma, 2014). Despite public policy that criminalizes sodomy and other homosexual behavior, Caribbean countries have yet to police practices that present as most problematic to the transmission of STIs. Some of these practices may operate out of the interpersonal script level.

Interpersonal Scripts

Interactions between heterosexual Black men and their peers, family members, and partners represent interpersonal scripts that may influence sexual health. This section identifies research that examines how these different subgroups impact sexual health. The studies in this section focus mostly on heterosexual Black men without the specific focus on Caribbean descent.

Peer influences on sexual health. Bowleg's (2004) exploratory mixed-methods study resulted in themes that highlighted the importance of social networks as influence on Black male sexual health, with the participants noting that they were often impacted by their friends' expectations that they maintain concurrent sexual relationships. One participant's story was particularly salient to this point. He said, "I'm the guy [my friends] used to hang out with and

pick up girls . . . pick out the targets: Bam, bam, bam! [But] I just don't have that in me anymore to do stuff like that. And [my friends are] like, "What happened to you? You're going to let yourself go out like that?" (p. 75). This man's narrative speaks to the difficulty that may be presented when a man chooses to depart from the cultural scenarios about Black men, when his peers have not made that decision.

One participant in research echoed similar sentiments. He shared that there were occasions when his friends (married and single) would attempt to live vicariously through him, encouraging him to pursue women rather than take his committed relationship seriously (Crowell, 2013). He offered that he has since shifted to a group of married friends whose influence has been beneficial in his own marriage, as they offered insight into married life that was unavailable in his family of origin because no one was married (Crowell, 2013). The idea of maturation and development versus being a perpetual teenager illustrates the impact contextual factors such as age have on sexual health. Peer groups who advance through the developmental stages often encourage that same development in individual members of the group.

Familial influences on sexual health. If we stick with the SST metaphor of actors, family relationships are the first stage for a number of performances, including those related to sexual health (Simon & Gagnon, 1984). The types of relationships modeled in a heterosexual Black man's family of origin may either conform to the cultural scenarios or depart from them, indicating to the individual the level of freedom he can experiment with in his decisions at the interpersonal level. Bakken and Winter (2002) confirm this assertion, indicating that Black men who were raised in two-parent households fared better than their peers who grew up in single parent homes on sexual health indicators such as number of sexual partners and age at first sexual experience. Caribbean families prioritize messages about manhood that include sexual

prowess and fathering children, such that the sons in these families see gender roles strictly determined by fathers and enforced by mothers (Kempadoo, 2009; Smith, 2011).

In addition to the presence of parents or other family members in successful sexual and/or romantic relationships, the messages and communication received from family about sex tend to hold weight with Black men. For example, males are allowed access to sexual exploration in a way that females are not. Although the mandate is that the exploration be heterosexual, males receive the message that their sexual initiation is expected and valued while females should be virgins until marriage. Family messages are enduring, for example a research participant expressed the view that a lack of communication within one's family about sexual health often influenced sexual health well into adulthood (Crowell, 2013). Given that only 18% of Black Caribbean immigrant households are composed of married adults with children, it is important to give the impact of this interpersonal script consideration in the sexual health of HBMCD (Thomas, 2012).

Fatherhood, regardless of whether one is married to the mother of his children or not, remains an important experience to Caribbean men, as it is an expression of virility. Being responsible for others often gives men an avenue through which they can mature and express positive aspects of their masculinity. In some instances, the heterosexual masculine role of protector can trump the less healthy sexual praxis endorsed in Caribbean culture (Kempadoo, 2009). Men who are fathers can excuse themselves from their peers' continued acts of infidelity when they emphasize wanting to provide a different example for their children, and this excuse is generally accepted by other men as a valid reason.

Partner influences on sexual health. The participants in Bowleg's (2004) study also emphasized the role their partners played in their sexual health, especially as it relates to condom

use and concerns about HIV. Most of the men expressed that their condom use was based on not wanting to get their partner's pregnant, as opposed to being afraid of contracting an STI from their partners. Corneille et al. (2008) presented findings that supported Bowleg's (2004) results related to reasons for condom use. Heterosexual Black men between ages 18 and 35 in the focus group cited pregnancy prevention as the main reason to use condoms. Personal protection was a rare response, which was couched in the distrust of women. Other themes that emerged were that men initiate condom use (cultural scenario), alcohol impacts interactions, but not condom use, and that good communication led to safer sex.

A quantitative survey study by Charnigo, Crosby, and Troutman (2010) built on the discussion of condom use among Black men, as it relates to their partners. Their subjects were Black men recently diagnosed with an STI, which may have skewed the results toward those who are less sexually healthy. They used condom use at last sexual encounter as their measure of sexual health and found that "of the 266 men, 127 (47.7%) reported they had used a condom at last sexual encounter" and noted correlation with "attitudes toward condom use, the measure of self-efficacy, sensation-related barriers to condom use, and partner-related barriers to condom use" (p. 306-307). The correlation between partner-related barriers to condom use conflicts with popular notions of men as sexual decision-makers (Corneille et al., 2008), and yet partner influence has been supported in another study among Black men (Thompson-Robinson et al., 2005).

Another study on younger heterosexual Black men (18-24) examined condom use qualitatively through focus groups and presented results that differed from Bowleg (2004) and Corneille et al.'s (2008) findings, in that the participants did cite fear of contracting an STI as a reason to use condoms (Kennedy et al., 2007). The young men reported assumptions that their

partners' STI statuses could be determined by looking at them and levels of attractiveness. This finding was also supported in a study of Black male adolescents (Gilmore, DeLamater, & Waastaff, 1996) as well as Bowleg's (2004) study. A particularly salient example emerged from Crowell (2013) wherein a participant shared:

> It may sound weird, but, for instance, if I see a woman who gets manicures all that time, and pedicures, she's clean a lot. Always clean. She's washing her hands. It gives me a good sense. I feel more comfortable laying down with that person, because if they're taking the time to manicure their nails, manicure their feet, washing their body, washing their hands all the time, they're probably going to do the same with their private parts.

These studies paint a complex picture of men who perceive barriers to communicating about sexual health with partners, and thus use inaccurate proxy methods of determining a partner's sexual health and assessing their own risk. Many of the men recognize that these methods are not medically sound, and yet their continued use of them may speak to a number of concerns, including aversion to actual medical attention, cultural folklore, and an attempt to satisfy intrapsychic desires, regardless of the risk it may present. They succumb to passion and impulse, avoid intimacy in asking about sexual health, and equate sexual health with being physically clean rather than assessing risk through communication with the intended sexual partner.

Interpersonal scripts are important in that this is the level at which HBMCD get to decide which behaviors they will use to represent themselves as sexual beings. They are the script co-writers, and yet their sense of autonomy appears to be influenced at best, and compromised at most, by their desire to belong. Peer group affiliation, as will be noted in the intrapsychic script level, has emerged as both a barrier and protective factor in various literatures (Livingston,

Neita, Riviere, & Livingston, 2007). It depends on what the peer groups endorse, and the intrapsychic scripts that inform a man's desires.

Intrapsychic Scripts

This section discusses research relevant to some intrapsychic scripts that may impact the sexual health of HBMCD. Of all the script levels, intrapsychic scripts have received the least amount of attention (Whittier & Simon, 2001). Simon and Gagnon (1984) contended that motivations influencing interpersonal choices are often nonerotic; therefore, factors such as masculine identity, racial/ethnic identity, acculturation, and attachment can function at the intrapsychic level in a way that influences sexual scripts, although they do not necessarily relate to sex. Additionally, Simon and Gagnon (1986) articulated that intrapsychic scripts are based on reconciling the desire of "what we expect to experience from something or somebody" (p. 100). This expectation, for HBMCD, colors the way sexual health is undertaken. These will be discussed in the sections below.

Masculine identity. Elder, Brooks, and Morrow (2012) stated that the *Centerfold Syndrome* includes five aspects of the male sexual self-schema informed by masculine ideology. They are "voyeurism, objectification, a need for validation, trophyism, and a fear of true intimacy and engulfment" (p. 167). At the intrapsychic level, these cognitions encourage men to compulsively "look at women and images of women" (p. 167) in a way that is sexualized, leading to objectification. Objectification creates the impression that women are sexual objects and reinforces the idea that men rely primarily on visuals in sexual attraction.

The need for validation is tied to the perception that when women, particularly those who are attractive, offer words of praise, the man's sexual performance is substantiated as good enough, or pleasurable, and it must be constantly validated for the man to maintain feelings of

value. The connection between need for validation and trophyism speaks to the value some men place on the ability to have sex with attractive women and their need to display this ability to other men (Elder, Brooks, & Morrow, 2012). Fear of intimacy and engulfment, or being overwhelmed by emotion, are also a function of internalized masculine norms that require men to be powerful, independent, and detached. These authors found support for the Centerfold Syndrome theory, as well as other aspects of heterosexual men's sexual self-schemas in a grounded theory study. In addition to the above aspects of sexuality, themes included "shame at one's sexual behaviors," "lack of confidence in appearance," and "avoidance of emotional talk with men" (p. 173).

Elder, Brooks, and Morrow (2012) also articulated the long-term consequences for these men's beliefs, one of which was that the men may engage in behaviors while they are acting out of these masculine norms that lead them to question whether they are worth loving. Simon and Gagnon (1986) address this consequence, with their contention that incongruence on the cultural scenario and intrapsychic script level create discord. When society attempts to socialize the need for intimacy out of men, any desire for intimacy must be masked through the outward displays that make intimacy less likely. Men, they suggest, may have hidden values that do not coincide with their actions. This discrepancy of value and action relates to some concern about whether men who endorse this model can and do behave in sexually healthy ways that, "exhibit skills that enhance personal relationships" and "identify and live according to one's values" (PAHO & WHO, 2001, p. 13). Thus, the intrapsychic scripts with which men may contend are related to their fears about intimacy and their desire for validation, consumption of women's bodies, and shame about the actions they take to fulfill their desires.

Racial/ethnic identity and sexual health. Espinosa-Hernandez and Lefkowitz (2009) studied the correlation between ethnicity, ethnic identity commitment, and sexual health in a college sample of Black, Hispanic, and White participants. They reported a negative, but non-significant, association between ethnic identity and condom use among only the Black students. However, Corneille, Fife, Belgrave, and Sims (2012) found a significant positive association between rejection of traditional masculine ideals, relationship mutuality, a measure of "empathy, engagement, and authenticity" in one's relationship, and ethnic identity, among heterosexual Black male college students attending an historically Black college/university (HBCU). They found no relationship between ethnic identity and condom use. Thus, there appears to be some difference in how ethnic identity influences social versus behavioral aspects of sexual health.

Oparanozie, Sales, DiClemente, and Braxton (2012) explored the correlation of sexual risk and racial identity (measure by centrality and private regard) among heterosexual Black men and discovered that positive feelings about one's race predicted sexual health, measured by fewer partners, a lower likelihood of having concurrent partners, and increased condom use. This finding provides support that racial identity may be a protective factor against sexual risk behaviors, but the study of ethnic identity and sexual health requires additional research. For men of Caribbean descent, high positive regard for and internalization of their ethnic identities, given the culture's emphasis of sexuality, is something worth considering further. Because ethnic identity and racial identity differ, as one is related to nationality and the other to the social construct of race, HBMCD may find ethnic identity more salient than racial identity. Related to ethnic identity and acculturation, Simon and Gagnon (1986) note, "the role of sexuality in providing identity confirmation, however temporarily, tends to become particularly salient during those moments when self-cohesion is itself in question" (p. 117). For a Caribbean

immigrant, moving from one country to another, managing ethnic identity in the face of the acculturation process, sex may be a way to solidify his identity.

Acculturation and sexual health. According to Livingston, Neita, Riviere, and Livingston (2007), "acculturative stress is viewed as the phenomenon individuals or groups experience in their adjustment to a new culture" (p. 216). For people of Caribbean descent, their intention is often to selectively acculturate into US society, motivated by their internalized racist belief that affiliation with Black Americans results in lower social status. Livingston and colleagues found that for Caribbean men, affiliation with Caribbean cultural groups was correlated with fewer depressive symptoms, which related to another finding that connected feelings of loneliness to a greater tendency to report depressive symptoms. Overall, the authors did support their hypothesis that acculturative stress was related to negative health outcomes. This finding is an area where the intersectionality of the cultural scenario and intrapsychic script emerges. Culturally, the script suggests that Caribbean people should not integrate into Black US culture, and on the intrapsychic script level, the resistance to becoming acculturated into US and/or Black American culture could have positive implications for health in HBMCD, at the price of further marginalizing US Blacks.

Williams et al. (2007) supported the above findings, as they discovered that US born Caribbean, especially third generation Caribbean descendants, had higher rates of mental illness than those who immigrated in their lifetimes. Caribbean people in their third generation are more likely to experience the US as Black Americans, rather than Caribbean Americans who have had the experience of living in a culture where they were the majority, and heritage culture provides a buffer that is removed by acculturation. They also reported that men experienced higher rates of mental illness than women. US studies on the sexual health of people of Caribbean descent are

scarce; however, with the connection between mental health and sexual health, and sexual health within the national borders of Caribbean countries being low according to global standards, further study is needed.

The sole study to investigate an aspect of sexual health and acculturation, as well as substance abuse, among Caribbean people in the US described the health benefits affiliated with new immigrant status as the *Healthy Immigrant Effect* (Saint-Jean et al., 2011). Their analysis of primary and secondary data highlighted that substance abuse was not a major issue for those in their country of origin or in the US. However, once the process of acculturation has been at work for years, these health benefits, in relation to substance abuse and other markers decline. The authors noted that sexual risk behaviors might be another way in which Caribbean immigrants attempt to reduce the stress related to acculturation. They suggested that sexual health indicators such as fewer casual sexual encounters are often endorsed while home, but for those who immigrate and wish to align with US norms, an increase in those behaviors might occur. Furthermore, condom use attitudes and concurrent sexual partnerships may also be influenced by acculturation, with those who are less acculturated often holding negative views toward condoms and being more likely to have multiple partners.

Attachment and sexual health. While literature on attachment and sexual health among Caribbean natives or immigrants remains scarce, some assumptions about its impact on sexual health can be surmised, given what is known about how attachment styles emerge and the immigration patterns of people of Caribbean descent. Attachment patterns typically emerge in early life, marked by the relationship between the caregiver and the child. Bowlby (1970, 1979) and Ainsworth, Blehar, Waters, and Wall (1978) determined that one could be securely attached, meaning he had a healthy and consistent relationship with his primary caregiver, or insecurely

attached, denoting that the relationship with the primary caregiver was unable to be consistent in some way, leading to anxious or avoidant insecure styles. Given the immigration patterns of Caribbean families, parents, typically women, often migrate first, leaving children with extended family until they are able to send for them (Saint-Jean et al., 2011; Thomas, 2012). Although extended family networks are typically tight, this loss of the primary caregiver, even with eventual reunification, may have some affect on the attachment styles of children who remain in the country of origin after the parents have left.

Insecure attachment styles have been connected to a number of sexual health indicators, including establishing and maintaining healthy relationships, protecting oneself against STIs, and participating in life-enhancing behaviors (Brassard, Shaver, & Lussier, 2007). Intrapsychic scripts that emerge from insecure attachments may include wanting to avoid intimacy to protect from abandonment or pursuing relationships in an anxious manner to secure an attachment figure. This fear of intimacy connects with masculine cultural scenarios, as identified by Elder, Brooks, and Morrow (2012). Given the immigration experiences of HBMCD, the imprint of attachment may serve as an intrapsychic script that needs further exploration.

Desire for pleasure and sexual health. SST articulates the function of desire at the intrapsychic script level, in that it acknowledges the human urge to experience something with someone (Simon & Gagnon, 1986). Because desire to experience an orgasm could be achieved without a partner, it is important to connect the added element of wanting a shared experience, even given cultural scenarios for men that encourage independence (Elder, Brooks, Morrow, 2012). In a more recent explication of SST, Simon and Gagnon (2003) state, "Sexual drives, impulses or instincts struck us as misunderstandings of the socially acquired character of sexual life–for us the phenomenological experience of either sexual desire or the desire for sex was a

learned way to label their interests within the context of specific interpersonal and intrapsychic conditions" (p. 492). So, the desire is not just to experience pleasure via orgasm. The pleasure is in the social aspect of sex as well.

Often times, studies of sexual health among marginalized groups, especially marginalized groups of men, depict men as exploiters of the sexual experience for their own gain of pleasure, without accounting for the intrapsychic scripts guiding the roles men choose in their sexual lives. Masculine scripts do not encourage men to seek closeness or shared experiences with women outside of sexual relationships, for many reasons including the fear of feminization. This fear is true for many men across culture, but it appears to be more salient for men of color. Through the lens of SST, a challenge to that popular notion might be that we do not understand, or try to understand, men on the margin, such as HBMCD, well enough to attend to their desires. The omission of intrapsychic scripts can dehumanize these men, in that what gets published is behaviors and the cultural components that inform them, if researchers do not view them as people with intersecting identities of privilege (male, heterosexual) and marginalization at work (Black, Caribbean). Qualitative research is well positioned to address this level, and my role as a psychologist in training situates me as an empathic, well-trained listener/healer with the ability to develop the rapport needed to reach mutual understanding.

Conclusions

Themes such as masculine identity, racial stereotypes, prejudices, and identities, partner attitudes and attractiveness, and peer influence have recurred in research on Black male sexuality overall. This study sought to explore sexual health among heterosexual Black men of Caribbean descent, with the assumption that the added layer of Caribbean ethnic identity may provide additional themes and nuances. The intersection of their cultural identities (male, Black,

Caribbean, heterosexual), as well as interpersonal and intrapsychic scripts, related to partner and peer dynamics, desire, acculturation, and salience of certain identities inform their sexual experiences and attitudes in unique ways (Simon & Gagnon, 1984, 1986, 2003).

This study contributes a dynamic depiction of both the strengths and limitations of HBMCD, as it relates to sexual health. As HBMCD have received very little attention in research, this study attended to their experiences and perspectives in a meaningful way. This research sought to expand the way Black people are viewed, highlighting heterogeneity through exploration of a particular group of ethnicities within the larger race. This heterogeneity also extends to the selection criteria, to be discussed in the next chapter, which included adult men between the ages of 30-50, given that most studies of Black men have been limited to adolescents and young adults. The researcher wanted to empower and challenge the men who participated in this study, giving them space to articulate their experiences and providing empathic confrontation when the discrepancies of what they say, think, and do surfaced. Specific research about this ethnic group of men is a gap in the current literature, based on the literature review.

Chapter III

Methods and Procedures

Research Design

Qualitative research seeks to describe or explain phenomena using the perspective and voice of the participants (Creswell, 2009). Based on a constructivist or interpretivist paradigm, it emphasizes multiple realities constructed by those who live the experiences (Glesne, 2011; Ponterotto, 2005). Ponterotto (2002) asserts that qualitative methodologies are especially relevant for multicultural research in counseling psychology. He notes that constructivist and critical theories emphasize the value of multiple perspectives, specifically those who are marginalized, given the field of psychology's historical ties to Eurocentrism. As this research examined Black men, methodology that reduced the likelihood of depicting them as deficient was useful. Furthermore, discussing the subject matter of sexual health served to empower participants in ways that maintain or improve their sexual behaviors and attitudes, with some benefit to them and the larger Black community (Ponterotto, 2002). Because this research embarked upon relatively new territory in sexual health research, the qualitative approach was employed, and subsequent related studies are to develop from the co-created theory constructed through the voice of the participants and researcher. Because the researcher sought to co-create theory on sexual health among heterosexual Black men of Caribbean descent (HBMCD), grounded theory was selected as the methodology.

Grounded Theory

Grounded theory is a methodology that uses the voices of participants to formulate a theory describing the examined phenomenon (Fassinger, 2005). Developed by Glaser and Strauss (1967) and further developed by Strauss and Corbin (1998) and Charmaz (2006), it outlines methods for collecting and analyzing qualitative data and includes acknowledgement of the researcher's role as an instrument of inquiry, which in turn produces themes that ground new theory on the examined phenomenon. The iterative process of collecting, coding, analyzing, and theorizing based on the data continues until one reaches saturation and no new information is obtained. Relationships are highlighted through recurrent themes, out of which a theory emerges (Fassinger, 2005). In this study, Charmaz's (2006) constructivist grounded theory was be used to develop a theory of factors that HBMCD identify as influential to their sexual health.

Constructivist grounded theory. While some grounded theory studies may evolve out of a positivist tradition, which attempts to conform to quantitative assumptions that there is one answer, which can be proven, constructivist grounded theory rests on the interpretivist paradigm (Charmaz, 2006). It assumes that the researcher and participants are co-creators of the emergent theory. It also assumes that this emergent theory provides only one possible way of viewing the concept being theorized. As Charmaz (2006) noted, "Constructivists study *how* – and sometimes *why*- participants construct meanings and actions in specific situations" (p. 130). This methodology was especially fitting for the study of sexual health through the lens of Sexual Scripting Theory (Simon & Gagnon, 1984, 1986, 2003), as they claimed the metaphoric nature of the sexual. Uncovering meaning behind how HBMCD define and experience sexual health required understanding the "larger and, often, hidden positions, networks, situations, and relationships" (Charmaz, 2006, p. 130), which speaks to the levels of scripting that intersect to inform one's sexual life. This specific sub-sect of grounded theory methodology situates the

analysis in the "time, place, culture, and situation" (p. 131) of the study, which includes the researcher's culture and the research participants' cultures.

Not only does constructivist grounded theory mark the research in its context, it calls for researchers to interpret, rather than simply report (Charmaz, 2006). In my subjectivities statement, I comment on how I am at an advantage as it relates to interpreting the sexual health of HBMCD, given my love for and understanding of these men. While participants shared the *how*, my positionality helped me offer the *why*, which Charmaz (2006) suggests is an important distinction between positivist and constructivist grounded theory methodologies. The suggestions for how to recruit, sample, code, analyze, and theorize are outlined, but the emphasis that there is to be some flexibility is stated as well, given the iterative nature of the grounded theory process.

Recruitment and Sample

Recruitment began with a purposive sampling, followed by a theoretical recruitment of men who self-identified as being Black, Caribbean, male, and between the ages of 30-50. The first focus group contained four participants (n = 4). The second contained three (n = 3). The third contained four (n = 4). On each occasion, one person was unable to attend, so they were not factored into the *n*. Purposive sampling allowed the researcher to recruit participants based on the original research questions, with the purpose of choosing participants who were most likely to have and share important insights about the topic. Theoretical sampling began after the first focus group, where additional participants were selected based on the theory emerging from the initial coding (Charmaz, 2006). While the study intended to host focus groups on heterosexual men, so as not to stigmatize, the researcher did not make note of a sexual orientation designation in recruitment materials, but through the screening process the researcher asked participants how they described their sexual orientations. All said heterosexual. Some added "very" to their

descriptions. Although some research on sexual identity in the Black community suggests that some Black men of Caribbean descent may self-identify as heterosexual, even if they engage in sexual acts with other men due to stigma attached to homosexuality (Cowell & Saunders, 2011; Washington, Wang, & Browne, 2009), this author believes that the men for whom this manner of identification is true would have been less likely to participate in a study about sexuality in Black men, because they may fear that questions about their sexual health will uncover their same sex behaviors. Additional details about recruitment and sample are outlined below.

Recruitment

The researcher made personal visits and phone calls to several Caribbean associations, groups, and restaurants in the metro-Atlanta area specified by the Atlanta Regional Commission (2009) and utilized personal networks of Caribbean men (see Appendix A for script). These organizations include: the Caribbean Association of Georgia, the Atlanta Carnival, soccer and/cricket meet up groups, and various Caribbean restaurants in the Dekalb, Cobb, and Fulton County areas. At time of the meeting or call, the researcher asked permission to post flyers requesting participation of men of Caribbean descent in a study on sex and relationships. The author posted full sized flyers and placed handbills on the counters. Additionally, handbills were placed at a large event for Atlanta Carnival, where the researcher also personally handed out flyers. The researcher contacted several men of Caribbean descent in her personal network and asked them to recommend people to the study. Personal contact was the most successful form of recruitment. Given the sensitive nature of the topic, a personal connection seemed to be the gateway needed for people to be willing to participate.

The flyer (Appendix B) included a brief description of the study, inclusion criteria, notice of monetary compensation ($20 per person) and the researcher's contact information. Interested

persons were asked to email or call the researcher to set up a screening phone interview. Upon screening, participants were selected to be in one of the focus groups, which were scheduled based on the availability of participants and the researcher. Data were collected over the course of three months, from May to July 2014. Because Charmaz (2006) suggests the use of theoretical sampling, after the initial recruitment and focus group, the first author employed theoretical sampling, which seeks to follow the direction the data took by seeking additional participants who spoke to the initial findings.

Description of Sample

Each participant was screened to assess the fit for this research. The inclusion criteria for the screening covered three areas: 1) Black, 2) Ages of 30 – 50, and a 3) Caribbean descendent (heritage from Antigua & Barbuda, Aruba, Bahamas, Barbados, Cayman Islands, Cuba, Dominica, Dominican Republic, Grenada, Guadeloupe, Haiti, Jamaica, Martinique, Puerto Rico, Saint Barthélemy, St. Kitts & Nevis, St. Lucia, St. Vincent and the Grenadines, Trinidad & Tobago, Turks & Caicos Islands, or Virgin Islands (Latin American Network Information Center [LANIC], 2013). The first author also asked questions about relationship status and sexual orientation, as well as what generation were they in the United States. These criteria were selected to fill a gap on extant research in Black male sexual health, which typically uses younger (18-30) men in at-risk populations, such as those who present at a sexual health clinic for treatment (Crosby et al., 2009; Kennedy et al., 2007).

Before beginning the focus group, each participant signed a consent form and filled out a demographic sheet. The sample included eleven men who identified as Black, Caribbean, between the ages of 30-50, and heterosexual. All men had attended college, with a few having graduate degrees. They descended from the islands of Puerto Rico, Jamaica, Trinidad, Guyana,

BVI, and USVI, and they represented first and second generation Americans. They ranged in

relationship status, with six single, three in a committed relationship, and two married.

Participant demographics are in Table 3:1.

Table 3.1

Participant Demographics

Pseudo	Age	Island	Gen	Education	# of part	Condom	Rela Status
Art	40	Trinidad	1st	Grad/Prof	15	Yes	Committed
Ron	34	Guyana	1st	Grad	50	Yes	Single
Jon	32	PR	2nd	College	16	Yes	Single
Don	31	Trinidad	1st	Grad	6	Yes	Single
Ken	33	Jamaica	2nd	College	30	No	Single
Joe	36	Trinidad	1st	College	12	No	Married
Dan*	39	St. Thomas	1st	Grad	10	Yes	Single
Koy*	42	Trinidad	1st	Some College	46	Yes	Single
Oscar*	30	Trinidad	2nd	Post-Bac	?	No	Married
Ven	30	Bahamas	2nd	College	115	No	Committed
Gen	48	BVI	2nd	Some College	?	No	Committed

* Participated in member checking

Data Collection

The first author used focus groups and follow up individual interviews to collect data for

this study. The details of the data collection via these methods are outlined below.

Focus Groups

As suggested by Morgan (1997), data were collected via focus groups, because they

offered a safe space where the phenomenon of sexual health could be discussed among

participants and resulting data could stand on its own. In describing the history of grounded

theory, Fassinger (2005) notes that it developed out of the sociological tradition of examining interpersonal interactions via symbolic interactionism. Focus groups allowed for some of those interpersonal dynamics to be observed by the researcher, which further thickened the analysis. If meaning is constructed through interactions with others, then the focus group offers space for the meaning of sexual health to be constructed among participants in the room. Additionally, several sexual health studies with Black male samples use focus groups as the main source of data collection (Corneille, et al., 2008; Kennedy, et al., 2007; Lindberg, Lewis-Spruill, & Crownover, 2006), setting a precedent for the use of this methodology in the study.

Within the focus groups, the researcher summarized the informed consent (Appendix C) and provided the participants a copy to read, question, and sign. A brief description of the research was explained once more. Then, the author used a semi-structured set of open-ended questions to begin the discussion (See Appendix D). Questions included asking participants to define sexual health, as well as to talk about a time when they were and were not sexually healthy. The researcher also showed the SIECUS List and asked for feedback from the group about how this definition aligns with theirs. The researcher used follow-up questions and probing as needed, often moving the conversation according to the insights of the participants. Participants also engaged in the questioning and moving of the discussion, by asking other members and the facilitators for further explanations, descriptions, and opinions.

The focus group was audio recorded to assist the researcher in identifying which participant said what. Participants did not seem cognizant of the recording, once conversation began. Overall, participants seemed comfortable and engaged in the discussion, based on the openness with which they shared. One participant shared that he was appreciative of this experience, because men often do not get a chance to process their experiences, feelings, and

sexuality with each other without jest. Focus groups lasted approximately two hours each. Participants were fed prior to the focus group, and each participant was offered $20 for participation. Some participants declined the compensation, indicating that the experience was enough or that they recognized a graduate student may not have funds to pay for participation. The researcher transcribed the focus groups verbatim.

Field notes and journaling assisted with the process of bracketing, whereby the researcher recorded observations, tentative analysis, feelings about the research experiences, and other reflections that may bias the analysis. Glesne (2011) offers some recommendations for this part of the process, which will be further outlined in the *Validity* section of this proposal. On one occasion, the researcher experienced such a strong reaction to the data during analysis that she reached out to her dissertation chair for support and processing. The process of using the committee to understand and analyze from a place of knowing one's subjectivities was particularly salient in that moment.

Individual Interviews

As a means of triangulation through member checking, all participants were asked if they were interested in follow-up individual interviews, where the researcher was to share emergent themes and developing analyses of the transcripts to member check for accuracy. In addition, individual follow-up interviews were intended to reduce some of the limitations of using focus groups as the main method of data collection, as they provide a space for participants to share additional aspects of their sexual health narrative without fear of confidentiality breeches that may be more likely in a group setting. Three participants agreed to be interviewed individually and were given the researcher's chapter four to review and discuss. Member checkers agreed

with the emergent theory and noted that they felt understood by the researcher. No suggestions or changes were recommended.

Methods for Data Analysis & Synthesis

Data were analyzed by following the framework set forth by Charmaz (2006). While emphasis was on the participants' attitudes, values, and experiences, the methods include: using theoretical sampling, gathering rich data, coding the data, and memoing (Charmaz, 2006; Creswell, 2007). Charmaz's constructivist grounded theory has been critiqued for having less rigor than that of Strauss and Corbin (1998); however, for the purpose of investigating a marginalized population, her variant meets the needs of interpreting the data in a way that understands the power dynamics and context that may influence the experience of marginalized groups (Creswell, 2007).

The author transcribed each recorded focus group. Recorded interviews were consistently reviewed for clarity throughout the transcription process. When a part of the recording seemed unclear, the author called the participant to clarify. Initial coding followed transcription, wherein the author used the line-by-line coding method to interpret and name the concept of each line of data (Charmaz, 2006). Each line of coding was a gerund phrase relaying the action and meaning of the line, by staying close to the data. An example line code for the line "I agree. I'd say, my health first, but also my partner's" was "prioritizing his health." Once each line of the focus group transcription was initially coded, the researcher read through all codes and began to select larger themes through the focused coding process.

In the focused coding step, larger themes were extrapolated from the line-by-line codes. After each focus group, the author added to the list of focused codes with any new content

descriptions. A total of 40 focus codes were developed in the code book, which included: "understanding context" and "protecting self."

An iterative process of returning to prior focus groups, rereading transcriptions, and revising coding to better articulate the meaning of sections of the interviews followed until the data reached saturation after the third focus group and the author gleaned the six sexual health themes of the focus groups. Themes will be discussed in the next chapter. Upon writing up the results, the author used member checking via individual interviews to determine the need to revise codes and themes. No participants suggested any changes.

Trustworthiness and Reflexivity

Establishing trustworthiness in qualitative research includes data triangulation, wherein the researcher using more than one form of data collection to compare and substantiate the themes emerging from the main sources of data (Creswell, 2007). It is also used to check the researcher's subjectivity. Trustworthiness was achieved through use of follow up individual interviews that allowed participants to view results and check for accuracy as themes developed, as well as processing the experience and observations with a member of the researcher's dissertation committee.

Reflexivity allows qualitative researchers to acknowledge that their research is not objective, and it helps clarify the ways the researcher's experiences before and during the research process influence all aspects of the process. The goal of maintaining reflexivity is to strengthen the validity of the study, although it does not provide validity in the same way as a quantitative study (Glesne, 2011). Four personal dimensions of reflexivity, as outlined by Glesne (2011), include: subjectivity, emotion work, positions, and positionality. Subjectivity in qualitative research emphasizes that objectivity is "neither possible, nor desirable" (p. 152), thus

one must be aware of her biases and own her experiences as influential in the research. The background I brought to this study is discussed in the section to follow, through a sharing of my background, experiences, and biases around this topic. Emotion work is the acknowledgement of the feelings that arise throughout the research process. They can be captured in field journals and used in service of the research, rather than suppressed to promote pseudo-objectivity. I maintained a research journal, and I made use of my advisor to process emotions that surfaced during this research project.

Glesne (2011) defined positions as "aspects of one's person that are not necessarily embodied in the person and include both ascribed characteristics (nationality, ancestry) and achieved characteristics (educational level, economic level, institutional affiliation, etc.)" and positionality as one's various positions in relation to the specific research project she is undertaking and the affiliated participants" (p. 157). As she noted that researchers have limited autonomy in their positions, it seems especially important to be aware of how they affect the research. The selection of a diverse research committee was an intentional part of my process, as I consulted with them to process how my positions and positionality are at work in my research. My positions and positionality are also outlined below.

Subjectivity Statement: The Primary Researcher's Background, Experiences and Biases

This subjectivity statement describes my position and positionality to the study to allow the reader access to what led me to study the topic, how my experiences and background may intersect with the topic, and the biases I am aware of up front (Glesne, 2011). Subjectivity is an ongoing process whereby one maintains awareness of how her background, experiences, and biases are at work along each step of the research process.

I am a Black woman who loves Black men. Given my position as an US citizen, this may be viewed as a revolutionary act, as I choose this love despite the negative societal depictions of Black manhood (hooks, 2004). My love and respect for Black men overall exists despite a few troubling experiences with individual Black men, but I am aware that these experiences have made me privy to the vulnerabilities experienced by these men that are often invisible to those outside of the culture. At the time of the dissertation proposal, I was engaged to a Black man of Caribbean descent. He and I are no longer together. The end of that relationship impacted both my motivation to do this work, as well as the emotions that surfaced as I coded and analyzed data. Some of the data represented parts of my experience in that relationship, so I journaled my feelings and shared them with my chair to bracket to the best of my ability.

I am a Black woman who has had sexual relationships with Black men, healthy and unhealthy. I see Black men as more powerful and influential in the heterosexual relationship dyad given societal norms, in most cases, despite my womanist stance that seeks to work towards equity in relationships across race, class, gender, and other cultural markers. I think some Black men may not recognize or want the responsibility that comes with that power. This belief was challenged throughout the data collection. I think, based on my pilot research, some Black men may resent Black women, whom they perceive as having more flexibility to express themselves as a gender. This belief was both confirmed and rejected by various participants.

I have traveled to four Caribbean countries, the Dominican Republic, Jamaica, Puerto Rico, and Trinidad, for vacation purposes. Those experiences led to conversations with male residents of the countries about sexual relationships and experiences, once I shared my area of research interest. Additionally, as my ex-fiancé is Trinidadian, many of my male friends are from Caribbean countries or have Caribbean heritage. Therefore, I have an interest in the culture,

beyond my awareness of their sexual health statistics, because of my relationships with these men and my travels.

I know Black men my age, but not across the lifespan, so my assumptions are limited to experiences with adolescent and young adult Black men. I had some hypotheses of how middle age and older Black men experience sexual health, based on distant relationships with my father, uncles, grandfathers, and instructors, but because the relationships are distant, I would not say I really know their intrapsychic desires. My desire to research this demographic may have emerged out of the distance in my relationships with older Black men, the way I see Black male and female identities as interdependent, and the difficulties I have witnessed in the sexual lives of Black folks, from unplanned pregnancies, concurrent partnerships, contraction of STIs, and dishonest and disrespectful relationships.

As a counseling psychologist, my training leads me to look for the cognitive, emotional, and relational underpinnings of sexual behavior. Furthermore, my position is one that embraces multicultural, social justice, and strengths-based aspects of psychology. As noted above, seeing the difficulties Black people across ethnicities experience in several sexual health markers, I am also interested in uncovering strengths that have not been promoted in research. I believe culture intersects with all facets of our lives, including the sexual, but it is not just Black Caribbean culture that results in sexual risk. Sexual Scripting Theory (1986, 2003) is the main perspective that shapes my understanding. It resonates most with me because I think culture, interpersonal scripts, and intrapsychic scripts all inform our sexual lives. This influence is just as true for Black men as it is for anyone else, except they may have different factors related to those three levels that other groups may not have. I was curious about what they identify as those factors, and how they differed from my beliefs.

Limitations

The limitations of this study include that this study proposes to examine men who self-identify as heterosexual, without operationalizing the term behaviorally. There may be some limitations that arise out of potential participants who identify as heterosexual although they sleep with men and women.

Given that the first author is a woman, gender may also serve as a limitation, because being a woman asking men about sexual health violates social norms. Hooks (2004) states, "allegiance to sexist thinking about the nature of leadership creates a blind spot that effectively prevents masses of black people from making use of theories and practices of liberation when they are offered by women" (p. xvi). Although it didn't seem this way during the focus groups, for some men, it may be difficult to disclose personal sexual histories to me or use the findings of this study in any meaningful way. It's also true that not being a member of that gender culture seemed useful in that the researcher could approach the participants with curiosity about something they might expect a Black male researcher to know (Glesne, 2011).

Another aspect that presented a limitation is the relatively broad definition of Caribbean descent, given that several countries and territories make up the Caribbean. While I recognize the diversity of Caribbean cultures, UNAIDS (2012) and other studies of Caribbean sexual health use this broad definition, thus I follow in their tradition. Additionally, while one may have been born in the Caribbean or have parents who were born in a Caribbean country, their ethnic identity may not necessarily be strong for their country of origin. I assumed that those who do

not hold a relatively high ethnic identity were less likely to choose to participate in a study that requests Caribbean participants, as it would be a less salient aspect of their identities.

Also, the men who participated in this study either had the means, or their families had the means, for immigration. They all had at least some college education, and most were professionals. Their socioeconomic privilege informed their perspective in ways that this study does not directly address. But, as is the nature of qualitative research, the results are not generalizable to the whole of Caribbean men.

Finally, as a woman who has had positive and negative experiences with Black men, my interactions with them may be colored by the biases I carry. Journaling, bracketing, member checks, and consultations with my committee members about potential biases were used to decrease their influence; however, as the tool of inquiry, my subjectivities will always be involved to some extent.

Chapter IV

Results

The purpose of this research was to understand how heterosexual Black men of

Caribbean descent (HBMCD) define sexual health, how their definitions align with and depart

from the SIECUS list, and what influences their sexual health using grounded theory to develop

a preliminary theory about sexual health among HBMCD. Such a theory could broaden the

discourse around sexual health throughout the Black diaspora by giving voice to those people

being studied. Because this was a grounded theory study, there were not any *a priori* hypotheses

to allow the data to guide the insights that emerged. This chapter presents findings from three

focus groups with a sample of men ($\underline{n} = 11$) who identified as Black, Caribbean, and

heterosexual.

Initial Definitions of Sexual Health

The researcher began the focus group by reviewing the informed consent document,

assuring participants of confidentiality, and then asking the group participants to define sexual

health. The definitions were varied, sometimes building upon the statements of others to enhance

their own understanding of sexual health in the moment. Overall, the preliminary definitions of

sexual health offered up themes related to protection and pleasure.

Protection

The theme of protection came up several times, in regards to protecting one's self and/or

partners through condom use. When asked what sexual health means, Ron said, "Oh, STD free. I

guess not having too many partners at the same time. And, taking adequate protective steps with

condoms." Don added, "Just to add to that, I think it is more of a case of being a responsible user

of contraceptives. Contraceptives also used in relation to monogamy, and in the instance where monogamy doesn't exist, then at least the responsible use of some form of protection. Some use of healthy sexual practice when you have multiple partners." Dan first emphasized his own health, but he offered that his partner's health is also important. "I agree. I'd say, my health first, but also my partner's. And the health part of it is, just practicing safe, conscious, just making conscious, healthy decisions about, you know, my sexual actions, and you know also taking precautions when I do engage in sex." Joe furthered this point by highlighting the way responsibility is constructed in a sexual relationship. He said:

Yeah, like what the guys said, just knowing your status first and foremost. Um, being responsible…understanding that your responsibility, when it comes to sexual health, that it's not only you, but your partner. And, understanding that you pretty much have that person's life in your hands, whether you make responsible decisions. So, understanding that. Understanding that, you know, that person is placing their trust in you, not only from an emotional standpoint, but also from a health standpoint. And, that is something that I personally hold…I take very important.

Joe also shared a unique practice of taking women to the clinic on the first date as a measure of up front protection. He stated:

I know a lot of people used to talk about when our first date used to be to the clinic. I did not like to go out four or five times first. First date…to the clinic…. What you scared at? Know what I mean? I'm going to take one; you're going to take one. Let's do this. And, you are judged. I was a psychology major, so I like to see human behavior a lot. So when I make that suggestion to a female, I get a

vibe from them, and then when I get that vibe I'm like, "let's go to the clinic."

Based on your reaction, you already tell me what planet you're operating on; you

see what I'm saying. So, that puts me in a stratosphere of like, these dos and

don'ts have come out. These are the dos and don'ts. Because I understand risky

behavior on this side here, and as I've said, sexual health is very, very important

to me, so um, I have to know status. And I expect my partner to know my status,

because it's a sign of respect. See what I'm saying? So, I have done that before,

and it has rewarded me greatly.

Overall, the men agreed that condom and other contraceptive use was important in protecting

themselves and their partners. Although they noted varying degrees of condom use and STI

testing, they were clear that whether or not they engaged in that behavior consistently, they

considered testing to be an important part of sexual health.

Getting screened for STI's was somewhat distinct from protecting others, as it related

more to protecting self through awareness or "knowing." Gen added, "Mentally, knowing that it

is a beautiful thing to partner with someone that you care for...Knowing that you have the

capacity to fall in love and also the capacity to love them for whoever they are…but there's just

that essence, that spirit that might draw you to them, that you probably can't even explain, and

then you want to explore that with them." Ken noted:

For me, personally, it's um, having knowledge of yourself and your actions. And,

uh, that's the general. And when I mean yourself, I mean just knowing what your

status is, knowing what you're doing, and not just out there going crazy. And um,

I think that's actions. So, uh, that, being healthy is that you gotta know what

you're doing and who you're messing around with. That's also healthy.

The men all expressed a sincere need to "know." Dan said:

> You know, if I have any, myself, you know if I have any STDs, and if they do as
>
> well. Every partner, as an adult, you know, I used to be married. I made sure that
>
> we both had HIV screenings before we engaged in sexual activity. So, yeah I
>
> think, definitely as coming out as a, you know STDs, but also, you know, like,
>
> what are your dos and don'ts, in relation to sex, because some people have
>
> different preferences. You have to know what lines not to cross, and I think, for
>
> me, sex is something that is, you shouldn't guess about. You should have open,
>
> honest discussions about sexual health, all aspects of it, you know, so that, when
>
> you actually are in the situation, no one is surprised. Because, you know, we
>
> discussed what our preferences are and tolerances are.

Ven added another perspective that followed up on this sense of knowing from a cultured

perspective. He said sexual health means, "getting tested, at least every, it depends on your

activity, but I'd say at least once every six months, to make sure nothing's going on. No reckless

first time encounters without condoms. I think also making sure your genital area stays clean

daily." The men in that focus group emphasized how important it was for them to be clean, as a

function of Caribbean cultural norms related to showering a few times a day, and they connected

it to sexual health because they believed that odor was often an indicator that a woman was not a

healthy choice of partner. The senses of smell and vision were often connected to their

assessment of a woman's health, including how she looked and how she smelled. Oscar stated,

"I'm actually physically uncomfortable with a nasty woman, and some of that may stem from my

roommate. I had a female roommate before who was disgusting, but I think it's sound logic. I

haven't completely unpacked all of the explanation behind it, but you know, I bet there's some

unpleasantry when she unwraps her gift." A few men later noted, when sharing incidents of being sexually unhealthy, how they were confused at how a woman could look so visually appealing, and yet smell unhealthy.

Pleasure

Pleasure, including being pleased and the ability to please, emerged as an important theme in the initial definitions of sexual health. Jon mentioned being able to please in the context of a relationship: "Virility. I mean, quite honestly, if you maintain what this gentleman said, the other things are being in a situation, you know a monogamous relationship, to have a sexual relationship with that person. Whether it be conversation. Whether it be able to get it up. Ultimately, to satisfy that person." Oscar stated, "I think confidence is a big thing too… It's very valuable to understand that you're pleasing your partner, and I think when you operate like that, it makes sex more valuable, a much better experience." He connected his confidence to his ability to please, and other men added that confidence was meaningful to them too. Gen said, "Yes. I want to let…I'll let her know how I want to be pleased. And, for her to accept that and to want to please me, because I'm a pleasing person. I want to please her too. So, I would hopefully get that reciprocated." Ven echoed this sentiment, "Yeah, I feel the exact same way. I think as far as a good healthy relationship, there should be no bounds or limits to how you can please each other." Koy offered that conversations about pleasure should be safe and nonjudgmental to feel healthy. "And not with judgment either, because that will shut things down faster than anything else."

Engaging the SEICUS List of Behaviors of a Sexually Healthy Adult

The men expressed knowledge about what it takes to be sexually healthy beyond simply using condoms. As they began to share examples of times when they were and were not sexually

healthy, they noted that even when they made unhealthy choices, they knew better. However, there were some aspects of sexual health that they did not initially state before the researcher introduced them to the SIECUS list. The men were given the SEICUS list (Appendix F) and given an opportunity to read through it before responding about what they believed aligned with and departed from their personal definitions of sexual health.

The most predominant theme that emerged in this part of all three focus groups was that sexual health is a heterosexual phenomenon. Ron immediately pointed out his concerns with this aspect of it. He said, "This one I might not fully understand. Exercise democratic responsibility to influence legislation dealing with sexual issues. Are we talking about sexual issues like sexual abuse or…so this is not like dealing with homosexuals or anything like that?" Once the researcher indicated that it could be all of the above, he made a specific delineation between what he deemed sexual health related, and what was not:

> I mean, just us as Black people, we've been dealing with this issue for years. Let's deal with that issue first. Then, deal with this, because gays are technically a smaller minority than Black people. Let's deal with the larger minority issue. Then, if we get to it in our life times, boom, we're good with that. Let's deal with the bigger problems…Now if you're talking about rape, or abuse, sexual abuse, people who are being, you know, like the situation with the girls in Nigeria, you know, these girls are being bought to be sexual slaves. That's a whole different realm. You know, they're not choosing to do this. They're being stolen, ironically enough, from school (nervous laughter) That to me makes more sense. That also talks about sexual health. For me personally, a man that's interested in sexual

slaves, I don't think you're sexually healthy, because if you have to force

somebody to have sex with you, then something is wrong with you.

Other men built on this perspective. Jon minimized the importance of homosexuality as a salient

identity, stating:

Like, that's my issue with, I don't want to say with homosexual, but I feel like at

the end of the day, I don't vote for someone's sexuality. I vote because I believe

in some of your values. You know, I don't want to encourage you to like the

women I like. You could say that about someone who doesn't date outside of his

race, you know. He's not a racist. He just chooses not to date outside of his race.

In another focus group, the topic of sexual abuse was also highlighted as a sexual health

concern by someone who later minimized the importance of LGBT issues as similarly

concerning. Joe said, "From a Caribbean cultural standpoint, prevent sexual abuse is something I

think is very…it's a taboo topic in Caribbean culture." He was adamant about the abuse involved

in the practice of teenagers with older sexual partners that he described as rampant in the

Caribbean, as well as the concept of marital rape. And while he challenged traditional definitions

of manhood often, including highlighting the double standard of the praise associated with when

adolescent boys are able to have sexual relationships with older women, he was in alignment

with the sentiment of nearly all men in all focus groups when the topic of gay men and public

displays of affection (PDA) surfaced. He said:

I don't have to walk around the place telling everybody, hey, I'm heterosexual. I

don't. I shouldn't have to be subjected to you throwing out the fact that 'I'm gay,

I like men. Or hey, I'm gay, I like women.' I respect you for who you are,

regardless of who you like in the time when the nighttime come. Whatever you

do, that's on you. But, at the end of the day, I don't need to hear about that. That's

the problem I have now about it, you know. They had a big thing on ESPN when

the pro-football player kissed his boyfriend. I mean, ok, it was a moment he

wanted to share that with his partner. That's fine. But the overboard and the extra,

I don't care for all that. And, being in a community now, a society now, where,

it's to the point where because I'm straight, I'm not able to voice my displeasure

because they are gay. I have a problem with that, you see what I'm saying. I

should be able to voice the fact that hey, it doesn't mean that I'm anti-gay or that

I'm prejudiced or anything like that. It just means that…if it was two straight

people, if it was a heterosexual couple, I don't want to see all that. Find a room.

Same thing with them. Find a room. I don't need the extra. And I find that, this

time a day, if I say something like that, to that effect they jump on you. And I find

that wrong.

His perspective suggested that it was less about the sexual orientation of the person, but more

about PDA. However, to an extent, it minimized the difference in how gay men are perceived

and received in the culture. Ken connected it to his Caribbean culture. He said:

If you have children, you don't want your child…I personally…maybe that's the

Caribbean in me, but I don't want my child to be exposed to that. If they happen

to go that route, then fine, but that's just not the person …I'd rather them have

images of heterosexuality. And that has sexual health implications, but maybe that

is a Caribbean bias.

Dan furthered Ken's sentiments about exposing his children to gay men kissing:

And with the kids aspect, it's even more important, because you have children

whose minds aren't developed to know the difference between…to separate

between these actions and putting them in proper context. All they're seeing is

you know what you expose them to. So now, when we go to Piedmont Park, and

you see guys swinging each other and holding hands, and I've got to explain to

my six year old, like, he's never seen a man kiss another man… we've become

too tolerant in society. We don't want to offend someone. We have no morals

anymore. It's like everything is out in the open, so that we don't offend anybody.

I don't agree with that. And the other thing about the Caribbean aspect of this, I

don't agree with the way things are in the Caribbean. Caribbeans won't let that

happen, but they will put a violent edge to it. You know, you shouldn't act on

your, you shouldn't kill other people or be violent with anybody, for any reason,

but that's not something that I grew up seeing, so it's already uncomfortable and

unusual for me to see it here.

He felt constricted by the level of tolerance for gay men he experiences in the United States as he

articulated the difference in what he used to see in the Caribbean. He noted that he didn't agree

with violence against gay men, while he simultaneously held the belief that they did not require

the same rights as others. This tension was apparent in session three as well, as the men grappled

with living in metro-Atlanta and being exposed to gay culture more openly than would ever be

allowed in their home countries.

Koy noted, "And this is just my interpretation. I may be misinterpreting it, but when they

talk about demonstrating tolerance for people with different sexual values and lifestyles, I used

to be very judgmental when I'd see people doing things that I wouldn't do. If it was anything

outside my realm of experience, I'd be like…you nasty." And Oscar immediately followed up, "I'm still there." This focus group immediately connected the emphasis on heterosexuality and the marginalization and judgment towards gay men and how it shapes their views on gay men to Caribbean culture. "Definitely orientation, and growing up in the Caribbean, that's kind of, I mean…we sing songs about killing gay men. Let's just put that on the table." The men in this group shared their attempts to become more tolerant of gay men, but the tension in this cultural dissonance was apparent in their discussion. Often, they were able to indicate that the way they best related to gay men was when the gay man did not have his sexuality as a salient identity. Koy said:

> You know what really kind of turned it around for me? I had a math teacher at
>
> college, a gay White man of all things. The only reason that I knew he was gay
>
> was because other people said it. He was a math teacher that happened to be gay.
>
> Gay wasn't his defining characteristic, and for me that's what makes a big
>
> difference. I'm kind of turned off by anybody who makes their sexuality a
>
> defining characteristic. And, that's very one-dimensional. Like, that's all I need to
>
> know about you? That's you as a person? That's how you choose to identify. I'm
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> like, I don't hate you, but I wouldn't want to deal with you, because what do we
>
> have to talk about… It's like, I don't care that you're gay, but I feel the same way
>
> about heterosexuals who are just like, again, back to your sexuality, it's like your
>
> primary identifier. I feel the same way when I see a gay man just going all out, as
>
> a straight man who walks in the spot and is like, where the bitches at. I'm like, for
>
> real dog? Like, come on, that's not what we're doing here. I like chicks as much
>
> as you, maybe more, but there's other things.

Oscar also offered that if he were to become more tolerant, gay culture should not be forced upon him, and Ven echoed the same. Oscar said, "Overdone is subjective, but I feel like it's ridiculous in many respects. I've had gay co-workers that I had really healthy relationships with. I respected them. I was their superior, and I respected them as employees. You know hey, you don't come here to be gay, you come here to work. And once they understand that, and they're not forcing anything on other people, I think that would do more for their interests, without sounding like a therapist or anything like that." Ven added:

> You're not comfortable. It's like they're acting completely out of their physical
>
> being. I feel like anybody acting that far out of their physical being, they're either
>
> trying to get attention or they're just acting out some kind of emotions that they
>
> feel or maybe they've been so oppressed that they feel free, so they can just let it
>
> out. I feel like you're wearing your wounds, you know. They're wearing their
>
> wounds. I don't know. I came up with this a second ago. But, it's so unnecessary,
>
> and I feel you when you say it makes you uncomfortable, because it's like,
>
> that's…whatever your sexuality is, it has nothing to do with someone you're not
>
> displaying or trying to share that sexuality with. So, why are you…why is it out
>
> there?

This particular group (session three) seemed to understand that perhaps tolerance, at a minimum, was an aspect of health, but they recognized that they were not yet there, with the exception of Gen. He said:

> I mean, before I moved here, New York has everything, so I grew up with it all.
>
> So I was like, no big deal. And then when I came down here, the whole big thing
>
> about Atlanta and they gay community, I was like shoot, DC, when I was growing

up, DC was the capital. Now, it's supposedly changed, whatever. And then San

Francisco is the…I don't know. I worked around a lot of gays, because in my

former career it was in advertising, so I never had a problem with it. I mean, you

stay in your lane, I stay in my lane, and it's all good.

The other men seemed to perceive his perspective as something to aspire to, and they agreed that

the violent responses to homosexuality that they witness in their culture were not appropriate.

Gen compared the plight of gay men to that of Black people, saying, "And you know what's

interesting, that's not so far removed from us being beat up because we're Black, for the color of

our skin."

Overall, the men agreed with the SEICUS List, and they broadened their definitions of

sexual health to include emotional and psychological aspects, when they were not presented in

the initial definitions. Don stated, "I was actually surprised to see the emotional and

psychological aspects mentioned in a conversation about sexual health. From my experience, I

would have just expected…a discussion of sexual health to remain purely on the physical, as

opposed to the emotional. I'm now beginning to appreciate how emotional sexual health is, but it

wasn't what I was expecting."

<div align="center">Factors that Influence Sexual Health</div>

After sharing anecdotes about their healthy and unhealthy sexual experiences, based on

their definitions of sexual health, the focus groups highlighted factors that encouraged and

prevented sexual health in their lives, as well as the lives of men like them.

Encouragers

The men identified many sexual health encouragers, including knowing the risk of

unhealthy sex, being in a loving relationship, and wanting to protect self and others. Jon said,

"Honestly, if it's just the physical aspect, the threat of living in Atlanta and this being the fourth rated place for herpes, AIDS, and any STD you can think of. You know this is a cesspool of it. I want to live. I want to at least live on this earth until God calls me home. So, I don't want to prematurely make that decision." He situated the context of sexual health specifically in Atlanta, which he identifies as having high rates of STIs. Don shared that he was still determining what might encourage sexual health from an emotional standpoint, although he noted that he drove his own sexual health physically, with the use of contraceptives, because he did not want to catch a disease. He said, "So, from an emotional standpoint, in terms of sexual health, I'm not entirely sure which factors are too…when I make that assessment, I will know that person when I see it." He attributed his emotional sexual health to the right interpersonal relationship with the right person, who he expected to know when he was in it.

Ron shared his experience of watching his father be sexually unhealthy in his family. Ron defined unhealthy with his father having several concurrent sexual relationships while still married to his mother. He articulated the impact that it had on his family, more specifically his sisters, and he said:

> And I've seen. Cause, when we were younger, we all knew that my dad was just
>
> out there. So I've seen my sisters have extremely low self-esteem when it comes
>
> to dating men. And, my thing is, because me and my sisters are really close, I
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> know all their issues, I would not want to have a daughter and have her have to go
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> through shit like that. So, I think that would drive me to try to develop and
>
> maintain meaningful relationships. You know, just, not saying that…at least make
>
> an attempt to conceal it. I don't know. But just not…I don't want to mess up my
>
> kids.

Koy shared that now that he experiences less of a sense of urgency and more confidence in sexual relationships, he gets a sense of empowerment when he makes a choice not to have sex with someone if it does not feel quite right. "I have to say that there's been occasions when I have had opportunities to close a deal, and I didn't. And I almost felt empowered by not making the decision, by choosing not to go through with it. Like, I know she wants me. I definitely want her, but this is not the right thing to do." Both Oscar and Ven emphasized the desire to protect the women they love as the main encourager for sexual health. Oscar said, "I would say, since I met (wife), I really feel this sense of this is the best thing that will happen to you on this earth. It's like, I really feel like God presented me with the perfect woman for me, you know. And I don't want to violate the gift that God gave me." Ven added, "It depends on the situation, because if I'm in a relationship, one I don't want to violate the trust of who I'm with." The desire to avoid violating their women spoke to their understanding of the relationship health, as far as staying monogamous, as well as infecting them with any STIs. Dan built on this desire by using the word, "responsibility". He said, "Love for others. Respect for others. When that person is with me that same way. The people I'm living for, like my family and people I am responsible for. Responsibilty." All of the men seemed to feel pride in this role of responsibility, rather than burdened by it. Although they shared that there were times when they fell short, they seemed to suggest a privilege in being responsible for someone. Joe's statement represented this sentiment well:

> Yeah, family, relationships, attachments, um, responsibility, maturity, um, just understanding that there's a bigger picture. My man here made a very good point, and I understand your analogy, trying to say about the pussy being Kryptonite. Totally get that, but you have to understand that you have to control this thing.

You have to be able to know within yourself, hey look, it can ruin you. It can

definitely ruin you in more ways than one. You might not get a disease, but

there's always some sort of trickle down effect. Always. And if it is that you're

vulnerable to that, you can't help yourself, you can't live your life happily. You

can't. It brings drama. It brings diseases. It brings foolishness. It just has multiple

layers of consequences. Some might be more unfortunate than others, in terms of

what kind of consequence they contract, but at the end of the day, you're going to

contract something. And, if you look at it from that point of view, and you

understand that, that alone should be a deterring thing. Just have some men who

are just messy. They enjoy mess, so they revel in that foolishness. But, again, I

challenge to see which of them lives a happy, long, life. Not many of them.

They're either dead by stress, or the disease, or something else.

He expressed the various ways making unhealthy sexual choices can affect men, and he offered

what seemed like a call to action for the men in the group who seemed less confident in their

ability to be sexually healthy because of vulnerability to sexual desire, however, that desire

seems to be tied to most women being bad.

Finally, Dan's comment expressed the idea of karma connects with his desire to protect

and his sense of responsibility. He shared:

And I believe in Karma. What you put out, you will get back. Maybe that's

something even more now that's real in my life, but I definitely believe in it, and

so the only thing that stops me now is just thinking about what would happen,

how would I feel if that person were doing that to me. Or, in the case of like

infidelity, just poor decision making, like unprotected sex or something like that,

I'm definitely like…first of all, I'm not sleeping with nobody at this point in my

life that I don't know. You know, on a deep level, like give me your history, let's

talk, show me the numbers, statistics, give me that report. Because, like he said, at

this point, I have very…my…I don't have the benefit of being 20 anymore, you

know what I mean. Like, yeah I can't make up this time. This is it. These are

things that are real, so I have a lot more at risk, like I was saying all throughout

the night. And I take that very seriously, so I'm not putting myself in jeopardy

just for…to bust a nut. I mean, it's not, to me, it's not that critical.

More than any other reason, protection and responsibility in the context of interpersonal

relationships were the most salient reasons that encouraged sexual health in these men.

Discouragers

In addition to factors that encourage sexual health, the men listed those that discourage as

well. Both Koy and Ven shared that a sense of urgency, coupled with lack of confidence that

they could recreate the opportunity to have sex led to some unhealthy sexual encounters. Koy

said, "I had the pussy on a pedestal. I was a late bloomer, in terms of like being sexually active,

so like at that stage of my life I was like, oh my God, she wants to have sex, so I better act on

this now, before she changes her mind." The theme of feeling like a "late bloomer" was also

connected with feeling like one had to make up for lost time, which resulted in engaging in more

sex than felt "right" just to reach a certain perceived expectation of acceptable. Oscar shared:

There was a sense of missing out. Like, I didn't know if I wanted to, I definitely

wanted to have stories and have experiences and have…not just stories to tell, but

like, I wanted the memories. And I still think that's valuable, like, even though it

probably wasn't my healthiest behavior, and I thank God I made it out alright, but

> I have some really, really great stories. And it made me, I believe it made me a
>
> better mate for my wife now. There's things I wouldn't allow. There's things I'm
>
> very, very keen to. There's things that you know cause she was a virgin, so there's
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> a lot of things that I can teach her. And there's a lot of elements that were
>
> valuable, even though I was unhealthy then, you know. So, like, I made it back
>
> from my tour to Afghanistan, symbolically.

He identified that although he made some unhealthy choices, the lessons learned from those

experiences prepared him to be a better husband. Ken shared that vulnerability is something that

prevented him from being sexually healthy. He noted that coming from a relationship where he

was not using condoms to going back to the single life was a difficult transition, and it affected

his condom use.

> Yeah, you know what, for me, with condoms, and this is just me personally,
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> sexually. I never had that many girlfriends, so when I had a girl, we didn't use
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> condoms, because I knew her. Like my man said, I knew her. And I guess being
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> exposed to that, with that feeling, you know, I didn't have sex without a condom
>
> for a while. And it was just the opportunity I was in, and I was…I guess I was
>
> weak and vulnerable. Because men, we get weak and vulnerable too, it's just in a
>
> different realm. We're not going to cry, but we're weak and vulnerable in the fact
>
> that…man, I ain't had no pussy in a while, and now I got.

He further added that the interpersonal dynamics of seeing the woman as very pretty and having

her encourage him to not use a condom preyed upon his weakness. Other men echoed the

important position women have played in their sexual health, as both encouragers and

discouragers. Jon stated, "A lot of it is put on men, put on Caribbean men, put on men period, but there is a factor where women play a part as well."

Dan indicated that ego discourages sexual health. He said, "And I'm talking about thinking, I don't even like this chick. How could I be so stupid? What doesn't stop you is probably part ego too. You know, you don't want to be like…ego. Also, what made you do it to begin with? Just, the opportunity was just there. You know, like, I mean, it's nothing scientific. And this has nothing to do with Caribbean." He made a distinction between his ego and his Caribbean heritage, suggesting that all humans, regardless of culture, fall into the experience of taking advantage of an opportunity. However, Joe felt that it was related more to masculinity than ego. He said:

> He said men are hunters. That's just how we're built. It's within our DNA. And, it
>
> was not until I got older that I seen truly what he was trying to tell me. You can
>
> use that analogy in any phase of your life, as a male. We compete at everything.
>
> We try to win at everything. That's just how we are. When it comes to women,
>
> when it comes to professional results, when it comes to whatever. Every part of
>
> our whole life. We hunt for our victory. So, when it is that you're in a sexual
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> situation like that, that innate being inside of you kicks in. And ain't no thinking
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> about pregnancy, HIV, STDs. They're not thinking about none of those things.
>
> All they're thinking about is, this chick gonna be talking about me tomorrow
>
> morning, because I'm going to put all this work in right now. You see what I'm
>
> saying. So, right after the act…buyer's remorse.

The concept of buyer's remorse resonated with the group, as they spoke of shame and guilt that follows an unhealthy sexual act. They shared how they question themselves about how they

could make such a poor decision, saying, "Buyer's remorse, right after you finish. Like, what the hell did I just do? Exactly like that."

<div align="center">Be a Man Model of Sexual Health for HBMCD</div>

<div align="center">"When I hear <i>be a man</i> I still look at it and say ok, you know….I'm going to be <i>my</i> man. I'm going to be the best man for me." (Dan)</div>

Six themes emerged from the focus groups to create the Be a Man model, a working model for sexual health among HBMCD. These themes resulted from consistency of response within and across focus groups and rich descriptions and explanations detailing the importance of the themes. While some themes contained examples that overlapped with other themes, the author made decisions about where to situate the examples based on interpretations of underlying meaning of the statements, if any. The themes for sexual health are below. For HBMCD, sexual health is:

1. Heterosexually Privileged

2. Protective

3. Contextual

4. Interpersonal

5. Cultured

6. Pleasurable

Theme 1: Heterosexually Privileged – "Let me get there on my own time"

The researcher experienced some conflict about whether this theme should be heterosexual, heterosexist, or homophobic. Each focus group, and most members individually, emphasized their discomfort, avoidance, and dismissal of homosexuality in a number of ways, but there was also an acknowledgement of the cultural socialization that led them to these

feelings and awareness that progress in their beliefs was necessary and/or developing. There was tension in how they were raised to be men: the hypermasculine expressions of maleness, the fear of feminization, and their perception of US society's tolerance for gay men. Ven stated:

> I feel like with society, they try to press it on me. They really try to spoon feed it, like with subliminals on like TV and they have all these gay shows now, and then I see they're like putting men in dresses, all these Black men in dresses and everything. You got True Blood, and they have like the sissy dude. You know what I'm saying? I just feel like they're trying to overly sissify Black men especially, and when I feel like oftentimes that makes it more permissible.

A few participants specified living in Atlanta as an extra consideration. Atlanta is an international city, and it was named the most gay friendly city in the country. Koy shared, "Living in Atlanta, you can't not be around it, so I just had to learn to come to peace with it in my own mind. I'm like, 'they're here.' Some of them are going to hit on me. I'm not going to like it, but I'm not going to fight them. I'm just going to move on. You can't fight all the time." In most men, despite their homophobic and heterosexist values, there seemed to be an earnest assertion that it wasn't as much about not being gay as it was about being heterosexual, which included being a man, desiring women, and valuing traditional masculinity. Joe said:

> In terms of how I was raised to be a man. You take care of your household. You work. You bring in the money. You take care of your family. You take care of your wife or your life partner. It's handled, from she shouldn't want for nothing, absolutely nothing. And this is where it comes, you're separating, as an adult, separating foolishness. I seen my two grandfathers *running a woman*. That was a norm in the Caribbean. You see the grandfathers have two/three woman on the

side. That's normal. And they will tell you, hey look, that's part of *being man*. So,

when you grow up as an adult, when you reach an age, you say, okay, look, I can

be instilled in the break bread, you taking care of your family, your wife, and

what not. That's important. And the code we talked about, there's no compromise

with that. But the womanizing part, you get to an age where that's the foolish part

of the culture.

The overlap with heterosexual privilege and culture was often highlighted, as above. Don

connected being a man with a lack of emotions and the capacity to engage with multiple women

sexually, without emotional connection:

Well, as you mentioned earlier, men, generally speaking, we're not well known to

be emotional individuals. I had a conversation just recently with a friend of mine.

We were talking about instances where we have multiple partners. She was trying

to understand why we men were able to easily associate with multiple sexual

partners and not be able to develop any sort of feelings or complications along

those lines. And well, we are primarily carnal creatures. We're of a physical

nature. If we want to develop an emotional relationship, we will. Otherwise, we're

quite, maybe callously so, we're quite capable of engaging with you on a

physical, sexual level, and then keeping it moving.

There was even discussion about the extent to which family members groom heterosexuality as

an aspect of sexual health. "And his in-laws were telling him, ladies go with the ladies, and the

men go with the men. But you have the men telling him, "You're a man." And he's like, "No,

I've got to go to sleep." And they're like, "No, you're a man. Take this drink and go." And that's

peer pressure. Because one, in his situation, he's trying to impress his in-laws." (Ken)

Because my counseling psychologist's lens leans towards strengths, I thought the category heterosexually privileged represented the articulation of their values along a process of heterosexual identity development. Koy's statement helped ground this decision, as it articulated the intention most of the participants shared about the basis of their beliefs. "The perception is that in spite of all our failings, we really love women. That's the perception of Caribbean men, and it's accurate. Like, I love women."

These men valued a heterosexual identity, and this finding was consistent across groups. In a group with a marginalized racial/ethnic identity, holding on to heterosexual and male privilege remained important to their sense of pride, culture, and their sexual health. Dan shared, "Look, you have a man right. I grew up in the Caribbean right, and a man says, you'se a man, do something. He's like, you don't need nobody telling you how to conduct yourself. You the man. You be a man. You don't need your woman's approval. You do it. And afterwards, you deal with it. That's the way we are." So, the term heterosexual was selected for the Be a Man model, using the context of heterosexuality identity development as the basis for the operationalization of that term.

Theme 2: Protective – "It's not just us we are living for."

An important aspect of sexual health was its protective posture. Closely aligned with their identity as men and the heterosexual theme, the desire to protect others and themselves emerged as a valuable consideration. They described protecting themselves physically, via use of condoms and contraceptives, as well as STI tests. Ven said, "I think it means, getting tested, at least every, it depends on your activity, but I'd say at least once every six months, to make sure nothing's going on. No reckless first time encounters without condoms. I think also making sure your genital area stays clean daily."

The men noted that having a child or significant other to protect often encouraged them to be sexually healthy. Joe articulated the importance of knowing his status and how that affects both him and a partner.

>Yeah, uh, like what the guys said, just knowing your status first and foremost. Um, being responsible…not…understanding that your responsibility, when it comes to sexual health, that it's not only you, but your partner. And um, understanding that you pretty much have that person's life in your hands, whether you make responsible decisions. So, understanding that. Understanding that, you know, that person is placing their trust in you, not only from an emotional standpoint, but also from a health standpoint. And, that is something that I personally hold…I take very important. So, that's understanding that, you know, you need to be conscious of where you find yourself, the environment that you're in, and making smart decisions.

Additionally, the men noted that protecting themselves was important, above and beyond any connection to another person. Ron was especially specific with this separation, stating, "You protect yourself. You take steps necessary if you're not ready for kids to not have kids. And, you don't really have to enhance the relationship, because there may not be one." Don followed up with, "From a physical standpoint, as he mentioned, just living in Atlanta, it just makes sense to be sexually healthy. So, I drive…I tend to drive my own sexual health, from a physical standpoint with use of contraceptives and so on."

The value of self-protection of men, especially men of color, has not been promoted in the same way as self-protection for women, as it relates to sexual protections, so for the men to articulate that they were worth protecting seemed especially significant. While most of the men

prioritized the protection of people under their care, they often shaped these arguments around the idea that those people gave them something to live for. Art said:

> For me it's sexually healthy, like post-bachelor days, you know I'm feeling never. You know, in a good relationship, you want to protect that person, when you're looking for a good family life. That's what's my drive: a good family life. My health and my partner's health in the long run, and the kids. My parents always put me first, so I always put my kids first. And that's my joy, so if I'm with somebody I want them to do the same thing. We will put each other first, not playing the field or anything.

This quote showed overlapped with another theme of context, whereby one's parental status was a context that drove sexual health. Jon mentioned that trust was not important in a sexual "situationship" as long as he took care of himself. He said, "I mean, I don't have to trust you, because…I mean, you protect yourself. Even in situations where you trust somebody, you protect yourself." Regardless of relationship status, protecting oneself was highly important.

When the context of protecting oneself was identified outside of significant others, men related their desire to be healthy overall as the overarching reason for their sexual health. But, there was overlap in the protective nature of sexual health, especially as it related to significant others, and the contextual nature of it. Koy articulated the connection from the perspective of a single man:

> And then, from a selfish perspective, you come to a woman with a clean bill of health, it's…it frees things up a lot. It shows her that you care enough about her to not put her at risk. It's like, I'll be like, I have no problem showing anybody my stats. I have them on my phone. (laughter). But, it's the same thing. Like, I try to

take care of myself just overall. There's a long history of cancer on both sides of

my family, so I try to take care of my body. I try to eat pretty healthy. So, it's just

a part of that logical path, because it's like, you only get one of these.

In the same way Koy emphasized that he only gets one of himself, his body, and it is worth

caring for, Oscar highlighted that he only gets one woman like the one he has. "It's like, I really

feel like God presented me with the perfect woman for me, you know. And I don't want to

violate the gift that God gave me…And so I say, I just cannot squander this. You know, I hit the

lottery."

Theme 3: Contextual – "It's age dependent."

The men articulated that sexual health looks different depending on one's age,

environment/location, parental status, and relationship status. Because the group was between the

ages of 30-50, they noted the differences in context from adolescence and early adulthood to

their current ages, with most men indicating that when they were younger, they had limited

views about what sexual health was. Art identified his shift in views in a way that connects the

above theme of protection with context. He said, "Like you said, it's age dependent. And later in

life, I mean, I'm 40 now, and back in the 30s, I was carefree, happy, and sexual health meant to

me just protection. But as you go later on, you know I have two kids, divorced, what becomes

important is just having a partner that you can trust. It becomes important. The multiple partner

stuff becomes a little different later on. You have kids. The whole definition of sexual health

changes."

Koy referenced "starting late," because he lost his virginity at age 19, and developing

confidence over his lifespan that led him to make better sexual health decisions. He said, "I had

the pussy on a pedestal. I was a late bloomer, in terms of like being sexually active, so like at that

stage of my life I was like, oh my God, she wants to have sex, so I better act on this now, before she changes her mind." Joe shared his perception on how some Caribbean men develop:

> I've had some fellas who they are die hard like that. They live and die like that. But, with maturity comes wisdom. So, I have good *bredrens* of mine. They get married at 25. Between 25 and 35, Lord, *woman have grey hair because all of the woman running in and out of their relationship*. But they are very sexual, and they realize, at the end of the day, a bunch of foolishness. They reach a maturity. Some reach the maturity gap faster than others. They have to go through what they went through, but at the end of the day, their wives didn't want for nothing. Bills were paid. The children was in school. The wife didn't want, she couldn't ask for nothing. Now, on the flip side, was he wrong for womanizing? Of course he was wrong.

Ron offered an alternative perspective, suggesting that he was in a healthier place when he was younger:

> That made me resent what he was doing, and when I was younger I was just like, naw man, I'm going to be a good father. I'm going to be a great husband. And that's the mentality you have until you reach a certain age. And then the carnal factor kicks in. We as men, I think we just have something. It doesn't matter if you're a Caribbean man; we just have something that it just draws us to women. And uh, so it's like up until 18, 19, I had a girlfriend all through high school. I was good with one girlfriend. Like at a certain age, it was like manhood just set in. Like, I cannot have one woman.

The men talked about environmental contexts, including Carnival culture, and how what one is allowed to do differs from what one might do in an everyday setting. Ken referenced the way he might approach a woman during carnival versus the way he would approach one during a regular day:

Yeah, I'm second generation, so I'm only interpreting from what my experiences are. Because, I've gone to the ones out of state and in different countries, but that's… What it views is that it is the setting and that's the environment that you're in. So, it is a little bit more acceptable. Because you're not going to, on a normal basis, have women scantily dressed. You have some of them in equivalent to a bra and panties, and they're walking the streets in that. But, they're not going to be doing it all the time. They're not going to be winding their waist in the streets all the time. It's a little different than just walking up and down. I can't just be walking up and down and see a girl and just start winding on her. That wouldn't be okay.

Joe stated that his idea of sexual health doesn't include in the typical way it is thought of. He shared that for him, intimacy is to be kept between the two parties involved, so public displays of affection (PDA) for his wife during Carnival might look like making sure she knows he isn't interested in other women, rather than kissing in public. "You know what my PDA is for Carnival? Making sure that by the end of Carnival, my wife and myself is not upset. Because if it is that my PDA at that point in time is, well, you have all the females around me, and I'm not going to disrespect my wife by entertaining these other females around me." They also discussed relationship status, and many indicated that when they were single, they may have used condoms

as a form of protection, but did not consider other aspects of sexual health related to psychological and emotional factors. Don's point highlighted this one-dimensional definition:

> Um, I'm still, I'm 31, I'm still within the realm of not exactly, particularly ready
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> to settle down in any. I mean, not that I'm opposed to it. I can if I find the right
>
> person. I just, as of present I haven't. So, um, I do on occasion have multiple
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> partners, and at this present point there isn't anyone that I have an emotional bond
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> for to go all the way and settle down for, at the moment. So, to answer your
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> question directly, at present, at 31, even though I recognize the emotional aspects,
>
> I have not yet had the motivation to act on those aspects.

His statement overlapped with the previous theme of self-protection, because there seemed to be a high value placed on how the context of a romantic relationship shaped the way the men viewed themselves as sexual beings.

Additionally parental status, whether the men were fathers or not, influenced their sexual health in a number of ways. Ken said, "My personal experience was people having children. And that was my fear. And matter of fact, I was on a hiatus, from having sex because of having my daughter. Because that kind of…that whole dynamic…I was chilling for a little bit. I literally was on a hiatus for like months, years." There was a well developed dialogue on determining whether sexual health had to be in the context of a committed relationship, and there seemed to be some agreement that while it didn't have to, monogamy often led to greater sexual health.

Some men highlighted monogamy as the epitome of sexual health. While a few argued that sexual health did not require a monogamous relationship, most indicated that although sexual health could be maintained in concurrent partnerships or non-exclusive "situationships," the standard was monogamy. Art stated, "Often monogamy is the straight thing. But, I think

monogamy is a sexual level thing. But you have a lot of people who flirt and that sort of thing. So, it has to be on a mental level too. It all starts from there. You got your basis and your foundation, and you're off to a good, safe sexual relationship." The discussion of monogamy resurfaced mostly after the initial definitions were requested, as participants opened up to each other about their relationships. The role of partners was also connected to the theme of knowing one's partner, which included her STI status and her personality, which leads to the fourth theme.

Theme 4: Interpersonal – "Women play a part as well."

The men acknowledged that sexual health is an interpersonal process. It involves both partners, although one can take responsibility for himself. They shared episodes when they were and were not sexually healthy, emphasizing the interpersonal nature of it. Jon said:

> One specific instance, I was in DC… I was at a bar in my hotel; I was there for
> work. This lady is clearly married. Her husband's at home, this is her night out.
> She asked me if I'm staying in the hotel. I'm like yeah. She was like, let me meet
> you up in your room later. She was just like that. So, granted, it's a carnal thing
> for me, but it's in ease, it's baited, it's raged. That's something that, now me,
> personally, my integrity will prohibit me from sleeping with a married woman. I
> can't do it. I can't. If you tell me you're married. Hands off... But, that's what it
> is. A lot of it is put on men, put on Caribbean men, put on men period, but there is
> a factor where women play a part as well.

Men shared their experiences with being baited by women and choosing to engage in behaviors they knew weren't healthy. Art shared a story about meeting a woman at Carnival and keeping in touch enough to convince him to visit her. He stated that when he arrived, she waited until she was nearly undressed to disclose her STI status:

"I want to tell you I have herpes." And I'm there, in your house, in Florida. I'm

like, okay. Naked. And to be honest with you, I had sex with her with a condom.

Right? I went out, basically went and researched it. My nature is science. I

research things. I check it out. And I'm like, this puts me at risk of a lot of things

actually. My kids. My relationship with my kids at risk, ya know. And that's a big

thing for me. But, the thing I could not get over is the fact that she waited for me

to buy three plane tickets return before you told me.

In this instance, STI status influenced condom use to prevent disease and reduce risk. He shared

that even though he felt that his trust was violated, he was willing to give her a chance because

he has been given chances before. Sexual health was something negotiated between two people

interpersonally and in the moment. Other men shared stories of seeing "red flags" but not paying

attention to warning signs, which led to unhealthy situations. Ron said:

It was like, I would constantly break up with her, then I'd be like, damn I'm

alone. So, I would end up calling her. We would pretend, and then I'd be like,

let's try it again. That went on for a year. But, everything in my soul told me that I

could not continue to date this woman. My mother…she met my mother. My

mother looked at her like, "yo, she's cute, why are her teeth brown?" She smokes.

Oh God, it was the most embarrassing day of my life. But I stayed. I kept staying.

I kept staying.

He noted that despite the signs that they weren't healthy, he stayed for a year. It took her

breaking it off for it to be over. Sometimes, flags were overlooked because the woman was

physically attractive to the man. "It was feeling good, it just didn't smell good, and she was so

pretty, that's what messed me up man."

The participants also discussed how peers and family influenced their ideas about and practice of sexual health. Several men shared stories about watching their grandfathers or other influential older male figures "run" women in their communities. Ron shared, "Well, uh, I got two older sisters. And, I've seen the…basically my father was the biggest whore in Nassau. Like, he didn't even care. My mom would be in the bedroom. I'd walk out. He'd be in the living room with a chick, with a woman." This quote also highlighted the overlap between this theme and the "cultured" theme, indicating that Caribbean culture was where the phenomenon was observed. Ken stated something similar:

> Another thing that I was going to say was in a lot of Caribbean cultures, and it may not have been in this focus group, but among my family members, numbers were everything in terms of women. I mean, you was a *gyalless or de gyal dem sugar* [author's note: being a man who is craved by women] if you had multiple women. And even if you had a wife, you had things going on. And that's how a lot of it, and that may not be traits that we personally have, but in that Caribbean culture, there is that peer pressure, I feel like it's peer pressure, I kind of do, because I'm sure they can see it. I'm sure y'all have family and cousins who just have girls galore.

Koy echoed the same sentiment, solidifying it across all three focus groups. "It's almost like a right, in the Caribbean…You know it's going down. Like I actually know, I dated a girl whose grandfather lived in the house with her grandmother, and his outside woman lived two doors down. It wasn't a secret. That was his outside woman." There was some conflict about defining manhood outside of this cultural norm, although most agreed that monogamy was the healthiest option. It was acknowledged that even if one took the bare minimum approach to sexual health,

using a condom, they were aware that it didn't offer 100% protection. So, they noted the importance of picking partners who were also healthy, which connected with an emphasis on women's power in the sexual dynamic, and men valued when women cared for themselves enough to not allow for unhealthy behaviors. Joe said:

> But, I think nowadays, with women having more rights and equality, I think that sense of ride or die or trying to build a man up or trying to build that relationship or contribute significantly from a sexual health perspective, I think that the woman's role is diminished power. They're not taking an active role in promoting sexual health. Because trust I'm telling you, as a female, if you're interested in a man, and you want to promote sexual health, it can get done, because you hold the cards. You hold the most important card. So, use that to your advantage.

The dynamics between people influence the sexual identity and expression. Issues of trust were also situated here. Don seemed to express conflicted views about the importance of trust in a sexual relationship. He said, "There's no need to have any level of trust…well…except for the fact that you're trusting that this person is being careful with their other partners in terms of protection. But in trustworthiness regarding emotional trustworthiness, I don't care. As long as they can show me that they are careful, then that satisfies that." So, physically, he recognized that trust was important, but emotionally, he regarded the sexual relationship as less of a space for interpersonal trust, as long as the physical elements were in place.

Theme 5: Cultured – "Maybe that's the Caribbean in me."

The Caribbean cultural experience, lived and remembered, was often cited as related to sexual health. Their respective countries histories and cultural norms were noted. Joe disclosed why getting tested early with dating partners became so important to him. He said:

When I was growing up in Trinidad at the time, um, HIV/AIDS was a big thing.

When it got bad, it really became public knowledge. Like, when there were actual

statistics for HIV and other STDs for them in Trinidad, I had friends of mine who

was part of those statistics, because Trinidad and Tobago is two different islands.

Tobago is more tourist oriented. The island Tobago went through a serious

epidemic during my teenage years, where most of them young guys around my

age or a little older than me was contracting HIV. And what was happening was,

these young guys were dropping out of school and weren't able to secure jobs.

You had these White tourists coming down from Europe, America, England, you

know, and they're coming down to the islands by themselves for one thing. Right,

and then you have these guys on the beaches or whatever, and they hook up with

these females. Boom, and now they're hooking up with these females…

Joe recalled how his experience as an adolescent watching the epidemic of HIV in the Caribbean

affect his peers connected to a fear and vigilance about STIs and protection. This cultured theme

also surfaced in another aspects of sexual health, related to prostate cancer. Koy disclosed the

history in his family and the ways various men dealt with it:

 I think, this is kind of personal for me, because it's happened in my family, when

we talk about sexual health, Caribbean men don't like to go to the doctor for any

reason. For any reason. Like, my uncle that died of prostate cancer. Prostate

cancer is one of the easiest ones to deal with if you catch it early enough, because

he's like, no man is giving me a prostate exam. I'm not letting anybody. And I'm

like, you didn't have to die. You didn't have to die. Because my father got

diagnosed last year, but he goes regularly, and they caught it early enough that

now he's fine. And it's the same with me. Like, I know it's in my family.

The intersections of manhood, Caribbean culture, socialization, and biological health were especially salient, when he added that another uncle chose a more traditional oriented mode of care, rather than a prostate exam. "But, I have another uncle whose daughter is trying to get him to go and he won't go. He's like, oh I'll just drink some tea. There's a closed-mindedness about things that are not considered 'manly' even when it doesn't make sense."

Also, some of the men spoke to the way Caribbean culture exposes them to sexuality early and the way the contexts in which they grew up informed their sexual health over time. Don talked about being stereotyped by a woman he is interested in:

She knows that I am interested in her. She is hesitant to move forward, and one of

the factors is that I am in fact a Caribbean man. She's had this horrific

relationship and association in her mind with Caribbean men. So, one, it's a bit of

an uphill battle with her, which I don't make very easy on myself, because I have

fed into the association, because of my own situations with others. Um, so on one

hand, I'm a self-fulfilling prophecy, and with Caribbean background, especially

with Carnival and Soca music, we're a very sexualized culture. So, in her case, I

have a preconceived notion in her mind that I'm working towards quelling, but at

the same time, some of my behavior patterns are fulfilling, in her mind, what I am

as a sexual, Caribbean man.

There was much overlap in these themes. For example, statements that could fit in both this theme and the heterosexually privileged theme relates to one's understanding of how LGBT identified people are perceived here versus in the country of origin.

Theme 6: Pleasurable – "It's very valuable to understand that you're pleasing your partner."

The men prioritized pleasure in many incidents of unhealthy behavior, but there were also assertions that being pleased by one's partner, and being able to please one's partner, was an important part of sexual health. Jon shared a non-monogamous relationship where he had a pleasurable experience as his sexually healthy moment. He said, "The health was the act of sex, the feeling that it was good, the fact that I was able to just release and just be myself." His statement represented several men, who asserted that they could engage in a sexual relationship that was only about sex and still feel it was healthy. Oscar shared an experience with a woman he had begun to resent, and he noted how that affected the pleasure. "Like, I, well, there was a lot going on. There were things I resented her for. She wasn't a pleaser. There were a lot of things that I didn't like about her, so I was just like, let's get this over with. And I can feel a difference, physically." Having working "equipment" was often tied to the ability to please, rather than any underlying health concerns. Jon noted that virility was important, "Virility…Ultimately, to satisfy that person."

Pleasure as a factor of sexual health often gets little mention, but there was consistent dialogue about the pleasure one gets from being with a woman he is interested in, and the enhanced pleasure one gets when he is with someone he cares about. Koy shared, "I was just talking about a healthy relationship, being faithful is easy for me personally. Because sex with somebody that you care about is infinitely better than just like….the other may be more technically skilled, but there's something about like a deeper connection that just makes it better."

The resulting theory, the Be a Man Model, indicates how sexual health must be considered in outreach, education, and relational settings if HBMCD are to buy into the concept

fully. Through their voices, they articulated how they define sexual health, how their definition aligns with the definitions of SEICUS, an established sexuality education organization, and what encourages and discourages their sexual health, providing examples from their lived experiences. These data, analyzed through my lens, and member checked through the lens of the participants, articulate the way HBMCD conceive of and experience sexual health. After review by three participants who agreed to individual interviews for member checking, they asked for no changes and overall felt good about the way they were depicted through my lens.

Chapter V

Discussion

Although there are several definitions of sexual health and proposed explanatory models, very little research or theoretical work is developed through the participation of the groups to which they will be applied. For example, the definition by the WHO (2006) was developed through a panel of experts from medicine, psychology, and public health. Although their expertise is noted, the way sexual health is viewed by specific cultural groups differs and demands attention to be able to effectively engage outreach efforts and work with clients around issues related to sexuality. Heterosexual Black men of Caribbean descent (HBMCD) were not studied in this study because they are in immediate danger, or an immediate danger to others, but rather as an opportunity to hear their often marginalized voices and give them a platform to contribute to the conversation about their own health. Although there are sexual health issues experienced by this group (St. Jean et al., 2011), the researcher's intention was not to further pathologize these men, but to understand them. While professionally sanctioned definitions of sexual health exist for good reason, the cultural context may not make these definitions as appropriate for all groups. Researchers and practitioners must understand that what is perceived as influential to sexual health from our worldviews sometimes differs from the people we serve.

With this perspective, this qualitative study used grounded theory methodology to co-create a preliminary theory on sexual health for HBMCD. The Be a Man model has six overlapping components: sexual health is heterosexually privileged, protective, contextual, interpersonal, cultured, and pleasurable. A discussion of the literature and implications related to these themes follow. Recommendations and a conclusion end this chapter.

Heterosexually Privileged

     As noted in chapter four, the researcher experienced some conflict around how to name this theme. The research informing the decision and the narratives shared by the men led to the term heterosexually privileged, over homophobic and/or heterosexist. Bowleg et al. (2011) also found that this theme emerged in their focus groups of heterosexual Black men (ethnicity not specified), and it was stated "Black men should be heterosexual" (p. 550). According to Adams, Wright, and Lohr (1996), a distinction between homonegativity and homophobia provides clarity on the cognitive and affective responses to homosexuality. They use Hudson and Ricketts' (1980) definition of homonegativity as the overarching umbrella, under which homophobia falls:

> To clarify this problem, Hudson and Ricketts defined *homonegativism* as a multidimensional construct that includes judgment regarding the morality of homosexuality, decisions concerning personal or social relationships, and any response concerning beliefs, preferences, legality, social desirability, or similar cognitive responses. *Homophobia,* on the other hand, was defined as an emotional or affective response including fear, anxiety, anger, discomfort, and aversion that an individual experiences in interacting with gay individuals, which may or may not involve a cognitive component. (p. 440)

Men in the groups exhibited both of these characteristics, based on conversation, but it seemed to be associated with a strong masculine and heterosexual identity, so digging deeper, the researcher chose to examine the definitions for both heterosexist and heterosexual to arrive at the selected representation of the dialogue's intention and meaning. Dean (2013) speaks to this association of masculine heterosexuality and homophobia, noting that while many authors suggest they are always aligned, he qualitatively found men who were able to separate the two.

He notes, however, that even though they don't have to be connected, "In practice, many heterosexual men invoke this exact strategy in performing heterosexual masculinities. That is, straight men often aim to be conventionally, even exaggeratedly, masculine in their identity performances as a way to project a heterosexual status" (p. 536). The participants in this study did just that.

Heterosexism is "The ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community" (Herek, 1995, p. 321). So, systemically, as all White people benefit from a system of racism, all heterosexual people benefit from a system of heterosexism. Given that all participants represented that dominant group (heterosexual), it didn't seem accurate diction to use heterosexist to define their sexual health, when that term isn't applied across all studies of heterosexual populations. Finally, because we live in a heterosexist society, the research often made assumptions and failed to operationalize heterosexual in many studies. Even Elder, Brooks, and Morrow's 2012 article about the sexual schemas of heterosexual men, wherein they ask the question "what does being heterosexual mean to men?" offers no specific definition that emerges out of their grounded theory study (p. 166). It is as if because heterosexuality is the normative behavior, it doesn't require defining (Dean, 2013). The relatively scarce literature on heterosexual identity development (Mohr, 2002; Morgan, 2012) offered a definition that captured the dynamic nature of a heterosexual identity that could better represent the participants in this study and their development, expressed through statements such as, "Yeah, I mean, who hasn't heard 'boom, bye bye?' Who hasn't…And I sung it along with the rest of them, and you know, but now it's like, as long as you're not coming after me, I could care less."

Mohr's (2002) theory of heterosexual identity offers four working models, one of which aligns well with the responses of the groups: compulsory heterosexuality. He notes that those endorsing this model often emphasize a focus on sexual behaviors and expression, and they believe heterosexuality is the morally and/or socially acceptable orientation. He states, "whether one is attracted to women or men is less important than whether one acts heterosexual (i.e., behaves in a manner that is aligned with the salient values and norms)" (p. 543). People with compulsory heterosexuality experience LGB people as disturbing and they are uncomfortable interacting with them, so they typically avoid such encounters. Oscar articulated this in the group, saying, "That's really what makes people uncomfortable, because I haven't told you what I do in my bedroom, and you didn't tell me, but you acting like this makes me feel uncomfortable."

Worthington et al. (2002) note, "biopsychosocial influences (e.g., biological aspects of development and maturation, gender norms, gender role socialization, culture, religion, systemic homonegativity, sexual prejudice, and privilege) are often lost or ignored as contributing factors in sexual identity development" (p. 501). Their model consists of five statuses in heterosexual identity development: unexplored commitment, exploration, diffusion, deepening and commitment, and synthesis. The heterosexual identity model is not a linear, meaning that one can go from unexplored commitment to deepening without experiencing exploration or diffusion. Most of the men in this study fell into the unexplored commitment status, which they indicate often houses individuals who endorse compulsory heterosexuality, or the deepening and commitment phase, which can be the result of a deepened attachment to one's heterosexuality, but does not require exploration. And the description of the participants' slow, but meaningful, growth around this heterosexual identity is also noted. Koy shared his growth process, saying, "I

hear where you're coming from. I probably wasn't that hard core about, but I definitely felt very, very anti. Like, I didn't want to be around it at all. Living in Atlanta, you can't not be around it, so I just had to learn to come to peace with it in my own mind. I'm like, they're here. Some of them are going to hit on me. I'm not going to like it, but I'm not going to fight them. I'm just going to move on. You can't fight all the time."

The men in the group also endorsed some rigidity around gender roles, indicative of the unexplored commitment status of heterosexual identity development. Both Oscar and Ven asserted, "I want my woman to be a woman." Oscar explained, "Even though she might have to work, she's still going to come home and cook and take care of her family. I was not budging on that no matter how much American media or whatever says." Ven added, "I'm going to be a man. I'll take care of protect the family and whatever else there is. Ima go get it. I believe in roles." And as Worthington et al. (2002) suggest, both men attributed these values around traditional gender roles to their Caribbean cultural backgrounds, differentiating between US values, which they felt were less stringent. According to O'Callaghan (2011), "heterosexuality has a pathological side" (p. 131). The men were not exempt from the expression of the strengths and weaknesses of their heterosexual identities. So, coding the ostensibly homophobic narratives as heterosexually privileged, on a spectrum of heterosexuality, was intentional, with the status of heterosexual identity including democratic, compulsory, politicized, and integrative (Mohr, 2002) or unexplored commitment, active exploration, diffusion, deepening and commitment, and synthesis (Worthington et al., 2002).

Implications for this theme are that conversations and outreach around sexual health must first affirm the value of heterosexual identity, before being thoughtful about carefully confronting heterosexist beliefs. Dean (2013) articulates that the way Black men's gender

intersects with race in the US makes it especially important for them to highlight areas where they have privilege. For Black men of Caribbean descent, an additional historical cultural factor might be the way European colonizers pathologized the sexuality of the Afro-Caribbeans to prevent miscegenation. Smith (2011) offers that these early assumptions and assertions about Caribbean sexualities became entrenched into the political fiber of most Caribbean countries, represented as an almost hyper-respectability to counter the image of the pathology. She connects some of the legislated heterosexuality to this historical context.

Given that history, I deepened my understanding of how heterosexual privilege in the unexplored commitment and deepening and commitment statuses served a purpose in the lives of these men. That isn't to say that I agree, but I accept and respect this difference in what sexual health means, even if I feel it may come at a cost to the men's ability to express heterosexuality in more dynamic ways that may also allow them to reduce some of the anxiety and discomfort related to maintaining such high levels of distance from and disdain for people who make up a relatively large minority in Atlanta. O'Callaghan (2011) supports this assertion, noting that maybe living in a place outside of their countries of origin will slowly allow them to express heterosexuality differently. She says, "Perhaps 'elsewhere' might offer Caribbean men too a space to perform their gender differently and with less hurt to others" (p. 134).

Protective

Often intersecting with the masculinity associated with the participants' heterosexually privileged identities, the protective aspects of sexual health were important to these HBMCD. Protective and preventative were collapsed into the same theme, because the efforts at prevention (of STIs and unplanned pregnancy) were exerted in order to protect one's self and others from the consequences of those potential outcomes. Despite broad definitions of sexual health in

policy documents such as the World Health Organization's 2006 report, much of the extant

sexual health research operationalizes sexual health as protecting one's self from STIs and

unplanned pregnancy (Buhi, Marhefka, & Hoban, 2010; Charnigo, Crosby, & Troutman, 2010;

Crosby et al., 2009). So, this theme aligns with that empirical trend, but the participants furthered

the meaning of protection in the traditional sense.

While much of the prevention research about Black people subtly suggests that Black

men are the disease carriers, the men in the group were conscious of not wanting to physically or

biologically harm, or violate, their partners. They wanted to please them and experience pleasure

with them. They wanted to empower them to challenge men who might be vulnerable to their

sexual desire, challenge them in a way that calls for sexual health. And they wanted to protect

themselves, just because of their own value, as well as to be able to maintain responsibility for

the people who were under their care (children, partners, or even parents). Oscar said, "I know I

have a more militant view than many other people, but I'm vigilant about protecting my mom

and protecting my wife and stuff like that." Even when some participants were adamant that an

emotional connection was not required to have a healthy sexual relationship, they often

communicated that they were invested in protecting something or someone. Lewis (2004) notes,

"preventative sexual responsibility focuses on the civic duty of sexually active persons to protect

themselves and their partners from exposure to disease…sexual responsibility is seen as a

protection of society in preventative discourses, while in eudaemonic discourses a more private

and relational responsibility is applied" (p. 227). His assertion speaks to some overlap in this

theme and the themes of pleasurable and interpersonal. The participants seemed to embrace the

position aligned with eudaemonic discourse, in that they did not see themselves as protecting

society, but as protecting loved ones, including themselves.

This theme has implications for extending the lay definitions of sexual health, given that most people assume that using condoms or contraception as protection is the whole of sexual health. Being a protector in this sexual health sense bridges the traditional masculine role of being a protector to healthy sexual behaviors in a way that challenges the less healthy aspects of hegemonic masculinity. For Caribbean men, whose countries of origin often endorse traditional gender roles as a value (Kempadoo, 2009), the identity of protector may begin to open conversations about concurrent partnering and the discrepancy between that behavior and the desire to protect one's family. Art spoke to this desire to protect, saying, "You know, anything that puts me at risk, my family at risk, I can't do."

Contextual

This theme demonstrated the importance of using this specific demographic of HBMCD ages 30-50 in this research. The men articulated a connection between their age and the way they defined and demonstrated sexual health, typically indicating that they would have likely defined it differently in their 20's. I chose a population between 30-50 with this developmental difference in mind, given that most sexual health research investigates men in their early 20's. Bowleg (2004) notes that age, SES, and racial/ethnic identity influence Black men's endorsement of masculine identities. Because masculine identity is interrelated with sexual health in meaningful ways with these participants, it makes sense that the developmental shifts would be offered as influential to sexual health as well. Corneille et al. (2008) conducted a study similar to mine, using Black US men ages 18-35. For most of these younger men, pregnancy prevention overshadowed STI prevention, while for my participants, many had kids already, or were prepared to raise kids, so STI prevention was more salient unless they had contentious relationships with the mothers of their children. Corneille et al.'s (2008) participants also

suggested that alcohol and substance use was unlikely to affect their sexual health, while my population indicated that they noticed the effects, although they recognized that they were still responsible for their behaviors, even while they were under the influence. A theme that did not occur among my participants, which presented in Corneille et al.'s (2008) study, was that condom use was to hide infidelity from the main partner. Most of my participants highlighted monogamy and desiring one woman, which is likely a function of developmental stage. People in the 18-35 age range may be less likely to seek a monogamous relationship than a 30-50 year old group.

Context also included status as a parent, as participants disclosed that they became more conscientious of their sexual health when they became fathers. HBMCD who are fathers recognized the effect of their parental status on how they do gender and sexuality. Thus, family often emerges as an encourager of sexual health. This finding overlaps with the protective theme, because parental status gave many participants another layer of responsibility and encouraged greater maturity. Crook, Thomas, and Cobia (2009) state, "Fatherhood is an essential aspect of African American men's perceptions of masculinity. Unfortunately, both the professional literature and popular media tend to emphasize absent African American fathers" (p. 362). The same applies for Caribbean men (Smith, 2011). In fact, according to the participants, they perceive themselves as more invested in the parental process than other men, to the extent that they recall witnessing family members have and take care of several children. Koy said, "I have an uncle who literally has 14 children with 11 different women. And he takes care of all of them." As a point of pride and connection, Ven echoed a similar sentiment. "My great uncle is the same way. He has 12 kids with six different women." Although most participants identify the

practice of concurrency as an unhealthy one, they identify fathering children as an important role and one that keeps them healthier, despite their familiar contexts.

Context also included environment, specifically as it relates to Carnival culture, partying, and the differences between what constitutes sexual health in and out of those spaces. Pinto (2009) states, "Perhaps no cultural event is identified with Trinidad and Tobago more than Carnival, the annual festival of music, dance, food, and culture that has come to symbolize the Caribbean in both theory and cultural practice outside of the region" (p. 138). There was disagreement within and between groups about what this environmental context offered. Ken argues that one could get away with different actions during Carnival time that might not be healthy, and might border harassment, during other times of the year or in other environments:

> It is the setting and that's the environment that you're in. So, it is a little bit more acceptable. Because you're not going to, on a normal basis, have women scantily dressed. You have some of them in equivalent to a bra and panties, and they're walking the streets in that. But, they're not going to be doing it all the time. They're not going to be winding their waist in the streets all the time. It's a little different than just walking up and down. I can't just be walking up and down and see a girl and just start winding on her. That wouldn't be okay.

And Dan shared the meaning of Carnival, "So, yes, a lot of PDA is the fete and in the Carnival environment, but, it's an observed tradition. And if you look at it from just solely a 'these people are just out here winding and grinding' you're not really understanding what this is all about. I would challenge you to go do the research and understand. Not you, but the collective you, because there's more to it than just that."

Joe also noted how environmental context could discourage sexual health, with partying and drinking of Carnival impacting their decision-making, although as stated above, there is still clarity that the decision is not healthy:

> Alcohol definitely plays a significant part in Carnival, because when you reach, especially Trinidad Carnival, you're on the road from Sunday night. When Tuesday roll around, and you ain't sleep in 48 hours, and you're on the third round, anything can happen at that point. Now, you ain't thinking, I love this person. This is a public display of affection. Hell no. You're drunk. Your tongue slip out your mouth, and your tongue slip into her mouth, and she's there. So, as far as I'm concerned, that is not affection, that is just lust.

He highlighted the extent to which sleep deprivation, the sensual culture of Carnival, and substances may encourage someone to engage in sex with a stranger out of lust. Pinto (2009) suggests that women's bodies are offered for performance and consumption during Carnival, which seems to align with the above men's statements. She notes that soca music, in particular, emphasizes sex over social justice, as "party music, public sexuality, and licentiousness—concerned more with the "female bottom" than with "uplift" and with a black performative cultural idiom" (p. 141). However, Dan asserts that he does not expect sex from women he meets during Carnival. Dan said, "Generally speaking, I don't go out looking for any one night stand action at all. Like you were saying, some of you were saying about you know, the Carnival, or whatever, to me it's just a dance. I don't expect anything beyond that if I dance with somebody, you know. And the times where it has led to like a number or something, even that was like, it was not even expected, but came out of it and maybe later on we might pursue each other." This

outlook counters the perspective from Pinto (2009) and other participants, but it speaks to the varied ways different people might perceive a context.

Age, parental status, and environment serve as important context when considering sexual health outreach. Appraising the salience of these contextual factors in the group is important as well, because the men identified that they were influential, but occasionally highlighted differences in the type of impact. With most sexual health education and outreach focused on younger demographics, scientist-practitioners miss the opportunity to connect with people who may have more knowledge about sexual health, but still make some missteps as it relates to the application of said knowledge. To connect with them, understanding the context means honoring their developmental stage, parental status, and the environments they frequent to relay a relevant message.

Interpersonal

According to Sexual Scripting Theory (Simon & Gagnon, 1984), interpersonal scripts inform sexuality through relationships with family, peers, and partners. The men spoke to all of these types of relationships in the interpersonal theme. A few participants shared that they grew up watching family members have numerous sexual partners. Most suggested that they now recognized sexual concurrency as an unhealthy behavior pattern, and just because they could do it didn't make it right. Oscar shared an unhealthy sexual experience where he had sexual encounters with three women over the course of the weekend. He reflected on how it just didn't feel right to him. He said, "I can't live that fast. That's not me. And I was capitalizing on my options, and that's not who I am." Ken also shared an example of family members encouraging behaviors he deemed unhealthy, under the push to "be a man."

The men attributed their healthier, more loving attitudes and behaviors to their mothers. Oscar said, "And, I spent a great deal of my childhood and adolescence there, so we have always been very, very tight, and that's what started my sense of character. I learned a lot from her, but you know, she gave me the information I needed as far as is what I want from a woman." Koy and Gen offered similar sentiments. Koy said, "Like, I know my father, but I grew up with my mother. My father and I are cool now, but it was me and my mom. So, it's definitely colored my experience with women. And, my father had three daughters with his current wife, and I'm super close with them, so it affects the way that I see women as a whole." Gen shared, "One thing I want to add is that even though my mother and father raised me, I was really close to my mother, and so…as far as when I'm in the presence of a woman, treating her right and making her feel special, that's what I got from my mother. So that's one thing I definitely wanted to at least impart to the discussion." The men noted that because of their close relationships with their mothers, they learned how to treat women and what they wanted in a mate.

The research identifies relationship with primary caregivers as important and related to sexual health, and the findings from this study confirm this influence (Bowlby, 1970, 1979). For HBMCD, Kempadoo (2009) states, "Informal polygamy and multiple partnering are commonly signalled in studies of family, masculinity, and HIV and AIDS. Such arrangements are usually associated with men and considered to be an accepted part of (African) Caribbean masculine social life" (p. 9). She articulates the overlap this part of the theme shares with the heterosexual theme. She argues that family norms allow for the genders to practice their sexuality in specific ways with little confrontation. However, in a follow up individual interview, Don indicated that there are in-house consequences to this behavior within a family, despite the fact that the couples

stay together. "We don't get away with that at home." But, "getting away with" seems to be relative if one is able to maintain a family system despite the upset.

Research also identifies peer influence on sexual health, although many of those studies are conducted with younger men (Kennedy et al, 2007). The older men in this study acknowledged peer influence to some degree, but they mostly articulated that they were able to, and preferred to, make their own decisions. Focus group two spoke specifically about not discussing details of intimate relationships with peers as they grew older, and this tendency was observed in the dynamics of the focus group, as they had to be encouraged more than other groups to share more personal experiences. Dan said:

> So when you're putting it out there for everyone to see it, how can I teach my son
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> that it's something he should be respectful of? You know what I mean. Because
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> this is a woman that I am with, nobody else should have any preview into this. It's
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> theirs, you know. I should never know how you and your wife get along. When
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> you're a man I shouldn't know that. I never know how my boys, what they do
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> with their women. I don't want to know.

Ken followed that with, "You have some that just love to share, and just tell you like, yeah, you know, I'm not going to be graphic, but, I did this and that with so on and so forth. I don't need to hear it. I'm like come on man, you hit it? Alright, cool. Next topic. I don't want to hear the details of how you had the leg up and all this other stuff." The men noted that peer influence played less of a role in their lives at their ages.

The men identified partners as the biggest interpersonal influence on sexual health, with distinctions between men in committed relationships and men who weren't. Men in committed relationships were less likely to suggest that women couldn't be trusted in interpersonal

dynamics. Overlapping with protection, single men spoke about feeling "baited" and "tricked" into unhealthy sexual encounters more often than committed men. In fact, the two married men offered counter examples of how their partners were their biggest encourager of sexual health, and Joe even suggested that men who were engaging in concurrent partnerships and other unhealthy behavior needed to be stronger as men. All of the men agreed that women play a big part in this dynamic, yet none acknowledged the powerful influence they have over women's sexual decision-making (Bowleg, Lucas, and Tschann, 2004). They didn't speak to any awareness of how a woman's fear of abandonment or desire for commitment might inform her decision to have sex without condoms. This has implications for developing that awareness in single men through therapy and outreach.

Cultured

For these participants, Caribbean culture socializes certain psychological norms related to sexual health and informs how one responds to biological concerns. One participant implied that acculturation in US culture improved his health behaviors and outcomes, given that both the access to and acceptability of seeking health care differed from his home country. Connecting it to his uncle's death from prostrate cancer, he noted the extent to which Caribbean men will avoid necessary services, opting for natural methods. He also inferred that avoidance and Caribbean presentations of heterosexuality were linked.

> Like, my uncle that died of prostate cancer. Prostate cancer is one of the easiest
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> ones to deal with if you catch it early enough, because he's like, no man is giving
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> me a prostate exam. I'm not letting anybody. And I'm like, you didn't have to die.
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> You didn't have to die. Because my father got diagnosed last year, but he goes

regularly, and they caught it early enough that now he's fine. And it's the same

with me. (Koy)

It is as if culture informs socialization, which informs thoughts and feelings, which

inform responses to one's biological makeup and changes. All groups indicated that music is an

important part of the culture, and it influences, although it may not overtly direct, sexual health.

They suggested that growing up listening to Buju Banton artistically articulate messages about

which sexual orientations were acceptable in Caribbean life and which did not deserve to exist

made an impact culturally and personally. And, growing up feeling like a "late bloomer" because

of sexual initiations that happened in late, as opposed to early, adolescence speaks to the cultured

response to one's biological and psychological maturation. In the Caribbean, participants noted

that starting at ages 17-19 felt comparatively late for males.

Therapy with HBMCD around sexual issues needs to be especially considerate of the

intersections of culture, socialization, and psychological aspects of sexual functioning. For

example, a man and his partner might wish to explore anal sex, but the cultural legislation around

sodomy and homosexuality may trigger fear and cognitive dissonance about his desires and

cultural norms. Therapists who understand these overlaps are better prepared to attend to these

discrepancies, to assist clients in accessing other avenues of sexual pleasure.

Pleasure

Pleasure stands as one of the less investigated aspects of sexual health. In a content

analysis presented at APA, Crowell and Delgado-Romero (2013) found that in counseling

psychology journals, 68% of studies on human sexuality were preventative models, rather than

eudaemonic models that focus more on other aspects of sexual health, like pleasure. Pleasure

includes sexual satisfaction for both partners, and the participants emphasized that feeling

pleasure and being able to offer pleasure represented sexual health. Conflict sometimes surfaced when participants prioritized pleasure over protection, which might include incidents where the participant's pleasure was at the expense of his partner's emotional investment or his own protection against STI or unplanned pregnancy. Don described a sexual experience with a woman that was very pleasurable because she introduced him to new things. He identified this experience as healthy until her feelings for him began to change. "Yeah, so the fact that she was great, she was fantastic, she was fantastic in bed. I don't want to say she was a fantastic fuck, but that's exactly what it was. But, not necessarily somebody I would take out in public, or be seen in public with. Right, but from a function agreement as a sexual partner, up until the point where she started wanting to be seen in public." He asserted that because he had been clear about the parameters of the relationship up front, they were healthy as long as they both consented and had a great time. When she wanted to shift the parameters, he began using avoidance, rather than addressing the discrepancy in desire for commitment.

One difficulty in sexual health education is that there is a rather common perception that condoms, and some other forms of contraception, reduce the pleasurable sensations of sex. Connecting condom use to pleasure proves difficult because of this perception, and that underscores why most participants reported that an honest, monogamous relationship, where both people had shared their STI status and were in agreement about pregnancy outcomes, was the healthiest option, because it allowed for open communication about pleasure and the safety to explore various options for pleasure, including sex without condoms.

Lewis (2004) describes the two discourses for sexual health: preventative and eudaemonic. The most frequent discourse in sexual health literature is preventative, based in the use of protection against STIs and unplanned pregnancy. Discourse around pleasure and sexual

functioning that contributes to pleasure is eudaemonic. For marginalized populations, the trend to focus on prevention is even more pronounced (Lewis, 2004). While there is some rationale behind this trend in the Black community, with HIV rates surpassing those of other groups, it does not belie the need to consider pleasure, as it relates to preventative efforts, and as it stands on its own.

Black and Caribbean masculinity scholars suggest that as a function of the intersection between race, ethnicity, and gender, the experience of marginalization may make one's sexual prowess a more salient aspect of an HBMCD's sexual identity. Cultural narratives about Caribbean men as being able to offer pleasure with abandon pervade sex tourism literature and media. *Sex and the Citizen* (2011) offers an analysis of the movie "How Stella Got Her Groove Back" to indicate the ways in which even Black people of American descent, who grapple with their own narratives about hypersexuality, buy into the idea that Caribbean men are for sexual consumption. So, there is both objectification and exoticization of Caribbean male sexuality, as well as his own opportunistic capitalization on these stereotypical perceptions. Oscar recalls a time where a woman saw his hair, which was worn in locs, and her perception of that aspect of his Caribbean identity lead to a sexual encounter. "She made a comment. She was like, 'you're like a Black Thor.' Within the half hour, I was beating it out." The term "beating it out" referring to a sexual experience, he recognized that he capitalized on the opportunity for pleasure, and then later felt regret that he had been so opportunistic. At the individual level, most human beings, regardless of race, ethnicity, or gender, seek to have pleasurable sexual experiences. With that said, the association of pleasure with sexual health is often missing in research with marginalized communities, because the cultural components often overwrite the biological and psychological desire for the pleasure that comes with sexual encounters.

Recommendations

As a womanist, the researcher noted the intricate way sexual health was tied into being a man and heterosexuality, and as the participants noted that sexual health was interpersonal, the relationship between men and women came to mind. There is an opportunity to encourage a cultural shift in sexual health in the way practitioners, parents, and peers discuss sexual health with boys/men and girls/women that this study gleaned. The underlying message of instructing girls/women about boys/men seems to be, *don't allow him to use you to define or bolster his sense of manhood in one specific way: sexually*. The message lacks clarity, in that it often comes out as *don't be promiscuous.* But, what this message is actually speaking to is the fragility of masculinity, heterosexuality, and manhood, such that it is vulnerable to use any socially acceptable means to bolster itself when it feels insecure. Higgins, Hoffman, & Dworkin's (2010) vulnerability paradigm explains the way this message influences research, but it does not indicate what can be done on the practical level through therapeutic and outreach interventions.

According to the participants of this study, women's bodies are the most highly regarded way acquisition of manhood or bolstering of masculinity happens for heterosexual men, and some boys and men are not conscious of the underlying drive to their sexual conquests. For men of color, who have experienced the cultural history of being colonized, oppressed, and emasculated, where women's bodies may sometimes seem to be the only avenues through which they can reach an approximation of the hegemonic masculine ideal, there is a compulsion to acquire, control, or conquer as many bodies as possible (hooks, 2004). This compulsion shows up in strict adherence to traditional gender roles, compulsory heterosexual identities, concurrent partnering, and other sexual praxis among the participants of this study (Elder, Brooks, & Morrow, 2012). Some men have an unspoken, but very salient, ideal of the number of partners

they must have and the time frame in which they must have it, to reach the masculinity they aspire to.

Masculine heterosexuality is particularly limiting for Caribbean Black men. Caribbean Black men police themselves and each other, arrested in the confines of what they should want, be, do, say, and think. And if feelings are ever allowed, there are restrictions on when and why. Men often outwardly express pride in this imposed stoicism, because they perceive very few aspects of themselves to celebrate. It seems as if this imposition is acceptable when other men demand it. But, the guidelines to what one can be required to do by other men align strictly with the boundaries of heterosexual norms. A Caribbean Black man cannot impose fidelity on his peer. A Caribbean Black man cannot impose emotional expressiveness on his peer. A Caribbean Black man cannot impose same-sex exploration as a right of passage. But the edict "be a man" can precede the imposition to go try to talk to a woman despite the man's anxiety. A Caribbean Black man can impose, and feel justified in doing so, anything that aligns with the known norms of heterosexual masculinity. The participants called this "the code."

Masculine heterosexuality serves several purposes in the Black Caribbean man's life. It is a mandate, a compulsion, a value, a privilege, a power, a barrier, and a constraint. It only allows for flexibility at the expense of others, not in its own right, and even then, there are limitations to how one can perform heterosexuality as a man. There is a psychological cost to privilege that often goes unexamined. One pays for privilege in authenticity, flexibility, and intimacy (hooks, 2004). To move from abusing privilege to using it consciously, with integrity, is a path unworn. Not many are able to sacrifice the sense of belonging (although not quite intimacy) that comes with the privilege of heterosexuality. Caribbean men are not an exception. To live in the United States with other marginalized identities, such as race, ethnicity, and possibly social class, one

may be even more likely to cling desperately to the areas where he can exercise power. But desperation is always expensive. Even with familial and cultural buy-in, a woman who "lets a man be a man," and a culture that politically privileges heterosexuality, the intrapsychic tax goes unexamined. In fact, it is often suppressed in a way that manifests malignantly in one's ability to connect with others on a deep level and be oneself across environments.

There is desperation to compulsory heterosexual masculinity, and some women encounter this desperation and manipulate it for personal gain. Some women struggle against it. Some women have insight into ways to bolster a man's sense of masculinity that do not exclusively include sex. Some women are victimized by the desperation and compulsion of it. Rather than teaching women what to do to manage the vulnerability of men, it seems important that we begin to give men additional ways, non-oppressive ways, to reach for their masculine ideals, if we are to buy in to this system that reaching that goal is important. If we do not buy in to it, we have to give men the tools to resist hegemonic masculinity in a society that imposes these masculine values from cradle to grave. For men with marginalized identities, HBMCD, we have to do this in the face of other oppressive impositions, such as racism, classism, and ethnocentrism. The following recommendations offer some possible interventions through counseling and outreach.

The six components of the Be a Man model can be used to employ culturally relevant counseling around sexual health issues, as well as outreach for sexual health education with HBMCD. Recommendations based on this theory follow.

Counseling Recommendations

Clients may present with a number of issues related to sexual health. Counselors are underprepared to serve in this capacity, given that many programs do not offer electives related

to human sexuality. For HBMCD presenting with sexual health issues, masculine and cultural values may make presenting an even more difficult task, so it is recommended that the therapist consider the heterosexual privilege, protective posture, context, interpersonal nature, culture, and pleasure when talking through sexual health issues with these clients. Asking questions to understand what heterosexual identity status the client is in may include broaching views on LGBT populations and what impact that may have on the presenting issue. Attending to the emotions of fear, anger, and disgust, not for the sake of changing the client's views, but of connecting that to how it may be influencing an issue like sexual concurrency. For instance, a client who presents with issues of infidelity may have strong beliefs about sex with women being tied to heterosexual manhood. A counseling psychologist could process what the client fears might happen to his heterosexual male identity if he was sexual with one woman exclusively.

Counseling psychologists are often trained to consider development across the lifespan, so we are well positioned to attend to the context of the client's age and parental status, as that influences sexual health. Framing the protective posture as a strength, counselors can discuss the ways clients have been protective forces at various stages of their lives, and what they would like that to look like in their current sexual lives. Furthermore, counselors can process the perceived weight and cost of that responsibility, especially in instances when the client chooses a less healthy sexual decision. With a stance of acceptance, the counselor attends to what it feels like to be responsible for self and others under the client's care and what it feels like to breech that often unspoken expectation.

Additional recommendations are creating a safe space to talk about sexual pleasure with clients. Clients may carry a desire to experience pleasure in ways not sanctioned by their cultures. Modeling acceptance of the varied ways clients wish to experience pleasure has two

potential implications. The lack of judgment allows a client to own and honor his sexual self, integrating the cultural and interpersonal scripts of Caribbean sexual health with his individual scripts of desire and fantasy. A second implication is the interpersonal process of modeling acceptance in the therapy space serves as an opportunity for clients to practice sharing these desires with their partners in a way that allows both of them to get their needs met and desires fulfilled. Koy spoke about the way judgment can shut a conversation down with a partner, so working with the client on how to enhance sexual communication as an aspect of sexual health offers new ways of connecting.

Outreach Recommendations

While much of the outreach literature focuses on how to make an impact with younger demographics in communities and universities, outreach can happen across the lifespan. Social, service, and civic organizations are great spaces to offer sexual health outreach for older adults (Bowleg & Raj, 2012). Often the focus of sexual health outreach on adolescents and college-aged people is due to convenience and the perception that they have the greater need for preventative interventions. However, most adults receive only informal sexual health messages from uninformed sources, so that they often enter adulthood with misconceptions about sexual health. For example, some participants suggested that they perceived a woman's looks to be linked to her sexual health status. Ven reported feeling confused when a woman who looked like a model smelled unhealthy during their sexual encounter. These pervasive misconceptions indicate the need for additional sexual education outreach for 30-50 year old men.

For HBMCD, Carnivals were highlighted as an important cultural event. Already encouraging sensual and sexual expression through dance and dress, it may be a great space for outreach that ties in the theme of pleasure. Knowing that for many Carnival attendees, alcohol

will be a part of the experience, we can assume that decision-making skills are compromised to the extent someone has partaken of libations. Passing out condoms while dancing and enjoying the event makes the contraception immediately available and associated with the joy of the fete, connecting condom use with pleasure.

Approaching clubs and organizations that have high HBMCD memberships is another avenue for outreach. A few participants spoke to how valuable they found the experience of participating in the focus groups, because men do not often have spaces where they can talk safely about their experiences without ridicule or judgment. Offering a sexual health conversation hour or workshop to the membership of organizations that these men already engage introduces the conversation and may offer a bridge to individual services or support groups related to sexual health concerns. Within the workshop, the facilitator can introduce the model of sexual health at the outset, and then spend time talking about each component of the theme build alliance and buy in among the group. Then a Q&A can follow, with the session concluding with connection to resources for individual and group therapy.

<div align="center">Conclusion</div>

Even within a specific ethnic subgroup of Black men in the United States, there is diversity of experience and perspective, as indicated by this study. However, the themes related to sexual health that emerged aligned with Sexual Scripting Theory (Simon and Gagnon, 1984) to a large degree, reflecting that cultural scenarios (heterosexually privileged, context, and cultured), interpersonal scripts (interpersonal, protective), and intrapsychic scripts (pleasurable, protective, cultured) are relevant areas of focus for sexual health therapy and outreach within this demographic. The researcher sought to co-develop a theory that prioritized the voice of the participants, but it is recognized that this theory is only one way to view these data (Charmaz,

2006). From a social justice perspective, studying marginalized groups using their voices attends to the understanding that they are often underrepresented in the field of psychology. There have been struggling efforts to develop a Caribbean Psychological Association, and one reason is the small number of people who identify as Caribbean in the field. As a counseling psychologist in training, espousing social justice and multiculturalism as values, the first author was conscious of this need for participant voices in the choice of methodology, but the limitations of qualitative research are noted.

Future research should test this theory quantitatively. It should also duplicate this study with Black men of US and African descent to determine what areas overlap and which differ. One participant in member-checking noted that on the spectrum of sexual health and traditional values, he believed African men to be one extreme, US men to be another, and Caribbean men to be somewhere in the center. If that is so, this study is a good starting place for additional research to pick up, as a means of exploring and explaining Black male sexuality across the diaspora.

References

Acosta, Y. D. & de la Cruz, P. (2011). The foreign born from Latin America and the Caribbean: 2010. *American Community Survey Briefs*. U.S. Census Bureau.

Adams, H. E., Wright, L. W., & Lohr, B. A. (1996). Is homophobia associated with homosexual arousal? *Journal of Abnormal Psychology, 105*(3), 440-445.

Akin, M., Fernandez. M. I., Bowen, G. S., & Warren, J. C. (2008). HIV risk behaviors of Latin American and Caribbean men who have sex with men in Miami, Florida, USA. *Pan American Journal of Public Health, 23*(5), 341-348.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Erlbaum.

Atlanta Regional Commission (2009). *Global Atlanta snapshots: A look at ethnic communities in the Atlanta region.* Retrieved from www.atlantaregional.com

Avert. (2013). *HIV and AIDS in the Caribbean.* Retrieved from www.avert.org/aids-caribbean.htm

Avert. (2011). *United States statistics by race and age.* Retrieved from www.avert.org/usa-race-age.htm.

Bakken, R. J. & Winter, M. (2002). Family characteristics and sexual risk behaviors among Black men in the United States. *Perspectives on Sexual Reproduction and Health, 34*(5), 252-258.

Banton, B. (1995). Untold stories. On *'Til Shiloh* [CD]. New York, NY: The Island Def Jam

Music Group.

Bowlby, J. (1970). Disruption of affectional bonds and its effects on behavior. *Journal of*

Contemporary Psychotherapy, 2, 75–86.

Bowlby, J. (1979). Attachment theory and its therapeutic implications. *Adolescent Psychiatry, 6,*

5–33.

Bowleg, L. (2004). Love, sex, and masculinity in a sociocultural context: HIV concerns and

condom use among African American men in heterosexual relationships. *Men and*

Masculinities, 7(2), 166-186. DOI: 10.1177/1097184X03257523

Bowleg, L., Lucas, K., J., & Tschann, J.M. (2004). "The ball was always in his court": An

exploratory analysis of relationship scripts, sexual scripts, and condom use among

African American women. *Psychology of Women Quarterly, 28*(1), 70-82.

Bowleg, L. & Raj, A. (2012). Shared communities, structural contexts, and HIV risk: Prioritizing

the HIV risk and prevention needs of Black heterosexual men. *American Journal of*

Public Health, 102(2), S173-S177.

Bowleg, L., Teti, M., Massie, J., Patel, A., Malebranche, D., & Tschann, J. (2011). "What does it

take to be a man? What is a real man?": Ideologies of masculinity and HIV sexual risk

among Black heterosexual men. *Culture, Health, and Sexuality, 15*(5), 545-559. DOI:

10.1080/13691058.2011.556201

Boyle, A. M. & O'Sullivan, L. F. (2010). General and sexual communication in established

relationships: An exploration of possible links to condom use among young adults. *The*

Canadian Journal of Human Sexuality, 19(1-2), 53-64.

Brassard, A., Shaver, P. R., & Lussier, Y. (2007). Attachment, sexual experience, and sexual pressure in romantic relationships: A dyadic approach. *Personal Relationships, 14*, 475-493.

Buhi, E. R., Marhefka, S. L., & Hoban, M. T. (2010). The state of the union: Sexual health disparities in a national sample of US college students. *Journal of American College Health, 58*(4), 337-346.

Byers, E. S. (2011). Beyond the birds and the bees and was it good for you?: Thirty years of research on sexual communication. *Canadian Psychology, 52*(1), 20-28.

Caribbean360. (2012). *More Caribbean women cheating on their partners.* Retrieved from http://www.caribbean360.com/index.php/news/jamaica_news/576656.html#axzz2RmIM G2lt

Carpenter, K. (2011). Introduction to the special issue on sexuality in the Caribbean. *Sexuality and Culture,* 15, 313-314. DOI: 10.1007/s12119-011-9117-y

Cazenave, N. A. (1984). Race, socioeconomic status, and age: The social context of American masculinity. *Sex Roles 11*(7/8), 639-56.

Center for Disease Control. (2011). *HIV surveillance report: Diagnoses of HIV infection and AIDS in the United States and dependent areas.*

Charmaz, K. (2006). *Constructing grounded theory*. London: Sage.

Charnigo, R., Crosby, R. A., & Troutman, A. (2010). Psychosocial constructs associated with condom use among high-risk African American men newly diagnosed with a sexually transmitted disease. *Annals of Behavioral Medicine, 39*, 303-310.

Clarke-Tasker, V. A., Wutoh, A. K., & Mohammed, T. (2005). HIV risk behaviors in African American males. *The ABNF Journal,* 56-59.

Corneille, M., Fife, J. E., Belgrave, F. Z., & Sims, B. C. (2012, January 23). Ethnic identity, masculinity, and healthy sexual relationships among African American men. *Psychology of Men & Masculinity*. Advance online publication. DOI: 10.1037/a0026878

Corneille, M. A., Tamedy, R. H., Reid, M. C., Belgrave, F. Z., & Nasim, A. (2008). Sexual safety and risk taking among African American men who have sex with women: A qualitative study. *Psychology of Men & Masculinity, 9*(4), 207-220.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches*. Los Angeles: Sage.

Creswell, J.W. (2007). Qualitative inquiry and research design: Choosing among five approaches (2nd ed.). Thousand Oaks, CA: Sage.

Crook, T., Thomas, C. M., & Cobia, D. C. (2009). Masculinity and sexuality: Impact on intimate relationships of African American men. *The Family Journal: Counseling and Therapy for Couples and Families, 17*(4), 360-366.

Crosby, et al. (2009). A brief, clinic-based, safer sex intervention for heterosexual African American men newly diagnosed with an STD: A randomized controlled trial. *American Journal of Public Health, 99*(1), S96-S103.

Crowell, C. (2013). *Sexual healing: Examining heterosexual Black male sexual health through the lens of Sexual Scripting Theory*. Unpublished manuscript, College of Education, University of Georgia, Athens, GA.

Crowell, C. & Delgado-Romero, E. (2013, August). *Let's talk about sex: A content analysis of human sexuality research in Counseling Psychology*. Poster presented at the American Psychological Association Convention, Honolulu, HI.

Cowell, N. M. & Saunders, T. S. (2011). Exploring heteronormativity in the public discourse of Jamaican legislators. *Sexuality and Culture, 15*, 315-331.

Dean, J. J. (2013). Heterosexual masculinities, anti-homophobes, and shifts in hegemonic masculinity: The identity practices of White and Black heterosexual men. *The Sociological Quarterly,* 54, 534-560.

Diaz-Loving, R. (2009). *A bio-psycho-socio-cultural approach to couple relationships.* Retrieved from http://e-book.lib.sjtu.edu.cn/iupsys/Proc/stock2/spv2ch18.html

Edwards, W. M. & Coleman, E. (2004). Defining sexual health: A descriptive overview. *Archives of Sexual Behavior, 33*(3), 189-195.

El-Bassel, N. et al. (2003). The efficacy of a relationship-based HIV/STD prevention program for heterosexual couples. *American Journal of Public Health, 93*(6), 963-969.

Elder, W. B., Brooks, G. R., & Morrow, S. L. (2012). Sexual self-schemas of heterosexual men. *Psychology of Men and Masculinity, 13*(2), 166-179. DOI: 10.1037/a0024835

Erving, C. L. (2011). Gender and physical health: A study of African American and Caribbean Black adults. *Journal of Health and Social Behavior, 52*(3), 383-399.

Espinosa-Hernandez, G. & Lefkowitz, E. S. (2009). Sexual behaviors and attitudes and ethnic identities during college. *Journal of Sex Research, 46,* 471-482.

Farmer, P. & Kim, J. Y. (1991). Anthropology, accountability, and the prevention of AIDS. *The Journal of Sex Research, 28*(2), 203-221.

Fassinger, R. E. (2005). Paradigms, praxis, problems, and promise: Grounded theory in counseling psychology research. *Journal of Counseling Psychology, 52*(2), 156-166. DOI: 10.1037/0022-0167.52.2.156

Figueroa, J. P. (2014). Review of HIV in the Caribbean: Significant progress and outstanding challenges. *Current HIV/AIDS Report,* 11, 158-167.

Forrest, K. A. (2001). Men's reproductive and sexual health. *Journal of American College Health, 49*(6), 253-266.

Frankel, L. (2004). An appeal for additional research about the development of heterosexual male sexual identity. *Journal of Psychology & Human Sexuality, 16*(4), 1-16. DOI: 10.1300/J056v16n04_01

Frith, H. & Kitzinger, C. (2001). Reformulating sexual script theory: Developing a discursive psychology of sexual negotiation. *Theory & Psychology, 11*(2), 209-232.

Garcia, P. J., Bayer, A., & Carcoma, C. P. (2014). The changing face of HIV in Latin America and the Caribbean. *Current HIV/AIDS Report,* 11, 146-157.

Gillespie, C. (2011). "Nobody ent billing me": A U.S./Caribbean intertextual, intercultural call-and-response. In F. Smith (Ed.), *Sex and the citizen: Interrogating the Caribbean* (pp. 37-52). Charlottesville, VA: University of Virginia Press.

Gilmore, S., DeLamater, J., & Wagstaff, D. (1996). Sexual decision making by inner city Black adolescent males: A focus group. *The Journal of Sex Research, 33*(4), 363-371.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory.* Chicago: Aldine.

Glesne, C. (2011). *Becoming qualitative researchers: An introduction* (4th ed.). Boston: Pearson.

Guy, T. C. (2001). Black immigrants of the Caribbean: An invisible and forgotten community. *Adult Learning, 13*(1), 18-21.

Herek, G. M. (1995). Psychological heterosexism in the United States. In A. R.D'Augelli & C. J.Patterson, (Eds.), *Lesbian, gay and bisexual identities over the lifespan: Psychological Perspectives* (pp. 321– 346). London, England: Oxford University Press.

Higgins, J. A., Hoffman, S., & Dworkin, S. L. (2010). Rethinking gender, heterosexual men, and women's vulnerability to HIV/AIDS. *American Journal of Public Health, 100*(3), 435-445.

hooks, b. (2004). *We real cool: Black men and masculinity.* New York: Routledge.

Hudson, W. W, & Ricketts, W. A. (1980). A strategy for the measurement of homophobia. *Journal of Homosexuality, 5,* 356-371.

Juhasz, A. M. & Sonnenshein-Schneider, M. (1979). Responsibility and control: The basis of sexual decision making. *The Personnel and Guidance Journal,* 181-185.

Kempadoo, K. (2004). *Sexing the Caribbean: Gender, race, and sexual labour.* New York: Routledge.

Kempadoo, K. (2009). Caribbean sexuality: Mapping the field. *Caribbean Review of Gender Studies,* 3, 28-51.

Kennedy, S. B., Nolen, S., Applewhite, J., Waiter, E., & Vanderhoff, J. (2007). Condom use behaviors among 18-24 year-old urban African American males: a qualitative study. *AIDS Care, 19*(8), 1032-1038.

LANIC. (2013). *Caribbean resources.* Austin, TX: The University of Texas Austin.

Lewis, L. J. (2004). Examining sexual health discourses in a racial/ethnic context. *Archives of Sexual Behavior, 33*(3), 223-234.

Lewis, L. J. & Kertzner, R. M. (2003). Toward improved interpretation and theory building of African American male sexualities. *The Journal of Sex Research, 40*(4), 383-395.

Lindberg, C., Lewis-Spruill, C., & Crownover, R. (2006). Barriers to sexual and reproductive health care: Urban male adolescents speak out. *Issues in Comprehensive Pediatric Nursing,* 29, 73-88.

Livingston, I.L., Neita, M., Riviere, L., & Livingston, S. L. (2007). Gender, acculturative stress and Caribbean immigrants' health in the United States of America. *West Indian Medical Journal, 56*(3), 213-222.

Livingston, I. L., Neita, M., Thompson, P., Warren, S., & Livingston, L. S. (2006). Exploring age differences in the acculturative stress-health relationship of Caribbean immigrants in the United States. *Wadabagei, 9*(2), 74-89.

Lorick-Wilmot, Y. (n.d.) Afro-Caribbean wealth in the United States: The power of race and immigration status on asset building. Paper presented at the American Sociological Association Conference.

McGruder, K. (2009). Black sexuality in the U.S.: Presentations as non-normative. *Journal of African American Studies, 13*, 251-262.

Migration Policy Institute. (2011). *Migration Information Source.* Washington, DC.

Mohr, J. J. (2002). Heterosexual identity and the heterosexual therapist: An identity perspective on sexual orientation dynamics in psychotherapy. *The Counseling Psychologist, 30*(4), 532-566. DOI: 10.1177/00100002030004003

Morgan, D. L. (1997). *Focus groups as qualitative research*. Thousand Oaks, CA: Sage.

Morgan, E. M. (2012). Not always a straight path: College students' narratives of heterosexual identity development. *Sex Roles, 66*, 79-93.

Myers, H. F., Javanbakht, M., Martinez, M., & Obediah, S. (2003). Psychosocial predictors of risky sexual behaviors in African American Men: Implications for prevention. *AIDS Education and Prevention, 15*, Supplement A, 66-79.

Nagel, J. (2000). Ethnicity and sexuality. *Annual Review of Sociology, 26*, 107 – 133.

Novotney, A. (2010). Appreciating differences: The burgeoning science of intersectionality is adding to the understanding of how our multiple identities affect mental health. *Monitor on Psychology, 41*(9), online version. Retrieved from www.apa.org/monitor/2010/10/differences.aspx.

O'Callaghan, E. (2011). Caribbean migrations: Negotiating borders. In F. Smith (Ed.), *Sex and the citizen: Interrogating the Caribbean* (pp. 37-52). Charlottesville, VA: University of Virginia Press.

Oparanozie, A., Sales, J. M., DiClemente, R. J., & Braxton, N. D. (2012). Racial identity and risky sexual behaviors among Black heterosexual men. *Journal of Black Psychology, 38*(1), 32 – 51.

Otto-Salaj, L., Traxel, N., Brondino, M., Reed, B., Gore-Felton, C., Kelly, J., & Stevenson, L. (2010). Reactions of heterosexual African American men to women's condom negotiation strategies. *Journal of Sex Research, 47*(6), 539-551.

PAHO, WHO, & WAS. (2001). *Promotion of sexual health: Recommendations for action.* Proceedings of a Regional Consultation convened by Pan American Health Organization, World Health Organization, & World Association of Sexology in Antigua Guatemala, Guatemala.

Parham, T. A. & McDavis, R. J. (1987). Black men, an endangered species: Who's really pulling the trigger? *Journal of Counseling and Development, 66*, 24 – 27.

Pinto, S. (2009). "Why must all girls want to be flag women?": Postcolonial sexualities, national reception, and Caribbean soca performance. *Meridians: feminism, race, transnationalism, 10*(1), 137-163. DOI: 10.1353/mer.0.0055

Perkins, A. K. (2011). Carne Vale (goodbye to flesh?): Caribbean carnival, notions of the flesh and Christian ambivalence about the body. *Sexuality and Culture, 15*, 361-374. DOI: 10.1007/s12119-011-9106-1

Ponterotto, J. G. (2002). Qualitative research methods: The fifth force in psychology. *The Counseling Psychologist, 30,* 394-406.

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52,* 126–136.

Poulson-Bryant, S. (2005). *Hung: A meditation on the measure of Black men in America.* New York: Doubleday.

Radcliffe, J., Doty, N., Hawkins, L. A., Gaskins, C. S., Beidas, R., & Rudy, B. J. (2010). Stigma and sexual health risk in HIV-positive African American young men who have sex with men. *Aids Patient Care and STDs, 24*(8), 493-499.

Saint-Jean, G., Devieux, J., Malow, R., Tammara, H., & Carney, K. (2011). Substance abuse, acculturation, and HIV risk among Caribbean-born immigrants in the United States. *Journal of the International Association of Physicians in AIDS Care, 10*(5), 326-332. DOI: 10.1177/1545109711401749

Saunders, P. (2011). Buyers beware, "Hoodwinking" on the rise: Epistemologies of consumption in Terry McMillan's Caribbean. In F. Smith (Ed.), *Sex and the citizen: Interrogating the Caribbean* (pp. 37-52). Charlottesville, VA: University of Virginia Press.

Schindler, D. (Producer), & Sullivan, K. R. (Director) (1998). *How Stella got her groove back* [Motion picture]. United States: 20th Century Fox.

Scholly, K., Katz, A., Gascoigne, J., & Holck, P. (2005). Using social norms theory to explain perceptions and sexual health behaviors of undergraduate college students: An exploratory study. *Journal of American College Health, 53*(4), 159-166.

Sheeran, P. & Orbell, S. (1999). Psychosocial correlates of heterosexual condom-use: A meta-analysis. *Psychological Bulletin, 125*(1),90.

Simon, W. & Gagnon, J. (1984). Sexual scripts. *Society, 22*, 53- 60.

Simon, W. & Gagnon, J. H. (1986). Sexual scripts: Permanence and change. *Archives of Sexual Behavior, 15*(2), 97-120.

Simon, W. & Gagnon, J. H. (2003). Sexual scripts: Origins, influences and changes. *Qualitative Sociology, 26*(4), 491-497.

Smith, F. (2011). Introduction: Sexing the citizen. In F. Smith (Ed.), *Sex and the citizen: Interrogating the Caribbean* (pp. 37-52). Charlottesville, VA: University of Virginia Press.

Snell, W. E., Belk, S. S., & Hawkins, R. C. (1990). Cognitive beliefs about male sexuality: The impact of gender roles and counselor perspectives. *Journal of Rational-Emotive & Cognitive Behavior Therapy, 8*(4), 249-265.

Stephens, D. P. & Phillips. L. (2005). Integrating Black feminist thought into conceptual frameworks of African American adolescent women's sexual scripting processes. *Sexualities, Evolution and Gender, 7*(1), 37 – 55.

Strauss, A. L., & Corbin, J. (1998). Basics of qualitative research: Techniques and procedures for developing grounded theory (2nd ed.). Thousand Oaks, CA: Sage.

Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). Hoboken, NJ: John Wiley & Sons, Inc.

T, T. (2014). *Caribbean life in the Atl: Documenting the Afro-Caribbean experience in Atlanta*. Retrieved from http://caribbeanatlanta.blogspot.com/2014/07/caribbean-organizations.html.

Tambiah, Y. (2011). Threatening sexual (mis)behavior: Homosexuality in the penal code debates in Trinidad and Tobago, 1986. In F. Smith (Ed.), *Sex and the citizen: Interrogating the Caribbean* (pp. 37-52). Charlottesville, VA: University of Virginia Press.

Thomas, K. J. A. (2012). *A demographic profile of Black Caribbean immigrants in the United States*. Washington, DC: Migration Policy Institute.

Thompson-Robinson, M. V., Richter, D. L., Shegog, M. L., Weaver, M., Trahan, L., Sellers, D. B., & Brown, V. L. (2005). Perceptions of partner risk and influences on sexual decision-making for HIV prevention among students at historically Black colleges and universities. *Journal of African American Studies, 9*(2), 16-28.

US Census Bureau. (2012). 2008-2012 American Community Survey. Retrieved from American Fact Finder.

US Census Bureau. (2012). 2012 American Community Survey. Retrieved from American Fact Finder.

UNAIDS. (2012). *Global report: UNAIDS report on the global epidemic of AIDS*.

UNAIDS Caribbean. (2012). *Data and statistics*. Retrieved from http://www.unaidscaribbean.org/taxonomy/term/64

van Veen et al. (2011). Concurrent partnerships and sexual risk taking among African and Caribbean migrant populations in the Netherlands. *International Journal of STD & AIDS, 22*, 245-250.

Washington, T. A., Wang, Y., & Browne, D. (2009). Difference in condom use among sexually active males at historically black colleges and universities. *Journal of American College Health, 57*(4), 411-416.

Weichselbaumer, D. (2012). Sex, romance and the carnivalesque between female tourists and Caribbean men. *Tourist Management, 33*, 1220-1229. DOI: 10.1016/j.tourman.2011.11.009

Weitz, C. (Producer) & Weitz, P. (Director). (1999). *American pie* [Motion picture]. United States: Universal Pictures.

Wester, S. R., Vogel, D. L., Wei, M., & McLain, R. (2006). African American men, gender role conflict, and psychological distress: The role of racial identity. *Journal of Counseling & Development, 84*, 419 – 429.

Whittier, D. K. & Simon, W. (2001). The fuzzy matrix of "my type" in intrapsychic sexual scripting. *Sexualities, 4*(2), 139-165.

Williams, D. R., et al. (2007). The mental health of Black Caribbean immigrants: Results from the National Survey of American Life. *American Journal of Public Health, 97*(1), 52-59.

WHO. (2006). *Defining sexual health: Report of a technical consultation on sexual health 28-31 January 2002, Geneva*. Geneva, Switzerland: World Health Organization.

Worthington, R. L. & Mohr, J. J. (2002). Theorizing heterosexual identity development. *The Counseling Psychologist, 30*(4), 491-495. DOI: 10.1177/00100002030004001

Worthington, R. L., Savoy, H. B., Dillon, F. R., & Vernaglia, E. R. (2002). Heterosexual identity development: A multidimensional model of individual and social identity. *The Counseling Psychologist, 30*(4), 496-531. DOI: 10.1177/00100002030004002

APPENDIX A

Phone/Personal Visit Script

Greetings,

My name is Candice Crowell, and I am a doctoral student studying counseling psychology at the University of Georgia. My dissertation research (IRB Approval # ------), under the advisement of Dr. Edward Delgado-Romero, explores sexual health among Black men of Caribbean descent. Since you are affiliated with a network of Black Caribbean men who might qualify to participate in this study, I am reaching out to you with a request for your help. You can help in one of three ways:

1. Allow me to speak with your organization in person, to give them a summary of my intended study and request their participation.

2. Allow me to post a flyer in your space that will explain the study and provide my contact information if the men choose to participate.

3. Refer men who fit the above description by word of mouth, by sharing the contact information I will provide to you.

The selected participants will participate in a focus group where they will discuss sex and relationships with each other and myself, as the facilitator. Focus groups are typically no more than two hours, participants can withdraw from the study at any time, and those who choose to participate will receive $20 for their time.

Interested persons may email me at crowellc@uga.edu or call me at (404) 397-8814 for additional information. In the email they should provide a phone number where they can be reached for a brief screening. They will receive a brief screening where I will determine whether they meet the requirements to participate. If so, they will receive a time and place to meet with the other participants and I for the focus group. I thank you in advance for your willingness to help with my dissertation research process. For any questions, feel free to email me at crowellc@uga.edu.

Sincerely,

Candice Crowell, MS

Doctoral Student

University of Georgia

APPENDIX B

Seeking Black Men of Caribbean Descent to Participate in a Focus Group on

sex and relationships.

Must be
Black Caribbean &
30-50 years of age

If interested,
Contact Candice Crowell
to set up screening
crowellc@uga.edu
or
(404) 397-8814

Participants will be compensated $20 for their participation.

APPENDIX C
IRB Consent Form

I, _____, agree to participate in a research study titled
"SEXUAL HEALING: BUILDING A THEORY OF SEXUAL HEALTH FOR
HETEROSEXUAL BLACK MEN OF CARIBBEAN DESCENT" conducted by Candice
Crowell from the Department of Counseling and Human Development Services at the University
of Georgia (404-397-8814) under the direction of Dr. Edward Delgado-Romero, Department of
Counseling and Human Development Services, University of Georgia (706-542- 0500). I
understand that my participation is voluntary. I can refuse to participate or stop taking part
without giving any reason, and without penalty or loss of benefits to which I am otherwise
entitled. I can ask to have all of the information about me returned to me, removed from the
research records, or destroyed.

The reason for this study is to explore the sexual health of heterosexual Black men of Caribbean
descent. If I volunteer to take part in this study, I will be asked to do the following things:

1. Participate in a focus group interview that will last two hours or less, which will be
   audiotaped.
2. Answer questions and discuss experiences about my sexual health, as well as listen to the
   experiences of others.
3. If I choose, the investigator will follow up with me after the data from this study has been
   analyzed to discuss themes that emerged from the focus group.

I understand that I may not receive any direct benefit from participating in this study but that my
participation may help others in the future. The members of the research team have offered to
answers questions I may have about the study and what I am expected to do.

No risk is expected, but I may experience some discomfort or stress from sharing my sexual
experiences or from listening to the sexual experiences of others. There may be risk that other
group members may share your sexual experiences with persons outside of this group. These
risks will be reduced in the following ways:

1. I understand that because of this study, there could be violations of my privacy. To prevent
   violations of my own or others' privacy, I have been asked not to talk about any of my
   own or others private experiences that I would consider too personal or revealing.
2. I also understand that I have an obligation to respect the privacy of the other members of
   the group by not disclosing any personal information that they share during our
   discussion.
3. I understand that mental health referral sources are available for me if I desire additional
   services after the focus group ends.

I will receive a $20 financial gift for my participation in the focus group. Even if I do not
complete the study or ask for my information to be withheld, I will still receive the monetary

gift.

All records with identifiable information will be maintained only by the co-investigator. Once data is collected, participant names will be converted to numerical codes, which will only be identifiable to the co-investigator. Electronic information, including digital voice recordings, transcripts, and personal notes will be maintained on a password-protected computer and will only be accessible by the co-investigator. Digital recordings will be erased after the transcription is created.

The investigator will answer any further questions about the research, now or during the course of the project. I understand that I am agreeing by my signature on this form to take part in this research project and understand that I will receive a signed copy of this consent form for my records.

_____   _____   _____
Candice Crowell   Signature   Date
crowellc@uga.edu
404-397-8814

_____   _____   _____
Name of Participant   Signature   Date

Please sign both copies, keep one and return one to the researcher.

Additional questions or problems regarding your rights as a research participant should be

addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd

Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-

Mail Address IRB@uga.edu.

APPENDIX D

Demographic Form

Please complete the following questions:

Identification Number:

1. Age _____

2. Island of Origin _____

3. Generation of Immigration

    a. First – I immigrated in my lifetime.

    b. Second – My parents immigrated. I was born in the US.

    c. Third – My grandparents immigrated. My parents and I were born in the US.

4. Highest Education Level Attained

    a. High school

    b. College

        i. Freshman

        ii. Sophomore

        iii. Junior

        iv. Senior

    c. Graduate School/Professional School

    d. Other: _____

5. Occupation Title (student, teacher, mechanic, business owner, etc.)

    a. _____

6. How many sexual partners have you had in your lifetime? _____

7. At last sexual encounter, did you use a condom?

    a. Yes

    b. No

8. After the data of this study is analyzed, would you like to be contacted to provide feedback?

    a. If yes, how would you like to be contacted?

        i. Email address: _____

        ii. Phone number: _____

APPENDIX E

Interview Script and Questions

Thank you for coming here today to participate in this focus group. My name is Candice Crowell and I am a Counseling Psychology doctoral student. Assisting me today is [Observer]. [Observer] will be a silent participant in our focus group today and will take notes about what he observes today. The purpose of this group is to gain a better understanding sexual health among heterosexual Black men of Caribbean descent.

I will be asking you some questions that I encourage you to answer to the best of your ability and I recognize that many of you will have unique experiences. All points of view, both positive and negative are important. There are no wrong answers but rather different points of view. Please feel free to share your point of view even if it differs for what others have said. What you discuss here will be very helpful for my individual research project and after today's session, you are welcome to ask me questions about the research and about our discussion.

Okay, so, I am going to give everyone a form now, which states that your participation in this group is entirely voluntary and that you may decline to participate and leave the group at any time. Please read this sheet carefully before signing it. It discusses potential risks to you as members of this group as well as the use of audio recording during this session. I'd like to give everyone the opportunity to ask any questions they may have before we begin the group.

Question/Answer...

Distribute informed consent forms Statement of Confidentiality

We will be audio recording this session in an effort to maintain the integrity of your dialogue. However, your identities will not be revealed to anyone, and only the researchers will have access to this recording. We will be on a first name basis, and in our later reports there will not be real names attached to comments. This discussion is to be considered confidential, and we hope that you all will respect each other rights to privacy by not repeating any portion of this discussion outside of this session.

Opening Question

At this time, we would like for each of you to say your first name, your major or occupation and why you are interested in participating in this study.

General Questions

    1. What does it mean to be sexually healthy?

2. Review this list of behaviors of a sexually healthy adult. What do you think of this?
3. Tell me about a time that stands out to you when you were sexually healthy?
4. Tell me about a time that stands out to you when you were not sexually healthy?
5. What prevents you from being sexually healthy?
6. What encourages you to be sexually healthy?

Closing Questions

Was there anything we missed that you think should be discussed about sexual health?

APPENDIX F

SIECUS List of Behaviors of a Sexually Healthy Adult

A sexually healthy adult would:

- Appreciate one's own body.

- Seek further information about reproduction as needed.

- Affirm that human development includes sexual development that may or may not include reproduction or genital sexual experience.

- Interact with both genders in respectful and appropriate ways.

- Affirm one's own sexual orientation and respect the sexual orientation of others.

- Express love and intimacy in appropriate ways.

- Develop and maintain meaningful relationships.

- Avoid exploitative or manipulative relationships.

- Make informed choices about family options and lifestyles.

- Exhibit skills that enhance personal relationships.

- Identify and live according to one's values.

- Take responsibility for one's own behavior.

- Practice effective decision-making.

- Communicate effectively with family, peers, and partners.

- Enjoy and express one's sexuality throughout life.

- Express one's sexuality in ways congruent with one's values.

- Discriminate between life-enhancing sexual behaviors and those that are harmful to self and/or others.

- Express one's sexuality while respecting the rights of others.

- Seek new information to enhance one's sexuality.

- Use contraception effectively to avoid unintended pregnancy.

- Prevent sexual abuse.

- Seek early prenatal care.

- Avoid contracting or transmitting a sexually transmitted disease, including HIV.

- Practice health-promoting behaviors, such as regular check-ups, breast and testicular self-exam, and early identification of potential problems.

- Demonstrate tolerance for people with different sexual values and lifestyles.

- Exercise democratic responsibility to influence legislation dealing with sexual issues.

- Assess the impact of family, cultural, religious, media, and societal messages on one's thoughts, feelings, values, and behaviors related to sexuality.

- Promote the rights of all people to accurate sexuality information.

- Avoid behaviors that exhibit prejudice and bigotry.

- Reject stereotypes about the sexuality of diverse populations.