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A qualitative analyses of male couples' coping with HIV: Disentangling the “we”

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Abstract

Research suggests that optimal couple functioning depends on adopting a “we” orientation to health. Using qualitative data from 20 male couples in which at least one partner was HIV-positive, we examined how couples viewed their health involvement, and its relation to social support. One group described their health as highly interconnected; in a second group, at least one partner viewed health as a personal responsibility. Results revealed that there was not a uniform “we” approach towards health; rather, sero-concordance, sero-discordance, and coping with other chronic illnesses strongly contributed to orientations towards health. Orientations toward health were not found to determine social support.

In the fourth decade of the epidemic, HIV continues to disproportionately affect gay, bisexual and other men who have sex with men (MSM) in the United States (Johnson et al., 2014). Researchers and service providers have increasingly noted the limited success of individual-level HIV primary and secondary prevention interventions, and have called for research that examines the social, relational and structural contexts that sustain risk behavior or promote optimal health behaviors among male couples (Diaz & Ayala, 2001). As such, researchers have examined how relationship dynamics contribute to health behaviors, such as medication adherence, psychological well-being, and sexual risk behavior among male couples (Hoff, Beougher, Chakravarty, Darbes, & Neilands, 2010; Johnson et al., 2012; Mitchell & Petroll, 2012). To date, there are few theoretically grounded studies on relationship dynamics among male couples in which one or both partners have HIV.

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Traditionally, research has examined how patients and their partners adjust to chronic illness from an individual-level stress and coping framework, whereby partner involvement is characterized as providing social support (Berg & Upchurch, 2007). Optimal health outcomes for the patient and the partner are suggested to occur via transaction of support and dyadic coping (Berg & Upchurch, 2007; Revenson, Kayser, & Bodenmann, 2005). The mechanisms through which romantic relationships benefit health outcomes among couples coping with chronic illness, as well as a consideration of how both partners exert influence on another's health, is a burgeoning topic of empirical investigation. A growing body of literature has accumulated on a variety of forms of dyadic coping, primarily exploring their association with patients' health and relational well-being, and, to some extent, partner outcomes (Badr, 2004; Badr, Acitelli, Carmack, & Cindy, 2007; Berg & Upchurch, 2007; Revenson et al., 2005). These processes have been examined within a wide array of chronic illness conditions (e.g., myocardial infarction, arthritis, cancer, diabetes, and pain) (Badr, Acitelli, & Taylor, 2008; Berg & Upchurch, 2007; Bodenmann, 2005).

Dyadic stress and coping researchers have posited that when couples face a common stressor, such as a chronic illness, the stress management resources of both partners may be activated to maintain or restore homeostasis in the relationship (Bodenmann, 2005; Fergus, 2011). Bodenmann (2005) has described how it is necessary to examine the partner's stress appraisals and coping efforts, rather than just the patient's. In synthesizing the couples health literature, Fergus (2011) identified that what is important across similar conceptualizations of dyadic coping is the recognition that illness is a shared threat, that both partners appraise a stressor (chronic illness) as "our" issue rather than "yours" or "mine," and that coping is the responsibility of both partners to undertake cooperatively.

As such, researchers have suggested that espousing a "we" perspective –whereby couples regard themselves as part of a collective unit when confronting a stressor –may affect coping efforts and consequently, the health of both partners and the relationship (Badr et al., 2007; Fergus, 2011; Lewis et al., 2006; Skerrett, 1998). A number of studies have found an association between couples' sense of "we-ness" and relationship well-being among healthy adults populations (Acitelli, Rogers, & Knee, 1999), and psychological adjustment for both partners in studies of cancer (Badr et al., 2008; Rohrbaugh, Mehl, Shoham, Reilly, & Ewy, 2008). For example, couples in conflict are less likely to remain in conflict if their conversations shift from being self-focused to more relationship-focused (Bernal & Baker, 1979). Similarly, communication researchers interested in the narrative construction of relationship stories have focused on the stories that couples and/or families collectively construct (Holmberg, Orbuch, & Veroff, 2004; Kellas, 2005, 2010). These jointly told stories of events in relationships (e.g., relational histories, courtship stories, stories of stressful experiences) have been associated with relationship quality and mental health (Buehlman, Gottman, & Katz, 1992; Frost, 2012; Kellas, 2005, 2010). For example, a longitudinal study found behavioral representations of intimacy and positive affect in couples' relational histories – measured as marital bond – to be associated with heightened relationship satisfaction and lower levels of depression (Doochan, Carrère, & Riggs, 2010). Research using automatic text analysis software has shown that countable linguistic features of transcribed narratives, specifically the use of first-person plural pronouns (*we*, *us*, *our*) in the context of couple communication predicts diverse aspects of adaptation, such as self-

reported depression (Pennebaker, Mayne, & Francis, 1997), social and cognitive responses to trauma (Cohn, Mehl, & Pennebaker, 2004; Pennebaker & Stone, 2003), recovery from anorexia (Lyons, Mehl, & Pennebaker, 2006), and decreases in patients' reports of heart failure symptoms (Rohrbaugh et al., 2008).

It is important to note that there have been mixed findings with these different approaches. Analyses of narrative conversations with relationship partners reveal that pronoun usage is associated with relationship quality, such as longer relationship duration, lower cardiovascular arousal during conversations, and more positive problem solving discussion (Seider, Hirschberger, Nelson, & Levenson, 2009; Simmons, Gordon, & Chambless, 2005) (Slatcher, Vazire, & Pennebaker, 2008). However, there is also conflicting evidence regarding pronoun usage and relationship quality in conversation studies. Specifically, first-person inclusive pronoun use has been associated with better relational outcomes in some (Seider et al., 2009) but not in all studies (Slatcher et al., 2008). Research on jointly told stories in families and couples has found that we-ness expressed in relationship stories was associated with increased relationship satisfaction in some instances (Buehlman et al., 1992) but not in others (Kellas, 2005). These mixed findings are of particular importance as very few researchers have explicitly defined "we-ness" within the couples' literature. Consistent with Reid and colleagues (2006), we posit that at the heart of we-ness is the understanding that relationships can create a dynamic and often unconscious struggle between a need to maintain mutuality and partnership while also preserving a sense of autonomy. For example, individuals differ in the degree to which they desire closeness or "we-ness" (Mashek & Sherman, 2004) and too much closeness or "we-ness" may become suffocating for one or both members of a couple (Mashek & Sherman, 2004). Other research suggests that too much "we-ness" may pose a threat to control and identity, and may cause someone to desire less closeness with a romantic partner (Aron et al., 2004; Frost & Forrester, 2013; Mashek & Sherman, 2004). Taken together, these findings suggest that adopting a "we" perspective to health may be beneficial for relationship quality and health when it takes the form of intimacy, caregiving, nurturance, and cohesion but detrimental when it takes the form of intrusiveness, loss of self, independence, social control, and enmeshment (Green & Werner, 1996; Lewandowski, Nardone, & Raines, 2010; Michael-Tsabari & Lavee, 2012; Werner, Green, Greenberg, Browne, & McKenna, 2001). To date, studies have only examined endorsing a "we" orientation and optimal support strategies among "healthy" heterosexual couples or heterosexual couples contending with a non-communicable disease.

The purpose of this study was to explore how partners in male couples who were coping with HIV described their orientation towards their involvement in each other's health, and the association of their orientation with giving and receiving support. HIV disease is an important understudied area because unlike many other illnesses (e.g., cancer), the consequences of coping with the illness affect partners' health and well-being; that is, dyadic coping not only affects psychological adjustment to the illness but also physical health: the virus can be transmitted between partners if dyadic coping is not effective. Using qualitative data from both partners in couples in which one or both partners have HIV, we investigated the following research questions: 1) How do partners describe their involvement in understanding and managing each other's health? 2) How are partners' orientations towards each other's health related to the provision and receipt of health-related social support? By

building knowledge about these issues, we aim to provide a more nuanced understanding of how a “we” perspective may be operationalized in male couples’ relationships, as well as how social support manifests among couples with more autonomous orientations.

Methods

Procedures

Participants were drawn from a larger sample enrolled in the Duo Project, which is a longitudinal, mixed-methods study of male couples in the San Francisco Bay Area in which one or both partners are HIV-positive and the HIV-positive partners are prescribed anti-retroviral therapy (ART). The overarching goal of the project is to understand how relationship dynamics relate to HIV treatment adherence.

Beginning in January 2009, couples were recruited for the Duo Project using passive recruitment methods, in which the researchers made the target population aware of the study through the use of flyers and participant and provider referrals, and allowed prospective participants approach the researchers (Lee et al., 1997). Couples who called the toll-free study phone line were screened separately to detect discrepancies in the eligibility criteria. Eligibility criteria were: 1) both partners defined their relationship as primary, meaning they felt committed to their partner above anyone else and the relationship was sexual; 2) at least one partner in each couple was HIV-positive and on an ART regimen for at least 30 days, which was confirmed by medication bottles, an official pharmacy list, or provider letter at the baseline interview; and both partners were 3) at least 18 years old; 4) born male and currently identified as male; 5) English speaking; and 6) able to provide informed consent.

Eligible couples were scheduled for in-person interviews at the Center for AIDS Prevention Studies (CAPS) at the University of California, San Francisco. In the Duo Project, both members of couples ($N = 266$) completed quantitative surveys at baseline and 6, 12, 18, and 24 months using a combination of Computer Assisted Personal Interviewing (CAPI) and Audio Computer Assisted Self Interviewing (ACASI) procedures. The content of these survey interviews is described below; quantitative results of the Duo Project are reported elsewhere (Johnson et al., 2012).

Qualitative data collection took place from July 2013 to April 2014. During this period, all forty Duo participants (20 couples) who completed their 24-month quantitative interview were offered participation in a qualitative interview. Prospective qualitative participants were told that they were eligible for an additional interview that would be conducted face-to-face with an interviewer, follow a conversational format, and focus on how they thought about their and their partner’s health. Both partners were required agree to the interview and be at the appointment together, but were consented and interviewed in separate rooms to encourage answering questions candidly and fully. All Duo participants approached for the qualitative sub-study agreed to participate. Each partner was compensated \$30 for completing the qualitative interview.

Quantitative Survey—Participants completed demographic questions, a four-item commitment scale (Kurdek, 1998) (e.g., “I am committed to maintaining my relationship

with my partner,” $\alpha = 0.96$) and the abbreviated dyadic adjustment scale (DAS) consisting of six items that assess each partner’s perception of overall relationship satisfaction (e.g., “How often do you think that things between you and your partner are going well?” $\alpha = 0.84$) (Spanier, 1976). Participants completed an adapted version of the Inclusion of Other in the Self (IOS) scale (Aron, Aron, & Smollan, 1992), which were comprised of 7 pairs of progressively overlapping circles, and each pair of circles had a corresponding letter on a scale from A to G (see Figure 1). Participants were asked: “Please choose the picture that best represents your health and your partner’s health.” The words “my health” and “his health” appeared inside their respective circles. Participants completed the Center for Epidemiologic Studies Depression Scale (CES-D; $\alpha = 0.91$) to assess depressive symptoms (Radloff, 1977; U.S. Department of Health and Human Services, 2004) and HIV-positive partners completed a self-report visual analog scale (VAS) for ART adherence behavior in the past 30 days (Walsh, Mandalia, & Gazzard, 2002).

Qualitative Interview—The purpose of the qualitative interviews was to explore the subjective meanings attributed to the adapted version of the IOS by participants. The qualitative interview protocol consisted of a brief semi-structured guide with open-ended questions structured to address the broader topic of participants’ relationships before narrowing the focus on health-related issues. It began with the interviewer showing the participant a printed replica of the IOS Diagram used in the quantitative survey. Participants were asked to recall which image they had selected during their survey interview that day to represent their relationship, and then were prompted to discuss what meaning they ascribed to that image. After speaking about their relationship, each partner was shown the IOS Health diagram and asked: “Which picture did you choose today to describe your health and your partner’s health?” The interviewers employed several follow-up probes to help contextualize participants’ reasons for their selections and to understand the meaning they ascribed to their responses. Additional probes were used to investigate the impact of the social and emotional support partners employed in their relationships in regards to their own and their partners’ health.

Analysis Approach

We employed a “Framework Analysis” approach (Srivastava & Thompson, 2009), which is particularly well-suited to studies that attempt to answer a focused set of questions. According to the specific steps outlined in Framework Analysis, we first familiarized ourselves with the interview content and then indexed, charted, and interpreted the data. The qualitative interviews were audio-recorded and then transcribed by the first and third authors. Transcribed data were organized in an Excel spreadsheet with one row for each interview question and responses arranged by participant ID number in columns. This method of organizing the data permitted the authors to easily compare study partners’ data, as their responses to questions were presented in adjoining columns.

Over a series of meetings, the authors read and re-read the data, discussed themes that emerged around partners’ involvement in each other’s health, and wrote analytical memos about those themes. Through an iterative process of discussion and review, the recurring theme of couples’ views of their health as relational or as personal came into focus. By

returning multiple times to the audio recordings and transcribed data, the authors examined how these views were articulated within partnerships, and developed their understanding of forms of “we” that differed from that primarily described in the existing literature.

Results

A total of 20 male couples ($N = 40$) completed qualitative interviews; descriptive characteristics are presented in Table 1. A little over half of the sample were in a serodiscordant relationship in which one partner was HIV-infected and the other not ($n = 22$). Approximately one-third of the sample identified as a racial/ethnic minority: 15% were Black, 7.5% were Latino, and 7.5% identified as Other. In addition, one-third of the sample earned less than \$20,000 per year.

Participants described two basic orientations towards health, which we termed “Relational” and “Personal.” Couples who held relational orientations described their health as interconnected and prioritized being aware of one another’s health status and care needs. Within this group of couples, a subgroup emerged that we labeled “Asymmetrical,” denoting couples in which one partner’s health was prioritized over the other’s. The personal orientations group consisted of couples in which one or both partners described their health and health care as independent and autonomous. However, this group also indicated that this stance was malleable and dependent on their partner’s health status.

Relational Orientations

In twelve couples, both partners described their health as highly interconnected and expressed feeling responsible for each other’s health. Knowledge and awareness of each other’s diagnoses, healthcare needs, medications, and other treatments were critical aspects of their orientations towards their health as a couple.

As one HIV-positive partner in a seroconcordant positive relationship [Couple 1] articulated, “We know everything about each other’s health. We go to doctor’s appointments [together]. We know everything, there are no secrets.” His partner echoed the same sentiments, “We need to take care of each other. I think health is part of our relationship. I think health is part of [a] relationship. It’s not just about having dinner, sex, it’s everything. Many people don’t take good care of their health and that’s the important thing. We don’t wait until there is a major problem. We are on top of it.” In addition to instrumental support, both partners described how the major influence their partner had on their health was through open communication and empathetic concern: “Just knowing what’s going on. He lets me know what’s going on so we can figure out why and get it fixed.” Another seroconcordant couple [Couple 2] similarly described how they were very invested in each other’s health: “We are both HIV-positive, which has brought us closer. I don’t suffer from the same ailments [as my partner] but I feel responsible for his health.” His partner stated simply, “I know all about his health. He knows a lot about mine.” Both took on daily responsibilities to care for one another, such as being aware of each other’s health status, cooking, regular medication reminding, and providing support and love, which they described as essential to good health.

For some couples, HIV concordance was a way in which their health became interconnected. As one HIV-positive man [Couple 3] described: “Besides being sexually intimate and we both have HIV, there is just commonality that our health is integrated. We are on our own but there is a commonality. I have my health, he has his health, but we are there for each other.” His partner echoed similar sentiments: “There is a certain degree of independence but there is more reliance [because we are both HIV-positive].” He went on to describe how he conceptualized the support he and his partner provided each other to adhere to their HIV medication as having meaning for them as a unit, rather than separate individuals: “I consider that [adherence support] to be about the strength of the relationship rather than my health versus my partner’s health.”

Importantly, relational orientations were held by both seroconcordant and serodiscordant couples. For example, in a serodiscordant couple [Couple 4], the HIV-negative partner described how his HIV-positive partner viewed their health as relational such that: “my health is my responsibility but my partner has to be aware [of my health] because he’s my partner.” His HIV-negative partner expressed similar sentiments describing how his partner took an active role in his own health by providing him education and support around his enlarged prostate. The HIV-positive partner described the relationship as providing a reason to take care of their health: “We are kind of motivators for each other to try to be healthy because there is a point to trying to be healthy for someone else, not just yourself.” Another serodiscordant couple [Couple 5] described how awareness and empathy were critical in terms of preventing HIV transmission and HIV disease management. The HIV-positive partner explained: “We are both very committed to our health. He’s HIV-negative and I am HIV-positive and we want to keep it that way. He’s also doing the PrEP medication and he’s been doing that for 6 months now. I used to take my meds [on my own], he now puts his in my container and he hands me my medications as I am taking mine. It’s not that I need his help but it makes me feel good. It’s very supportive. It makes me feel like he understands more why I take my medications.” His HIV-negative partner described how there was considerable overlap in their health because they had a major influence on each other. When asked what his partner did that impacted his health, he replied: “He takes care of his health, which is part of taking care of my health. That’s the number one thing.”

Asymmetry—We noted a subgroup of four couples that expressed relational orientations towards their health in ways we termed “asymmetrical.” Asymmetry commonly existed when one partner’s health was declining and the other partner assumed a greater responsibility for his care. Importantly, health concerns were not always about HIV but also other chronic conditions.

For example, a seroconcordant couple [Couple 6] explained that one partner had recently had a stroke. Both partners described how the healthier partner took on more responsibility and was very involved in his partner’s medical care. The partner who had fallen ill stated: “We look out for each other’s health. He definitely looks out for mine. He is overprotective of me, especially since I had my stroke.” Both partners expressed that they felt responsible for supporting one another’s health, typical of the relational styles described above, however, there was a shared view that because one partner had had a health crisis, the other needed to take on more responsibility as a caretaker.

In a serodiscordant asymmetrical couple [Couple 7], the HIV-positive partner expressed strong concerns about his HIV-negative partner's recent cancer diagnosis and desired to know more and have more involvement in his health conditions. The HIV-negative partner explained that he knew more about his partner's health, while acknowledging that he shared less information about his own health. When asked about how they viewed their health as a couple, he explained that he perceived their health as a shared responsibility but minimized his own health concerns by describing his concern for his partner's health: "I am concerned about his health, his mortality, what I- or rather we – have to do should his health take a turn [for the worse]."

Personal Orientations

In six couples, at least one partner viewed health as a personal responsibility rather than a relational issue; however, viewing their health as autonomous did not preclude both partners from staying informed about and involved in their partner's health and providing support.

As stated by one HIV-positive participant in a seroconcordant relationship [Couple 8], "I felt that we are both responsible for our own health and decisions. My health is my job, and his health is his job." His partner held similar views: "I don't expect him to be responsible for me, and he doesn't expect me [to be responsible for him]. Our individual health is our responsibility." However, this couple was also deeply aware of each other's health and indicated that their relationship served as a motivator to continue to take care of their own health. "Being together gives me a positive feeling about myself. I think that helps. And we eat together. He makes sure the medications are there and I make sure the meals are there." His partner echoed the same sentiments when asked how his partner influenced his health: "He makes me breakfast and dinner every day and packs me a lunch. Just being in a relationship. Just having someone to care about me, and it does motivate me to do things." While couples with personal orientations viewed their health as their own responsibility, they also described how they provided instrumental and emotional support around each other's health (e.g., regular medication reminding, pharmacy refills, cooking), indicating that viewing health as separate from the relationship did not preclude acting in supportive ways.

Three couples described their health as autonomous but acknowledged that their health would become more intertwined and relational in nature if one person were to suffer a decline in health. These couples described how their health was stable and medication adherence was not problematic. For example, one member of a seroconcordant couple [Couple 9] stated: "We are both in a static state of health so there is not a lot of impact on our relationship." His partner similarly stated: "Neither one of us has to worry about taking the meds. We both know that without the meds we wouldn't be standing here. I am glad we don't have to worry about each other taking meds." However, there was an understanding that one partner would take on more responsibility if one of their health was to decline.

Discrepancies—Individual partners within two serodiscordant couples held different orientations toward their health, meaning that one partner viewed his health as his own personal responsibility and the other partner viewed his health as a relational issue. For three of the couples of the six couples with personal orientation, HIV was the crux of the

differences in their perceptions of health. In one serodiscordant couple [Couple 10], the HIV-positive partner described their health as a relational issue: “I don’t consider HIV to be one of the mitigating differences between us. His health and my health are equally important.” Whereas, his HIV-negative partner stated: “I chose that picture [in the IOS] because he is HIV-positive and has had a lot of medical issues over the years. I am HIV-negative and basically healthy. There’s not much problems with me so I see our health as very separate.”

In one serodiscordant couple [Couple 11], HIV did not separate them but rather communication served as a barrier to being on the same page about their health. The HIV-negative partner stated: “I know more about his health. I am more in his bubble [referring to the IOS picture] than he is in mine. I don’t share as much about my health.” His partner echoed the same sentiments but expressed a desire for more openness: “As far as health goes, he doesn’t ever want to talk about it. It’s hard to get him to have an adult conversation. Especially with the cancer, he had to be there. He even went to doctor’s appointments to know what was going on. I’d like us to be closer and know what is going on with our health.” Despite the different perceptions of their health, each of these couples described how their partner had a tremendous impact on their health, such as medication reminders, cooking, exercising together, and looking after each other.

Discussion

The purpose of this study was to provide an in-depth description of how male couples coping with HIV described their orientation towards their involvement in each other’s health, and the association of these orientations with giving and receiving support. The dominant model within the dyadic coping literature identifies the couple as the unit of study, and examines the interplay between the individuals in the relationship as they cope together with a stressor (Manne & Badr, 2008). Much of this literature is predicated on optimal support arising out of couples espousing a “we” perspective, whereby couples view themselves as collective unit (Acitelli & Badr, 2005; Fergus, 2011; Lewis et al., 2006; Lyons, Michelson, Sullivan, & Coyne, 1998); however, there have been few explicit definitions of the term “we-ness.” Our analyses revealed that there was not a uniform “we” approach that male couples held toward their health. While we cannot assert that the full range of situational factors that contributed towards participants’ perspectives were addressed in the qualitative interviews, our analyses of the data indicated that couple HIV status and other chronic health conditions contributed to couples’ orientations towards their health. However, having a relational or personal orientation did not necessarily determine partners’ level of involvement and provisions of support. With advances in HIV treatment, HIV is now a manageable disease, and transmission risk is substantially reduced for serodiscordant couples if the HIV-infected partner has a suppressed viral load (Cohen et al., 2011). It was notable that within these interviews other health conditions were often prioritized over HIV disease management. With these shifts in HIV prevention, future research is warranted to better understand how male couples cope with other chronic illness.

Our findings illustrate the complexity of “we-ness” in understanding how couples contend with health conditions. While discrepancies in conceptions of “we-ness” within couples and

more autonomous views towards health conditions have been shown in prior studies to produce less effective communal coping strategies, such withdrawal, holding back, and protective buffering (Badr, 2004; Berg & Upchurch, 2007; Bodenmann, 2005; Feldman & Broussard, 2006; Kayser, Sormanti, & Strainchamps, 1999), our findings suggest that couples' orientations towards their health can be productively explored within the situational context of illness. Akin to coping efforts, "we-ness" may be a changing concept, which may be re-defined within the relationship over time (Dunkel Schetter & Dolbier, 2011). Couples who held more autonomous orientations to their own and their partners' health also were satisfied with their partners' support strategies. As such, an emphasis on couples' desired level of involvement in each other's care positions the relationship as an important starting point for HIV clinical and health care. Providers can help the couple and each partner individually to enhance and develop strategies to negotiate their desired level of involvement with each other's care to sustain both the relationship and the partners' well-being.

The current study allows for the extension of prior work in interdependence and dyadic coping theories. First, couples' "we-ness" has almost exclusively been used to predict relationship quality and psychological adaptation (Aron et al., 2004; Frost & Forrester, 2013; Mashek & Sherman, 2004). Moreover, the results have been varied in regards to "we-ness" and health outcomes. This variability most likely occurs because prior studies have only assessed one health domain; for example, a cancer diagnosis. However, couples may have other competing stressors and/or they may be in remission. For example, one study found that a one-time messages framed to provoke a couple-mindset in regards to smoking cessation produces greater intentions to quit smoking and lower daily cigarette consumption compared to individual-focused messages among heterosexual couples in which both partners smoke (Lipkus, Ranby, Lewis, & Toll, 2013). While the mechanisms through which a couple-mindset induced reductions in smoking are unclear; this project allowed couples to decide for themselves how to address smoking cessation together. As such, allowing for the discussion of health as a couple in an open-ended manner provides for a more holistic and representative view of their relationship and health.

A number of other relationship theories can explain the complexity of these processes and provide future directions for couples health research. For example, research using self-determination theory (SDT) has demonstrated that relational well-being and mental health result from obtaining a balance of both relatedness and autonomy (Patrick, Knee, Canevello, & Lonsbary, 2007; Sheldon, Joiner, Pettit, & Williams, 2003). In addition, too much closeness as measured by the IOS has been shown to pose a threat to one's identity, and can cause someone to desire less closeness (Aron et al., 2004; Frost & Forrester, 2013; Mashek & Sherman, 2004). Similar problems arise when considering the phenomena of enmeshment in marital and romantic relationships. Feeling less connected than desired may be indicative of an unmet need for relatedness or involvement in the context of the health, whereas feeling too much connectedness may indicate, in a sense, over-relatedness, which poses a threat to the need for autonomy. As such, theoretical models must allow for both relatedness and autonomy as subjectively experienced by the individual and the couple. Moreover, these processes between couples may be better conceptualized as an iterative and transactional process which changes over time to meet the needs of the immediate situation (Dunkel Schetter & Dolbier, 2011).

Several limitations should be considered when interpreting the findings of this study. The cross-sectional nature of the study design precluded the ability to evaluate how couples' relationships and health changed over time. In addition, the study relied on a convenience sample recruited in the San Francisco Bay Area where there have been efforts to ensure HIV-positive adults are connected to care and all of the HIV-positive partners were prescribed an ART regimen. HIV disease management may be more of a stressful and pertinent topic for couples who do not have HIV care or access to medications. Finally, the couples who completed qualitative interviews had been together for an average of 8 years when they enrolled in the project, and well-being processes may be different for newer couples.

Conclusions

Our study provided an in-depth look at how male couples coping with HIV view their health and provide support to one another. This study underscores the importance of not imposing an expectation of what a relationship "should" look like on couples (e.g., healthier relationships = more well-being). The findings from this study suggest that healthcare providers and counselors working with couples should be attuned to their desired level of involvement in each other's health. For example, counselors and health care providers can assess current and desired levels of involvement in their partners' health, which would allow couples to openly discuss how to get on the same page about their involvement to provide effective support to each other. Further, if one partner feels there is a problem in their relationship, efforts to determine where a discrepancy exists between the partners should be addressed so couples can achieve their health goals together. Allowing couples to work together to reach common goals and build solidarity around their level of involvement in each other's health should be incorporated into HIV prevention, as well as other areas of health. Future work must take seriously how much involvement or autonomy couples desire in their health care in order to promote optimal support and health over time.

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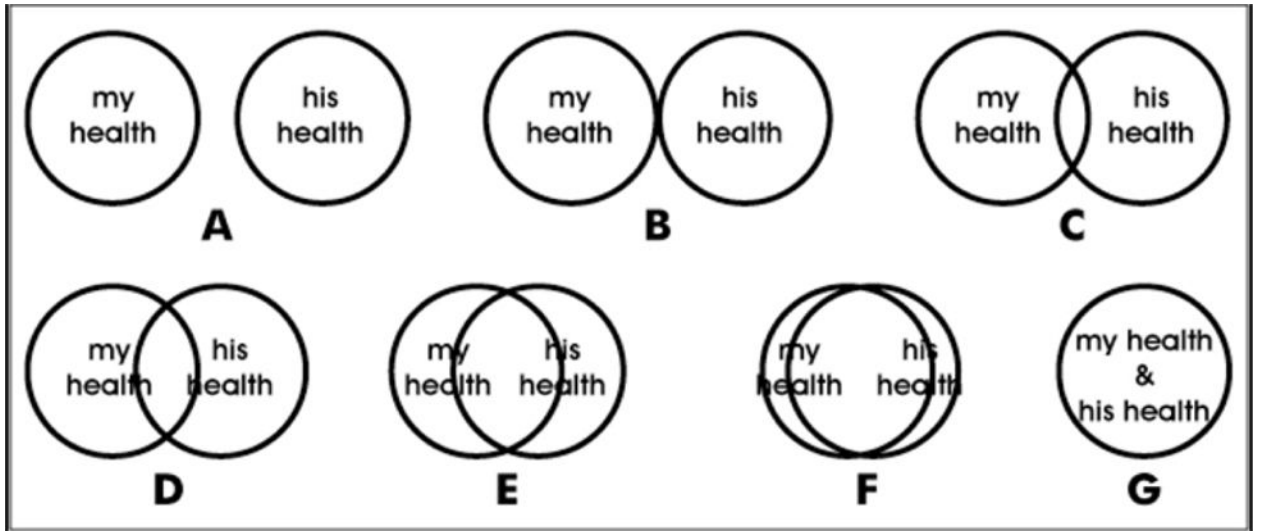


Figure 1.
Adaptation of the Health Inclusion of Other In Self

Table 1

Sample demographics (N = 20 couples, 40 men)

	Total Sample Baseline
<i>Age, mean (SD), years</i>	50.57 (9.96)
<i>Relationship length, mean (SD), months</i>	100.23 (92.13)
<i>Couple Serostatus, n (%)</i>	
Serodiscordant	22 (55.0)
Seroconcordant	18 (45.0)
<i>Race, n (%)</i>	
Black	6 (15)
White	28 (70.0)
Latino	3 (7.5)
Other	3 (7.5)
<i>Income, n (%)</i>	
Less than \$20,000	14 (35.0)
Greater than \$20,000	26 (65.0)
<i>Perfect 30-day Adherence</i>	
Yes	9 (31.0)
No	20 (69.0)
<i>Viral Load</i>	
Detectable	15 (51.7)
Undetectable	14 (48.3)
<i>Depressive Symptoms</i>	11.82 (0–32)
<i>Health IOS</i>	4.10 (1.24)
<i>Commitment</i>	34.95 (22–36)
<i>Relationship Satisfaction</i>	24.68 (15–31)