Place Attachment and Mobility in the lives of HIV positive Men

by

Libby L. Black

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This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

Susan Saegert, Ph.D.____________________

______________________ ____

Date Chair of Examining Committee

Maureen O'Conner, Ph.D., J.D.__________

______________________ ____

Date Executive Officer

David Chapin___________________________

Nicholas Freudenberg, MPH, DrPH.______

Joseph Glick, Ph.D._____________________

Tamara Buckley, Ph.D.__________________

Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

Abstract

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Adviser: Professor Susan Saegert, Ph.D

Research Question & Theoretical framework: This study explored how transformative effects of an HIV diagnosis inform our sense of place and connectedness to a setting/place attachment and the influence on our use and movement in social space. Using Bourdieu's Sociological perspective I explored the notion of 'knowing' or 'habitus,' by investigating the nature of a person's position and the conditioning (social learning) of that position which can be viewed as a transformative process that effects, changes, and creates both the position and the conditions that govern practice.

Methods: The research included semi structured interviews and (2) focus groups, where one set of groups had the specific objectives of the study disclosed to them, and the researcher surveyed the respondents on the types of questions and information they believed needed to be collected to capture their sense of social space. The final group was presented with the results of the initial group and asked to critique and inform the results. A total of 36 subjects were interviewed or were a part of the focus groups. Using cognitive mapping, I explored the places they frequent, noting physical settings, how these settings were used, evaluated and perceived and how they spent their time.

Research findings: The findings reveal themes related to respondents' sense of place and connectedness and their sense of connection to those people and

places they deem significant. There are examples of life philosophies that appear connected to positioning and are connected in influential ways to ones sense of 'constriction' or 'expansion.' When dealing with socially impoverished, isolated men, and their HIV diagnosis, their positioning and conditioning in social space, it appears their 'situatedness' directly effects and instructs their 'practical sense,' or everyday practices and this allows creative and instructive thinking that transforms their experience of becoming HIV positive into an experience of expansion and growth. Broader, the meanings people attribute to their histories, suggests how one comes to choose, use, and is transformed by the spaces supportive of them, are themselves products of the same cultures and social structures that produce and reproduce the 'practical sense' of an agent.

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Background

This paper is informed by my work at community-based organizations since the early 90's throughout New York City working with homeless people living with HIV/AIDS, and my research of their living spaces in Single Room Occupancies (SRO) in New York City from approximately 1998 to 2005. I would visit and advocate for people living within supported as well as commercial (unsupported) SRO residences, and I had the opportunity to hear how people living with HIV/AIDS suspected their physical, as well as social environment had played a significant role in their ability to thrive. What is apparent from this work and my research and made clear from the literature is that HIV disease may have some influence toward limiting or constricting interaction and movement within a person's 'post-diagnosis' supportive networks, but also it could expand the lives of HIV positive people through a transformative dynamic of 'otherness' where people embrace this newly forming self and the community that supports it.

This notion of 'helping and hindering' was apparent in respondents reports of not just receiving assistance in acquiring the safe secure housing that they so desperately needed, or having access to services that attended to their social, financial and emotional needs, but that they also experienced "discouraging" interaction with supportive services staff and service providers. This constriction, restriction, or closing off of territorial resources may be self-imposed or externally imposed through the use of increased surveillance, as noted in my previous work (Black, 2005) by 'suspicious' or 'random' interrogations within the SRO by police whenever a criminal act occurred in the surrounding vicinity. The use of the word ‘constriction’ is significant, because it is seen as a technique by those living with HIV to maintain privacy about ones’ HIV status, but could also be used as a technique by the local authorities to discourage full integration in the social surroundings. Also noted by respondents were the constantly reoccurring ‘assessments and reassessments’ by case managers and caseworkers that although in place to assist with gaps in services, were found in some cases to further polarize individuals. There appeared in some cases to be a ‘mortification or degradation of self’ which Goffman (1963) suggested could be communicated through social arrangements such as those noted above that are ‘read’ by the individuals and others for an image of him or herself to be communicated. In fact these imposed perceptions may have had some influence on their reported low morale and feelings of isolation.

Perhaps more than any other contemporary disease, HIV/AIDS has served as a powerful signifier for a range of cultural anxieties around “otherness” and invasion, sexuality and deviance, contagion and death (Duncan, Harrison & Toldson, 2005; Herek, Capitanio, & Widaman, 2002; Herek, G.M. Mitnick, L., Burris, S., Chesney, M., Devine, P., Fullilove, R.E., Gunther, H.C., Levi, J., Michaels, S., Novick, A., Pryor, J., Snyder, M. & Sweeney, T., 1998). Given the potency of these anxieties and the significant stigma still attached to HIV, an important extension of this work is in exploring the transformation of the self from HIV negative to HIV positive and the effects on one’s connectedness to settings and movement through social networks and supportive spaces.

Introduction

Historical Perspective of HIV/AIDS

Throughout the 1980's and 1990's, HIV/AIDS was closely linked to homosexuality[1] and deviance in the minds of many Americans. This association can be traced to the syndrome's initial epidemiology in the United States (Herek, 1999). AIDS was first identified in 1981, when clusters of gay men in Los Angeles, San Francisco and New York were diagnosed with Kaposi's Sarcoma and Pneumocystis Pneumonia. Early media reports referred to it variously as a 'gay disease,' 'gay cancer,' or 'gay plague,' and some health care providers and researchers informally labeled it "gay-related immune deficiency" (GRID), reflecting an initial assumption that it struck only gay men (Epstein, 1996). The cultural contextual nature associated with sex, sexuality and HIV are distinct influences that uniquely interact with race and ethnic identity (Beatty, Wheeler, & Gaiter, 2004; Scott, Gilliam, & Braxton, 2005; Wilson & Miller, 2003). The literature suggests that HIV related disparities among African Americans are the byproduct of contextual factors that contribute to an increased risk for HIV acquisition and transmission (Adimora, A. Schoenbach, V., Martinson, F., Coyne-Beasley, T., Doherty, I., Stancil, T., et. al. 2008). This means that the effects of the socio-physical spaces of people living with HIV can be created and re-created by virtue of their positioning and conditioning in

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[1] We use the term 'homosexual' to refer to Men who have sex with Men (MSM). It should be noted, that there is a difference between sexual identity (i.e. homosexual, heterosexual) and sexual behavior, Men who have sex with Men or Men who have sex with Women (MSW). However, the use of the term here 'homosexual,' or 'heterosexual,' will refer to MSM, or MSW.

that this particular ‘situatedness,’ and the meaning attached to it, allows the agent to adjust and generate practices and strategies best suited for them.

By June 1982, more than 400 AIDS cases had been reported to the CDC, with 19% of these cases occurring among non-Hispanic Blacks (Centers for Disease Control and Prevention, 1996). In 2011, Blacks accounted for 14% of the population of the United States, yet they accounted for 44% of the new AIDS diagnoses that year (Center for Disease Control and Prevention, 2011; U.S. Census Bureau, 2011). Among U.S. racial and ethnic minority populations, African American communities are the most disproportionately impacted. HIV transmission rates among African Americans are the highest in the nation (CDC, 2011). In New York City, the Department of Health and Mental Hygiene Bureau of Sexually Transmitted Disease Control, the HIV data shows a 41% drop in deaths among Black persons living with HIV/AIDS between 2001 and 2010. Despite this progress, Black New Yorkers – representing 25% of the New York City population – disproportionately accounted for almost half of all new HIV diagnoses (48%) in 2010, a proportion that has remained almost unchanged for the past 5 years (2012).

HIV/AIDS is considered a health crisis for Blacks. With that said, today with the advent of highly active antiretroviral therapy (HAART), the overall progression of HIV infection to AIDS and from AIDS to death has slowed (Pallella, 1998). However, it cannot be overstated that the HIV/AIDS epidemic has evolved from primarily affecting White people to primarily affecting Black people. When compared with other races and ethnicities in the United States today, the latest surveillance data consistently demonstrate that Blacks are disproportionately affected by HIV/AIDS at all stages---from infection with HIV to death with AIDS. Of the estimated 173,956 adults and adolescents age 13 years and older diagnosed with HIV/AIDS in the 33 states with name-based HIV reporting during 2010-2012, nearly half (49.9%) were Black. In comparison, Whites age 13 years and older accounted for 29.9% of all HIV/AIDS diagnoses among adults and adolescents made during those years, while Hispanics/Latinos accounted for 18.1%, Asians/Pacific Islanders for 1%, and American Indians/Alaskan Natives accounted for less than 1%.

Among all adults and adolescents, Blacks accounted for the largest percentages of HIV/AIDS diagnoses for high-risk heterosexual (27%) and Intravenous Drug Use (9%), IDU transmission categories (CDC, 2011). Of HIV/AIDS diagnoses among Blacks, most were attributed to high-risk heterosexual contact and male to male sexual contact (48%). Blacks also accounted for the largest percentage of HIV/AIDS diagnoses in all age groups. Most (60.3%) HIV/AIDS diagnoses were among adults' ages 25-44 years regardless of race or ethnicity, with Blacks accounting for 46.6%. The rate of new infections for Black Men is more than six times as high as that of White Men, and more than two times that of Hispanic Men and of Black Women. For example, African American Men, compared with White Men, have less access to healthcare services because many of them are underinsured or are not insured (DeNavas-Walt, Proctor, & Smith, 2009). Additionally, it has been suggested that African American patients, compared with White patients, are more likely to receive health care from physicians with less training (Bach, Pham, Schrag, Tate, & Hargraves, 2004). Further, African American Men who do access health care services are more likely to seek primary care at an emergency department than through ambulatory health services (i.e. primary care clinic), which results in less favorable health outcomes (Shenolikar & Balkrishnan, 2007). Finally, and compounding these structural factors is the reluctance of many African Americans to seek medical care because of a commonly shared distrust of the government and public health entities (Bogart & Thorburn, 2005).

As of 2011, the Centers for Disease Control (2011) has recorded 1,178,350 diagnosed cases of AIDS in the United States, of which men who have sex with men (MSM) which represents just 2% of the population, accounted for 61% of all new HIV/AIDS infections in the U.S., as well as nearly half of people living with HIV (49%). White MSM account for the largest number of annual new HIV infections of any group in the U.S., followed by Black MSM and Hispanic MSM. The rate of new HIV diagnoses among MSM in the U.S. is more than 44 times that of other men, and more than 40 times that of women. Diaz, Ayala, & Bein (2004) found those who experienced multiple forms of discrimination, including racism, homophobia, and poverty were more likely to engage in risky sexual situations, which provided the context for HIV sexual risk behavior. Further, Black MSM report higher rates of HIV disease progression (Hall, Byers, Ling, & Espinoza, 2007) and AIDS mortality (Blair, Fleming, & Karon, 2002) among MSM in the U.S. than rates reported by MSM of other racial or ethnic backgrounds. Adding to this, the Center for Disease Control & Prevention estimates that about 19 million new STD's (Sexually Transmitted Diseases) occur annually in the United Sates with the greatest burden of the diagnosis among 15-24 year olds, Women and African Americans (CDC, January, 2011). Rates of Chlamydia, Gonorrhea and Syphilis are higher among African Americans than any other racial/ethnic group. More than 1.1 million cases of Chlamydia, a bacterial infection and the most commonly reported STD in the United States, were diagnosed in 2010 (CDC, March, 2011). Of these cases, approximately 48% were African Americans, translating into a rate eight times as high as the rate among Caucasians (CDC, January, 2011; CDC, March, 2011). Additionally of the approximately 356,000 cases of Gonorrhea, reported in 2010, about 70% of the cases were in African Americans (CDC, January, 2011; CDC, March, 2011). This translates into a Gonorrhea rate among African Americans that is 19 times the rate in Caucasians.

While the racial gap in syphilis rates has narrowed since 1999, significant racial disparities still exist for African Americans. Approximately 11,466 cases of Syphilis were reported in 2010 (CDC, January, 2011). The Syphilis rate among African Americans (2.0 per 100,000 population) was seven times that among Caucasians and rates of Primary and Secondary Syphilis, the most infectious form of the disease in African Americans increased for the fifth consecutive year (CDC, January, 2011). Additionally, significant gender differences in Syphilis diagnosis exist within the community. The largest increase, 28.2% among African Americans was found in males, and mainly among men who have sex with men (MSM); rates of Primary and Secondary Syphilis among females increased 14.3% (CDC, January, 2011).

The disparities in STD diagnoses for African Americans are important because there is evidence that the presence of STDs like Chlamydia, Gonorrhea, and Syphilis can increase the risk of HIV acquisition and transmission (Gavin & Cohen, 2004; Weinstock, Berman, & Cates, 2004). The available literature suggests that co-transmission of HIV and other STDs may be a common occurrence (Cohen, 2004) and that biological mechanisms, (i.e., impaired integrity of the genital mucosa creating an environment more conducive to transmission) (Cohen, 2004; Gavin & Cohen, 2004) and immunological mechanisms, (i.e. immune activation) Reynolds, Risbue, Shepherd, Zenilman, Brookmeyer, Parajape, Divekar, Gangakhedkar, Ghate, Bollinger, Mehendale (2003) are possible explanations for increased risk of HIV transmission in persons infected with STDs. Finally, and adding to these 'contextual relations,' African Americans, compared with Whites, are less likely to receive a diagnosis of HIV in the early stages of infection and less likely to adhere to antiretroviral medication regimens (Milberg, 2001; Reif, Whetten, & Theilman, 2007; Schwarcz, 2007). Late HIV diagnosis and lack of adherence to treatment regimens contribute to higher viral loads and increased risk of transmitting HIV to sexual partners (Quinn, 2000). This clearly demonstrates the relevance and significant public health risks this population faces. Given this data, it accentuates why exploring the dynamics or the journey of HIV, the data, as well as identifying and treating co-infections of HIV among African Americans is a relevant method for prevention and reduction of health disparities.

The causes for these health disparities are interrelated and fundamentally due to contextual and structural factors like higher poverty rates, lack of access to adequate healthcare, higher incarceration rates, lower income and educational attainment, and racism (Adimora, Schoenbach, Martinson, Coyne-Beasley, & Doherty, 2008); Chu & Selwyn (2008). So although, there are individual based sexual behaviors that contribute to HIV disparities among Blacks such as those discussed here and others, it must be situated in a way that makes the Macro issues related to poverty, increased incarceration rates, economic and social segregation, and all that entails 'structural inequality' as major contributing factors. Adimora & Schoenbach noted that while individual-level sexual behaviors can contribute to the disparity in HIV prevalence, these observed differences in individual behaviors do not fully explain the marked racial differences in HIV infection prevalence (2002). Even when comparisons are stratified by education, poverty index, marital status, age at first sexual intercourse, lifetime number of sex partners, history of male homosexual activity, illicit drug use, injection drug use, and HSV-2 antibody positivity, HIV prevalence among African Americans exceeds that of whites, typically substantially. Continuing racial disparities in HIV infection more than two decades after the identification of the virus and the availability of an accurate test indicate existing interventions have failed to control the epidemic in African Americans in part because critical features of the socioeconomic context promote behaviors that transmit HIV and increase the risk of HIV infection even among those who do not have high-risk behaviors.

The historical dynamics that set the stage for the economic downturn in the nations' inner cities, the dramatic decline in industrial jobs and therefore the dynamic movement away from employment requiring little formal education set the trend of mass unemployment and underemployment, social isolation, limited access to healthcare, and generational poverty rates for minority inner city residents that continue still today (Jones, 1972).

As the face of HIV/AIDS has changed, and the associations have widened to include intravenous drug users (IDU), sex worker's, and young Black's and Hispanic's of low socioeconomic status, so too has the stigma to belonging or being associated with any of these groups grown.

The Association as the Mediator for Stigma

The expression of the association with intravenous drug users, sex worker's, and poor Black and Hispanics was a response to people living with HIV/AIDS on the basis of their group membership or association, irrespective of the social or behavioral 'facts' the specific person had. What should have been an interpersonal interaction transpired as an intergroup encounter. Thereby enacting a response determined more by the expectations, assumptions, and beliefs about the group to which the person belonged or was assigned, than by the qualities of the given individual. These assumptions of deviance and low economic status presuppose that somehow all members of the group are alike in some specific and distinctive way and therefore ‘color’ the interaction with members of the group and can guide behavior.

The low socioeconomic status of Black and Hispanic males in New York City who are HIV positive were therefore inextricably linked in our minds to deviant social groups who posed a threat to the larger society. This dynamic can be explained through the notion of ‘illusory correlation.’ This is the perception that two things are correlated or associated when, in fact, they are not. It is claimed that illusions of association between two variables are heightened when they share ‘distinctiveness’ and ‘infrequency.’ Somehow, our mental processes attach a greater degree of association to those things that stand out but are not statistically more likely to occur. According to Jones, this association is not motivated by self-enhancement tendencies or by a need to belong to a highly regarded social group. It is a fault of how we process social information. McArthur and Friedman (1980) conducted a study using demographic group pairings (old and young people; Black and White people; men and women). The subjects were presented with eight 4 by 6 inch index cards that provided ‘case histories’ describing desirable or undesirable behaviors. Each card included a photograph of a patient that had been evaluated by a psychiatric social worker. The infrequency of each demographic category (i.e., for race, half the subjects saw two Black and six White patients; the other half saw two White and six Black patients). In each case history, undesirable behaviors were less frequent than desirable behaviors were. They found that illusory-correlation effects occurred when infrequency distinctiveness and associative distinctiveness combined. That is, when low-frequency stimulus groups (i.e., Black people, old people, and women) were associatively linked with the undesirable behaviors, illusory correlations were found. Whereas, when the low-frequency stimulus groups (i.e., White people, young people, and men) were associatively linked with undesirable behaviors the reverse was true. When Whites, young people, or men were the infrequent group, the more infrequent desirable behaviors were more strongly linked to them. Further, when they were the more high-frequency stimulus group, associatively linked with undesirable behaviors, they continued to experience a stronger link with desirable behaviors. Further, impressions weight infrequent behaviors more heavily when the actors appear infrequently than when they appear frequently. On the other hand, when distinctive, undesirable behaviors were paired, the participants overestimated how much the minority group exhibited the behaviors, and therefore shared infrequency effects did not occur for the young, white, male groups. Rather, impressions may weight frequent, associatively linked behaviors more heavily when the actors appear frequently. It is important to note that these reversals of the shared infrequency effect are not illusory correlations based solely on associative connection. Rather, they reflect a shared distinctiveness effect in which the perceived correlation between demographic group and behavior is overly influenced by actor-behavior pairs, in which the actor is distinctive by virtue of associative connections to the actors group. This finding suggests that shared infrequency may reflect a way in which minority groups who are associated with distinctive, negative, and infrequent behaviors continue to be stigmatized. It also suggests that, for majority people with positive associative links to behavior, a positive 'halo' is perpetuated by the illusory-correlation processes.

Further, the findings suggest the existence of a stereotyping paradox for persons from minority groups that already have negative social stigma. Examples of positive behaviors by members of these groups do not influence judgments of the group as much as instances of negative behaviors influence such judgments. Conversely, negative behaviors by members of the positively regarded majority groups do not influence judgments of their group to the same degree as instances of positive behaviors do. The implication here is that once a group has a positive association, it is much harder to deflate it. Once a group has a negative association, it is much easier to maintain it. Therefore, people who are associatively linked with undesirable behavior may experience this negative association. This seems relevant as a part of this study, in that I pose it is yet another 'effect' of the broader contextual issues confronted by those living HIV/AIDS. That although false associations between membership in a statistical minority group (those living with HIV) and rare (typically negative) behaviors (IVDU, or having unprotected sex with multiple partners) as variables that are novel or deemed socially deviant tend to capture attention and help to inform the strategies and everyday practices toward those deemed 'other.' In this way stereotypes form and endure and have lasting effects in the lives of people living with HIV.

The historical dynamic and enduring nature of HIV stigmatization can effectively shape and transform the lives and attitudes of HIV infected persons in numerous ways; however my interest is how it can influence a person's sense of social space.

The Transformative Nature of HIV Disease

Shelley, Bernard, Killworth, Johnsen, & McCarty conducted a social stigma study of seventy HIV positive individuals who completed in-depth semi-structured interviews to assess whether they perceived their networks as smaller than those who were not HIV positive. The results suggested people with HIV do in fact perceive their networks as smaller, and 'constrict' or 'constrain' the information and places they share their status. They also noted in some cases, an expansion or an 'opening' or increase of network size, where respondents reported that HIV sero-conversion actually changed their life for the better. Further, the researchers suggest that social stigma is associated with the type and amount of information shared (1995). This notion of 'constriction' or 'limiting' the information others know about one's status is an important idea as it relates to this study. The cultural and structural factors related to living with HIV cannot be underestimated and need further investigation. Although network effects are important, I zero in on the possible changes in the person's life space. Specifically, analyzing if their life spaces show dramatic 'constriction' in the early stages of one's HIV diagnosis, and considering explicitly evidence in persons who have lived with their diagnosis three or more years to a return to a more 'expansive' or a more 'open' sense of social space? This notion of ‘constriction’ and ‘expansion’ or ‘openness,’ where respondents may experience a sense of a larger support network, is relevant to this study and will help discern the characteristic changes experienced in the lives of people living with HIV.

To explicitly answer the question of why the use of the term ‘constrain’ or ‘constriction’ when discussing HIV disease and its effects on the individual in socio-physical space, we must take note of the substantive evidence linking social stigma, racism and poverty to a host of chronic health conditions, adverse mental health outcomes and excess mortality, particularly among African Americans (Brondolo, ver Halen, Pencille, Beatty & Contrada, 2009; Harrell, Hall, & Taliaferro, 2003; Jones, 2000, 2003; Kreiger, 2000, 2005; Kreiger, Rowley, Hermann, Avery, & Phillips, 1993; Kwate, Valdimarsdottir, Guevarra, & Vovbjerg, 2003; Mays, Cochran, & Barnes, 2007; Randall, 2006; Williams, 1999; Williams & Williams-Morris, 2000). I argue these multiple overlapping social structures can act to lessen, shrink, limit, reduce, restrict, shorten, confine, decrease, diminish or narrow one’s ability to expand, develop and increase one’s social networks. Therefore it is necessary to take into account these historical contextual issues, and the legacy of historic and contemporary forms of racism and discrimination towards African Americans (Latif & Latif, 1994; Washington, 2006), that have contributed to conditions of poverty and inequality (e.g., limited access to educational and employment opportunities and quality healthcare). The government of poverty, meaning regressive tax structures, the drastic ‘downsizing’ or ‘contraction’ of its social welfare sector with its apparent aim at imposing de-socialized wage labor as a norm of citizenship for the deskilled fractions of the postindustrial working class (Wacquant, 1999) coupled with a deregulated labor market that ultimately demarcates and secludes the underclass in a separate physical and socio-symbolic space that it itself created leads us toward a much needed examination of the interplay of broader level contextual factors related to HIV/AIDS.

According to the CDC (2011), African Americans are disproportionately affected by HIV/AIDS and continue to shoulder the burden of infections. However, prior prevention and control efforts have largely been limited in reducing such disparities. These social dynamics can have 'deleterious' effects on ones connectedness to place and how ones lived space is perceived, therefore exploring the nature of these constrictions is an important aspect of how people living with HIV attach meaning to their positioning and conditioning. Further, it seems crucial to explore their possible experience of a corresponding expansion or opening in life space as there can be a range of responses in the form of 'practical sense.'

The effects of HIV dynamics can clearly have devastating repercussions on one's ability to connect and utilize support services/systems and move in social spaces considered beneficial. Social and behavioral research has raised important questions about the role of place in today's society. This research examines three phenomena related to place in the lives of people recently and those diagnosed three or more years prior with HIV: (1) connectedness to a setting/place attachment and (2) 'habitus,' and finally (3) physical mobility.

In the following paragraphs, I will illustrate the elements of connectedness and place attachment, 'habitus' and mobility using a perspective of social learning from Pierre Bourdieu's sociological perspective to explore people diagnosed with HIV/AIDS six months or less 'perception of constriction,' and in contrast, those diagnosed three years or more 'sense of expansion' or 'openness' related to a person's sense of social space and how changes in one's position and concurrently one's conditioning can thereby alter and govern practice. Further, I will specifically seek examples of perceived expansion, opening, facilitation, or in contrast, constriction, limiting, reduction, diminishing or narrowing in these elements of connectedness, sense of attachment and mobility.

To this end, this research asked the question: **How does connectedness to a setting/place attachment and 'habitus,' inform the perspective of people living with HIV in their use and movement in the social world?**

Elements of Bourdieu’s Sociological Perspective

The use of elements of Bourdieu’s perspective are valuable in that they give us a platform by which to explore the nature of a person’s position in social space and the conditioning (social learning) of that position that can in and of itself be viewed as a transformative process that effects, changes and creates both the position and conditions that direct and govern practice, and therefore demonstrate changes in the person’s life space. It is through this ‘dialectic practice’ that Bourdieu suggests a person comes to form ‘habitus,’ or attach meaning to their positioning and conditioning in social space. Bourdieu’s notion of ‘habitus,’ is most appropriate here in that ‘habitus,’ he explains, colors our worldview and shapes our choices and is integrally situated in the positioning and the conditioning of one’s social space and therefore directs us to see the world in a certain way because of that positioning and conditioning. It is in this ‘situation’ that ‘doxa’ which serves as an organizing function of thought or what we ‘know,’ or how we attach meaning that allows us to begin to ‘act out’ ‘habitus’ via ‘practical sense.’ This notion of ‘practical sense,’ or everyday practices are therefore embedded in the dispositions or position and conditions that create and re-create it.

Bourdieu’s sociological perspective suggests the context in which an individual is geographically and socially positioned and therefore conditioned is connected to the schematic representations or ‘doxa’ that guide everyday behavior, our routines and routes and therefore our physical mobility. This means the ways we are connected to a setting or place are intrinsically woven into our positioning and conditioning. Bourdieu's perspective of 'a dialectic' of positioning, conditioning, and sense of place lends itself to the phenomenological approach which is primarily interested in how places create their meanings. Alexander (2002) fittingly portrayed this idea when he noted that what we see and experience in 'places' is a part of an extended and undivided continuum. It is not an isolated fragment in itself, but a part of the world which includes the gardens, walls, trees, streets beyond its boundaries, and other buildings beyond those (p. 80). This means that everything that exists 'has to be viewed as orders of connecting relationships rather than as mere objects in space' (Kunstler, 1993 p. 249).

The social institutions within the social spaces of people living with HIV/AIDS have definite conditions of existence which are grounded in their geographic and social positioning and conditioning. They form a part of a network of governance and social ordering that includes Day Treatment Programs, Medical providers, Housing providers and other social services institutions. They refer to, and are supported by other social institutions and social controls like racism and economic inequality respectively, and are grounded in specific configurations of cultural, civic and economic action. So while people with HIV/AIDS have a certain autonomy and a capacity for internally generated development and change, any transformation in their lives will tend to signal the correlative transformation in the structure of the social spaces and institutions that are contiguous to it. Therefore, the conditions of existence within the social spaces and institutions people with HIV live in, work, seek support and otherwise frequent, will be changed/transformed by a network of governance that is sustained and created by the contextual artifacts embedded in the positioning and conditioning of those social spaces and institutions. The specific 'situatedness' informs the everyday practices of those utilizing the services. For example, the program who gives metrocards as 'incentives' for attendance to support groups, could find themselves with great support group attendance, but buckling budgetary issues that drain services elsewhere. If the programs response to this situation is to institute a '3 group' minimum for (1) metrocard, this decision could in effect change the way people use the services, and move about their social worlds.

The lives of people living with HIV/AIDS can be characterized by two interlocking and mutually conditioning patterns of action: the formal controls exercised by social institutions and the informal social controls that are embedded in the everyday activities and interactions of those living with HIV/AIDS. Through a network of governance of informal social controls, where interactions with other HIV positive people, specialized staff, medical, psychological, social networking, and exchanges in ideas and information in safe, welcoming, communal spaces, the character of everyday life changes, thereby enacting a transformative process that is contextually linked to place and ones positioning and conditioning in social space. The changing habits and routines often have consequences for the structure of informal controls in that the activities and routes of people living with HIV/AIDS are transformed as they go about their everyday lives and ordinary routines. A reconfigured response to formal social controls entails new practices and a revised conception of social ordering that is illustrated in the emergence of different objectives and priorities, and the appearance of new ideas, 'practical sense,' as a result of changes in the person's life space. This suggests the nature of this transformational process is grounded in the dialectic of positioning, conditioning, and sense of place. The notion of 'constriction,' and therefore the corresponding notion of 'expansion' or 'openness' in the lives of people living with HIV, can in fact be created and recreated from 'deleterious' effects of particular social dynamics in the everyday lives of people living with HIV. Further, these effects can in some cases and in relation to one's positioning and conditioning in social space be a transformative experience whereby one's adaptation to this newly realized 'position,' informs the everyday practices or 'practical sense' of an individual living with HIV. As noted earlier, the effects can be created and recreated from the contextual factors contiguous to 'habitus.' Implying, the notion of the meaning attached to positioning and conditioning in social space and all that is relevant to that position is integrally related to 'doxa,' or how we attach meaning and therefore our behavior in that 'situatedness.' This means for example, the Black Homosexual Man who along with the possible experience of homophobia, may also 'restrict' or limit the information he shares with friends and loved ones about his status, while also responding to the environmental deficits proverbially 'written' into his geographic position in a crime ridden poor neighborhood that may or may not offer the specific services he may be seeking, and that through these embedded dispositions his everyday practices emerge. Further, these dynamics are not happening in isolation of each other, but are created and recreated from and within these very dynamics. These dynamics and the creation from and within them I call the 'relational dialectic' which creates an ideal bridge when discussing Bourdieu's perspective of positioning, conditioning, and sense of place as it relates to the nature of one's becoming connected and attached to place.

Connectedness and Place Attachment

The study of feelings that people develop toward the places where they were born and brought-up and the function these places fulfill in their lives is a research area which has been receiving increasing attention in recent years on the part of environmental psychologists. As is known, research on 'sense of place,' began with human geography, they adopted 'study of places' as the defining feature of their discipline (Cresswell, 2004) and drew heavily on the phenomenological tradition represented by Heidegger (1962) and Merleau-Pnty (1962). Seamon (2000), one of the leading figures in phenomenology of place, described the task of a phenomenologist in the following way:

> The phenomenologist pays attention to specific instances of the phenomenon with the hope that these instances, in time, will point toward more general qualities and characteristics that accurately describe the essential nature of the phenomenon as it has presence and meaning in the concrete lives and experiences of human beings (Seamon, 2000, p. 159).

The phenomenological reports are therefore not idiosyncratic descriptions of individual experiences, but are collected with the ultimate goal of discerning the essential features of the phenomenological experience to help identify the nature of the experience of places that give rise to aesthetic appreciation, meaning, and place-related emotions.

Currently, there seems to exist a certain consensus in the use of the term 'place attachment.' In general, place attachment is defined as an affective bond or link between people and specific places. For example, Shumaker and Taylor (1983) noted it is a 'positive affective bond or association between individuals and their residential environment.' Hummons (1992) considers it 'emotional involvement with places,' and Low (1992) defines it as 'an individual's cognitive or emotional connection to a particular setting or milieu.' What is understood to be the main characteristic of the concept of attachment is the desire to maintain closeness to the objects of attachment (Ainsworth & Bell, 1970; Bowlby, 1969, 1973, 1980). If I incorporate this specific property into the previous definition of place attachment (Shumaker et.al, 1983), it could take the following form: a positive affective bond between an individual and a specific place, the main characteristic of which is the tendency of the individual to maintain closeness to such a place. I can only find one description of place attachment in these terms, although under a different name. Sarbin (1983) speaks of the Spanish term *querencia* which reflects the frequently observed tendency of people to prefer to stay near specific places. It is the propensity of human beings and other animals to seek out the place where they were born or find a place in which they feel comfortable and secure.

According to Altman and Low (1992) places to which people can be attached vary in scale, specificity, and tangibility, from the very small (for example, objects) to the planet earth or the universe. A research study which simultaneously analyzed several different spatial levels is that of Cuba and Hummons (1993). The measure employed in this study ('Do you feel at home here?') has been used in other studies as a measurement of place attachment (i.e. Kasarda & Janowitz, 1974), so we can consider their results as relevant in this research. In that study, the existence of different levels of spatial identification was analyzed (feeling 'at home') among inhabitants of Massachusetts County. The three places analyzed were house, community and region. Most subjects (42.6%) stated that they identified with the three places, followed by (16%) who only identified with the region, (13%) that identified with the house only, and finally (10.3%) identified with only the community. These results seem to indicate that it is precisely toward the most studied place (the neighborhood or community) that the least number of people feel attached. In fact (Gustafson, 2001) suggests place attachment and connectedness may be directed toward residence, neighborhood, city, region, or country (and indeed toward several places of different spatial scale) and may involve not only the present home place but also earlier places signifying childhood and origin in addition to other meaningful places. Attachment to numerous places continues to be strong concerning both places like home or neighborhood to higher levels such as cities and towns (Bonaiuto, Furnara & Bonnes 2006; Fried, 1982; Gustafson, 2009b; Hidalgo & Hernandez, 2001; Lewicka, 2010). ‘Place and its meaning,’ in the contemporary world, has actually grown (Gustafson, 2006; Janz, 2005; Kruger & Jakes, 2003; Terkenli, 1995). This includes nonresidential places as well (Hammit, Backlund & Bixler, 2006; Kaltenborn & Williams, 2002; Stedman, 2006). This suggests places of recreation, working places, meeting places, or even frequently visited or local shopping places may be capable of triggering attachment and a feeling of connectedness. A portion of place research is indeed concerned with how people are attached to places and explicitly link place attachment to a person’s contextual positioning. It is therefore relevant to discuss the nature of ones’ positioning, their ‘situatedness’ in social space, as ‘doxa’ or what we ‘know’ can have a profound impact on our everyday choices.

Positioning

Bourdieu (1984) laid out a diagram that describes his theory of positions and conditioning and its relationship to ‘habitus,’ ‘schemas,’ and practices which he named ‘lifestyles.’

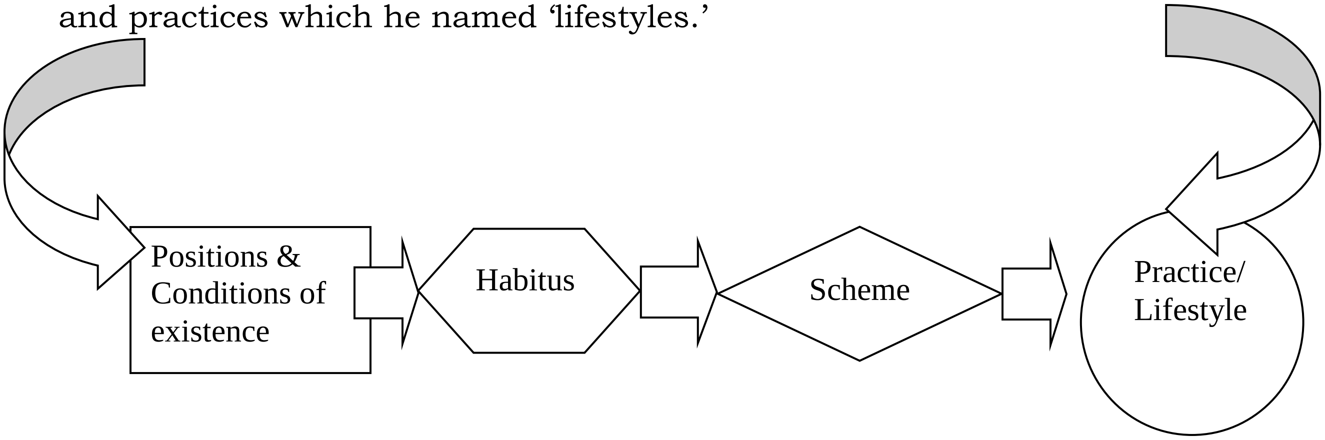


Figure1.

By examining the ‘position’ of people living with HIV, the context in which they live, their social position and conditioning, specifically the historical dynamics of their social milieu, and their relationship to all that makes up these entities as well as the everyday stigma that they as a group and as individuals must contend, the sociological perspective of Bourdieu facilitates this inquiry. HIV transmission rates are interrelated and fundamentally due to contextual and structural factors like higher poverty rates, lack of access to adequate healthcare, lower income and educational attainment, and racism (Adimora, 2006; Aral, 2008; Chu & Selwyn, 2008; Gehlert, 2008; Laveist, 2007).

Through this ‘relational dialectic,’ this interchange of the historical and current, the transaction between one’s positioning in social space, one’s economic status, one’s geographic and social conditioning all play a role in one’s expectations, habits, and practices. It is therefore necessary to explore specifically the historical context and structural environment more closely.

Racialized Position

The practice of historic and contemporary forms of racism and discrimination towards African Americans (Latif & Latif, 1994); Washington, 2006) has not only contributed to conditions of poverty and inequality (i.e., limited access to educational and employment opportunities and quality healthcare), but has served to produce and reproduce a network of governance and social ordering through the interchange of dynamics such as those noted above. This dynamic illustrates the notion of the 'relational dialectic.' According to the CDC, African Americans are disproportionately affected by HIV/AIDS and continue to shoulder the burden of infections (2011). Critical inquiries into a range of social, economic and political forces impacting African Americans' health are urgently needed. Unfortunately, to date, there is a lack of research examining the complex interplay between these broader level contextual factors and HIV/AIDS related outcomes. Although discussions about racism and poverty are mentioned in public health literature (Clark, 2001; Darity, 2003; Kreuger, Wood, Diehr & Maxwell, 1990; Utsey & Hook, 2007), few attempts have been made to extensively address their relationship to HIV in research or health promotion or prevention interventions. I assert that understanding the social and economic realities faced by African Americans is a necessary requisite to effectively explore the facet of place attachment in this sample of people living with HIV/AIDS.

James Jones (1972) defined racism as the 'use of power against a racial group identified as inferior by individuals and institutions with the intentional or unintentional support of the entire culture.' Bulhan (1985) expanded on this definition as a 'form of violence' whereby persons are violated on the basis of race. Further, Clark, Anderson, Clark and Williams (2002) employed the definition as 'attitudes and beliefs that demean individuals or groups as a result of physical attributes and/or ethnic group affiliation.’ Jones (2003) described racism as a ‘system that structures opportunity and value based on race, thereby undermining the full potential of the entire society because it unfairly disadvantages some communities while it unfairly advantages others.’ Overall, these definitions maintain that racism is used to justify inequality towards, supremacy over, and exclusion of particular individuals based on race, thereby infringing upon the physical, psychological and spiritual well-being of the community (Washington, 2006).

Position of Poverty

Poverty, a complex and multidimensional concept, has been defined in different ways; however, more commonly it refers to ‘income deprivation.’ The World Bank defines poverty as ‘an income level below some minimum level necessary to meet basic needs.’ The greatest challenge however, lies in measuring poverty and determining a poverty line or a threshold at which an individual or a household is classified as poor (Coudouel, Hentschel, & Woden, 2002). The official poverty measure used in the United Sates is an absolute one and is based on a formula developed in 1964 by the Social Security Administration (Dalaker, 2005.) It is widely suggested that the current measure is outdated and no longer accurately portrays the amount needed for a decent living in the United States (Iceland, 2003). In contrast, more recently developed relative measures such as those created by the National Academy of Science (NAS) are believed to more accurately reflect those living in poverty (Iceland, 2003) by taking into account such factors as geographic location, family size, costs of food, housing, utilities, clothing, non-cash benefits, and some cases medical expenses and work related expenses (Dalaker, 2005). Depending on the definition used, poverty estimates can range substantially. However, according to the official poverty measure, 46.2 million people or 15.3% of people in the United States, in 2011, lived in poverty and 27.6% were Black, the highest for all racial groups (U.S. Census, 2011) www.census.gov/acs/www/Downloads/data_documentation/AccuracyACS_Accuracy_of_Data_2011.pdf.

Inequalities in mortality and infirmity have remained consistent for African Americans from the inception of the government tracking these statistics (DHHS, 2011). In the United States, a history of deeply rooted racist ideologies resulted in widespread, institutionally-supported, discriminatory practices used to exclude African Americans from full participation in society (Bulhan, 1985; Randall, 2006; Washington, 2006; Wiliams, 1987). Some suggest that the resulting health consequences have been most profound among African Americans as evidenced by their suffering the brunt of the health disparities (Clark et. al., 2002; LaVeist, 2002; Mays, 2007; Paradies, 2006.) For example, the effects of racism have been linked to the health disparities in chronic conditions such as cardiovascular health (Harrel, 2003; Kreiger, 2000; Wyatt, 2000), mental health (Jackson, 1996; Kwate, 2003; Williams & Williams-Morris, 2000), emotional health (Lewis-Trotter & Jones, 2004; Morris-Prather, 1996), and HIV/AIDS (Bhara, 2003; Lemelle, 2003). The most commonly reported outcomes of studies on race-based discrimination are negative mental health outcomes (Klonoff & Landrine, 1999). Depression, stress, anxiety and pessimism have been shown to be associated with experiences of racial oppression (Bowen-Reid & Harrel, 2002; Moor, 2000) and poverty (House & Williams, 2000; Williams, Yu, Jackson, & Anderson, 1997).

Although there are a number of causal pathways through which poverty affects health, it is critical to understand the cyclical nature of these relationships, these ‘relational dialectics’ that get played out in our habits, our thinking and our lifestyles.

Conditions of poverty (i.e., lack of access to quality healthcare) can result in poor health, and poor health can hinder one’s ability to be economically self-sufficient (i.e., not being able to maintain employment due to illness). Explanations for increasing levels of unemployment, underemployment and income inequities among African Americans are vast and continue to be issues of growing concern and constant debate. In recent analysis, Woolf, Johnson, and Greiger (2006) reported that poverty has increased most dramatically among the most marginalized, including African Americans. Although there have been increases in occupational mobility and wage parity over time, African Americans continue to experience stark disparities in employment rates and job earnings and are more likely to be chronically unemployed for a period of 6 months or more (Census, U.S. Census Bureau, 2011). Racism also impacts the economic health and stability of the family.

According to the 2011 Current Population Survey, African Americans were more likely to have never been married, and more likely to be divorced and separated when compared to other racial/ethnic groups (Census, 2011). Moreover, nearly one out of every three African American families with children under the age of 18 is maintained by the mother only (Census, 2011).

It is therefore impossible to note in this study the universal properties of places that give rise to appreciation, meaning and place-related emotions without first discerning the essential features of the context, and the experience of the geographic positioning.

Geographic Positioning

Although African Americans are knowledgeable about HIV risk factors and report fewer high-risk HIV related behaviors than other high risk racial or ethnic populations (Hallfors, Iritani, Miller, & Bauer, 2007; Kaiser Family Foundation, 1998; Millet, Peterson, Wolitski, & Stall, 2006), such knowledge may not translate into engaging in fewer risk behaviors or lower prevalence of HIV in African American communities. To date, most HIV prevention research has focused on determinants of infection at the individual level, such as socio-demographic characteristics and current sexual and drug risk behaviors, or increasing knowledge and improving decision making about behavior and risk. Research that addresses more distal causes of HIV risk behavior is less developed. Over the past few decades, a growing body of literature suggests that the more distal causes of HIV risk behavior, such as the experience of violence and the psychological sequelae that follow, such as depression, stress syndromes, and substance abuse may contribute to increased HIV risk behavior among African Americans.

Although a direct causal association between traumatic events, mental health, and HIV risk behavior has not been established, a number of studies have associated traumatic life events with behaviors related to increased risk of HIV. This suggests that the '*place in which one is situated*,' the location, their 'station' if you will, could serve as a mediator through which traumatic events impact HIV risk behaviors. It is therefore paramount to consider that the 'relational dialectic' discussed earlier as part of Bourdieu's sociological perspective is playing a binding role in bridging the social positioning of the African American to its' geographical positioning, and in doing so mediates or facilitates the possibility of increased exposure to certain traumatic events, such as exposure to violence or violence victimization, particularly as they occur within the context of cultural norms that limit access to and use of support services.

High Crime Neighborhoods

High crime neighborhoods have increased reports of violent events and this has a great impact on the residents living within the confines of these places. For instance, a survey of the New York City Police Department's 'CompStat,' a report presenting figures of Crime Statistics in specific precincts in New York City that reflect the New York State Penal Law definition of violent crimes demonstrated that predominately Black neighborhoods, like those represented in the 73rd and 83th Precincts which includes Bushwick, East New York, Ocean Hill-Brownsville, Cypress Hills, Starrett City and City Line, reports to date, 24 Murders, 48 Rapes, 688 Robberies, and 789 Felony Assaults (November, 2011). The neighboring predominately Black Queens Precinct, the 113th Precinct, which includes the Southeastern area of Jamaica Queens, St. Albans, Hollis, Springfield Gardens, South Ozone, and South Jamaica reports 14 Murders, 26 Rapes, 366 Robberies, and 438 Felony Assaults to date (November, 2011). The 26th and 32nd Precincts in Manhattan encompasses Morningside Heights and Central Harlem, also has a large predomination of Blacks reporting 8 Murders, 27 Rapes, 211 Robberies, and 295 Felony Assaults. The 43rd Precinct in the Bronx, which includes Parkchester, and Castle Hill and also has a predomination of Black and Hispanic residents reports 16 Murders, 21 Rapes, 459 Robberies, and 484 Felony Assaults. These statistics are in stark contrast to some predominately white neighborhoods in New York City like the 84th

Precinct in Brooklyn which includes neighborhoods like Brooklyn Heights, Boerum Hill and Vinegar Hill which report for the same time period, 1 Murder, 3 Rapes, 150 Robberies, and 118 Felony Assaults. Further, the 19th Precinct in Manhattan which encompasses the Upper East Side of New York City, is predominantly White and has the highest Income Ratio per household of any other Precinct reports, 2 Murders, 13 Rapes, 121 Robberies, and 100 Felony Assaults. The precinct of 112th encompassing the Forest Hills, Rego Park and Middle Village sections of Queens respectively and are predominantly White reports 2 Murders, 9 Rape, 105 Robberies, and 62 Felony Assaults. Finally, Staten Island's 123rd Precinct which includes the South Shore of Staten Island and is predominantly White, reports 2 Murders, 1 Rape, 31 robberies, and 45 Felony Assaults. I have included an interactive map http://projects.nytimes.com/crime/homicides/map created by Dr. Steven Messner, a Professor of Sociology at the University at Albany, State University of New York noting all homicides in the five boroughs of New York City since 2003, the race of the victim and perpetrator, gender, age and specific geographic location of the crime (New York Times, 2009). The statistics demonstrate a stark difference in violent crime and therefore experience with violence between Blacks and Whites in New York City. These statistics do not however account for the misdemeanor crimes which far outnumber the felony crimes and can arguably be more devastating, as they occur more frequently and can act as 'primers' for those living in these high crime neighborhoods and lay the foundation for ongoing victimization.

Traumatic events are unanticipated and uncontrollable events characterized by a sense of horror, helplessness, and threat of serious injury or death (CDC, 2011). The lingering effects of trauma vary and are largely a function of the type of trauma experienced, for example interpersonal or natural disaster, age and developmental level at the time of the traumatic event; perceived severity of the traumatic event; repetitiveness of the trauma; and relationship with the perpetrator of the trauma event (Breslau, Chilcoat, Kessler & Davis, 1999; Briere & Elliot, 2003; Cusack, Frueh, & Brady, 2004; Felitti, 1998). Emotional and behavioral symptoms can be short-term (i.e. days or weeks) or long-term (i.e., months or years), and can first appear months or years after the original event occurred. Most people recover from traumatic events without intervention, but some, particularly those who have experienced previous traumatic events or face ongoing stress related to the event, require intervention (Gillespie, 2009; Wyatt, Guthrie, & Norgrass, 1992).

Prevalence rates of experiencing traumatic events vary widely, ranging from 20 to 89.6% (Alim, 2006; Cusack, 2004; Breslau, 1998). According to the National Comorbidity Study (NCS), the first nationally representative mental health survey of U.S. males and females aged 15 54 years, approximately 60.7% of males and 51.2% of females experienced at least one traumatic event in their lifetime (Kessler, Sonnega, Bromer, Highes, & Nelson, 1995). The most commonly reported events were witnessing someone being injured or killed, being in a natural disaster, and being in a life-threatening accident. Males were significantly more likely to experience these traumatic events than females (1-36% vs. 14-15%), whereas females were more likely to report rape, sexual molestation, childhood parental neglect, and childhood physical abuse (3-12% vs. 1-3%). Race, sex, gender, age, income, personality traits (i.e., neuroticism, extroversion), early conduct problems, family history of psychiatric disorders, and previous assault history have been identified as risk factors of experiencing traumatic events (Heck & Parker, 2002; Acierno, Resnick, Kilpatrick, Saunders, & Best, 1999; Breslau, Davis, & Andreski, 1995; Zierler, Witbeck, & Mayer, 1996).

Exposure to traumatic events may not be random; environment and location of residence as discussed earlier can play a role (Breslau et al., 1995). Neighborhood characteristics, social controls and discrimination may contribute to increased exposure to and experience of violence for residents living in impoverished communities. Compared with Whites, African Americans appear to be at higher risk for certain types of traumatic events, related in part, to the structurally and economically disadvantaged urban neighborhoods where they are more likely to reside (Alim et al., 2006; Breslau et al., 1998; Kisera & Black, 2005). Characteristics associated with such neighborhoods often include high unemployment rates, homelessness, crime, violence and substance abuse (Wilson, 1987). Factors at the neighborhood level—such as poverty, residential instability, and discrimination may serve as an underlying mechanism through which structural inequalities operate. These mechanisms may impede the establishment of formal and informal institutions of neighborhood organization and social ties that are believed to maintain and foster strong and safe neighborhoods or communities (Browning & Cagney, 2002).

Data confirm that non-whites who live in urban settings are at increased risk for violence victimization. Breslau (1998) estimated the lifetime prevalence of assaultive violence (rape, sexual assault, and being badly beaten up) to be two times higher among non-whites than Whites, persons who have not graduated from college versus college graduates, and persons living in low-income households versus college graduates, and persons living in low-income households versus persons living in high-income households.

It follows that a person positioned in high crime environments, primed to expect violent acts in their social space will face multiple stressors on a number of levels, and these multiple effects can only help solidify structural inequalities that impede and thereby affect one's ability to form attachments in the community. It is here that we must again inject into the discussion the notion of 'relational dialectic,' as it is apparent that it is 'in the nature of the person's position and the conditioning (social learning) of that position' that the transformative process that effects, changes and creates both the position and the conditions that govern 'practice' takes place. By 'practice,' I mean, their 'practical sense' or 'common sense habits of thought and routines' that are embedded in the precedents of the social milieu, the 'relational dialectic.' Further, and adding to this notion, the transformative process is in response to, and initiated by the 'relational dialectic.'

When examining these elements from this sociological perspective of positioning and conditioning, the effects of this 'sense' and its impact on a person's practical use and movement in social space come into view.

Habitus

Rogan, O'Connor, and Horowitz (2005) used semi-structured interviews of ten participants to explore a person's sense of place in the context of their surroundings, and found that places are more than mere drop-backs to experience, as participants described complex and intimate relationships with their environments. Through narrative analysis they found places were instilled with highly personal meanings and were vehicles for learning and personal growth. They represented family continuity, provided places of spiritual significance, regulated emotional attitudes towards their surroundings, and highlighted the complexity and breadth of community attitudes. Further, knowledge and understanding of the physical environment was a significant theme discussed by the participants and was commonly expressed in terms of an ongoing, developmental process (Rogan et. al., 2005).

Dixon and Durrheim (2000) suggest that intimate knowledge of a place is incorporated into the self-concept, a premise central to the concept of place attachment. Knowledge is mentioned in the literature within the context of place attachment although generally refers to 'knowing' the location of physical features within the environment (Gustafson, 2001; Horowitz, Lindsay, & O'Connor, 2002). The interviews suggest 'knowledge' has a much greater significance in the development of place meanings than is acknowledged in the literature. Bourdieu (1984) noted that 'habitus' is simply the dispositions acquired through the relationship between the initial and present position in social space. I argue, these dispositions are themselves 'knowledge,' that they actually constitute the 'practical sense' or 'common sense' of the agent in its various forms based on their initial and present position in social space. Bourdieu goes on to explain, they are regarded here not as 'true' or 'valid' or 'scientific' knowledge but rather as effective, truth-producing dispositions that provide discursive conditions for real social practices (1984). These dispositions are themselves products of the same cultures and social structures that produce and reproduce the 'practical sense' of the agent. Therefore, what constitutes 'knowledge' or I submit how a person comes to 'know' is also worthy of further consideration in light of this perspective.

Practical Sense/Routines

Pierre Bourdieu's work (1984) offers a way to explore the nature of experience and its effects on a person's practical use and movement in social space. It should also be noted that these practices are themselves created and supported by those same relations and Bourdieu suggests it is in this method that a person comes to 'know' through the notion of what he interchangeably calls 'synoptic schema' or 'habitus.' He further explains 'habitus' is that which guides everyday life and is grounded in the social conditions and conditioning characteristic of a given position in social space. He suggests that it is not just that which is acquired through acculturation into certain social groups such as class, a particular gender, a racial group, family, or peer group, but that of the conditioning located within a particular position that exerts its influence on personal evaluations, use and actions within the physical environment. With this in mind, perspective may therefore effect practice, and therefore a person's use and movement in their social and physical environment.

Mobility

When mobility is discussed in relation to place attachment and connectedness to a setting (an affective bond or link between people and specific places), the focus is often on change in permanent residence. However, (Gustafson, 2001) suggests that temporary forms of mobility (i.e. travel for leisure or work) should also be considered. The study presents findings from a qualitative interview study that suggests that people may regard place attachment and mobility, and the relationship between them, in several different ways and suggests a 'roots/routes' perspective that investigates the perceived meanings of relationships between place attachment and mobility.

Social theorists are often somewhat skeptical about the importance of place and place attachment, as people seem to be increasingly mobile, and their social relations and other everyday experiences are increasingly dis-embedded from physical locations (Calhoun, 1991; Giddens, 1991).

Generally, movement is a means available to some people for gaining greater congruence between salient needs, access to environmental or territorial resources (Stokols & Shumaker, 1982; Stokols & Taylor, 1983; Stokols & Martinez, 1983), enhancing aspects of the life situation as well as a means to advance within society (Harris, 1981). Knowing the place, knowing the people living there, and maintaining good relations with neighbors and other local residents is important. It gives a sense of security of being part of a local place-based community. Gustafson (2001) found when focusing on place as 'roots,' people often strongly associated places with the people living there. Continuity, long-term relations with place and people was also found to be highly valued together with place-bound traditions, local organizations, and other associations of various kinds (Hay, 1998). In addition, 'roots' were found to involve identification and a sense of representing one's place in encounters with people from other places. Therefore, 'roots' mean that place is highly specific, something literally irreplaceable. The researchers found that place was tightly bound to individuals, biographies, experiences, emotions, local social networks, and other forms of context-dependent knowledge and resources.

Further, the 'routes' theme focused on mobility, traveling, and discovering and exploring new places that fulfilled important needs. Finally, the studies indicate that place attachment as well as mobility may contribute to individual well-being and life satisfaction. Further, both appear to mean different things to different people in different situations and suggest careful examination of peoples ‘roots’ as well as their ‘routes’ may be a fruitful approach toward understanding the role of place, place attachment and mobility in contemporary society.

Aims of the Study

Drawing on the literature of Altman & Low (1992), Gustafson (2001), and Bourdieu (1984) I explored how the transformative effects of an HIV diagnosis and heterosexuality or homosexuality (sexual identity) and sexual behavior (men who have sex with women, or men who have sex with men) are different but are both a part of the 'relational dialectic' that informs and effects behavior and may influence the perspective of what people living with HIV/AIDS 'know' or their 'habitus,' and inform their sense of place and connectedness to a setting/place attachment, and influence their use and movement within social space. In consideration of these issues and their possible impact on 'practical sense,' it is a relevant issue for this particular study. Further, using cognitive mapping, I explored the places frequented, noting physical settings, how these settings were used, evaluated, perceived and individual movements within these settings.

Research Question:

How does ones' positioning and conditioning, connectedness to a setting/place attachment inform ones' 'practical sense,' and sense of constriction or openness in ones' post-diagnosis world?

Subquestions:

1) How, do HIV+ newly diagnosed people and those diagnosed three or more years prior use, evaluate, move and internalize their physical surroundings?

2) How is the experience of use and movement in socio-physical space as well as perception transformed for newly diagnosed people and those diagnosed three or more years prior?

3) In what ways are use and movement of newly diagnosed HIV+ people and those diagnosed three or more years prior conditioned by their position in social space

4) In what ways do newly diagnosed HIV+ people and those diagnosed three or more years prior believe they are influenced by their social space and surroundings

5) How does heterosexuality or homosexuality inform one's experience of use, movement, and perception for newly diagnosed people and those diagnosed three or more years prior

Methods

Research Design

This research uses a mixed theory approach of grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990) and phenomenological tradition represented by Heidegger (1962) and Merleau-Pnty (1962) to examine the (3) phenomena related to place in the lives of people recently and those diagnosed three or more years prior with HIV: (1) connectedness to a setting/place attachment and (2) 'habitus,' and finally (3) physical mobility. As is typical of a grounded theory approach, data analysis began during the data collection phase and proceeded on the basis of the issues that emerged from the initial focus group. It is for this reason a second group was necessary. The group dynamic was also important as 'knowing,' or 'habitus' according to Bateson (2000), 'only exists thanks to the movement of the perceiver relative to his or her surroundings,' which are themselves created by the conditioning in which that positioning exists. It appears this notion of probing consciousness changes, forms, and patterns, both on a social and individual level and how that translates into 'practical sense,' or what Pierre Bourdieu calls 'intuitively responding from personal emotional resources to 'act spontaneously out of his own integrity,' which I submit includes one's movements and roots/routes is relevant in this phenomenological approach (2000). Further, the individual interviews were used to respond to these initial data collection phases and were in essence a method by which to gather a thicker description of detail in the transformative effects of an HIV diagnosis, connectedness to a setting/place attachment, and a diagnoses (either newly diagnosed, or diagnosed 3 or more years) influence on use and movement within social space. For example, throughout the data collection phase a chart was maintained of the demographic data of the respondents. This chart was continually reviewed to ensure diversity, varied on race (Black or White), income, marital status, and sexual identity (heterosexual or homosexual) because these demographics emerged as important in earlier studies (Brown & Perkins, 1992; Chawla, 1993; Clark, 1989; Dovey, 2002; Keith & Pile, 1993; Moore, 2000; Seamon, 2000; Virden & Walker, 1999; Taylor, 1989). This procedure follows Trost's (1986) recommendation for strategic non-probability sampling, which aims for variations in qualities of respondents as a way to explore phenomenon, rather than for representativeness for statistical generalization (Gustafson, 2001). The individual interviews were also used as a method to pay close attention to specific instances of the phenomenon noting qualities and characteristics that accurately describe the essential nature and meaning of social space in the lives of people living with HIV/AIDS. This research had (2) phases, the first phase included (2) focus groups (See Appendix A for the transcript), and the second phase included semi-structured interviews (See Appendix B for the transcript). The focus groups were performed prior to the individual interviews.

Focus Groups

In the first phase, which included (2) focus groups, one set of groups had the specific objectives of the study disclosed to them, and the researcher surveyed the respondents on the types of questions and information they believed needed to be collected to capture their sense of social space. The focus groups and their interactions were used as a way to gain information about this very focused and specific issue of space in the lives of HIV positive people and their experience of its use, their movement, evaluation and interactions within the spaces they signified as important, frequented, and most ‘at home’ in. Their answers to these particular questions were also recorded.

The (2) focus groups consisted of (8) respondents with the initial group comprised of (2) newly diagnosed homosexual and (2) heterosexual HIV positive people, and (2) homosexual and (2) heterosexual HIV positive people who had been diagnosed three or more years prior. This particular group of respondents were each given a copy of the specific objectives of the study which were also read aloud during the group, then they were asked to comment or suggest questions that they might want to have included, excluded or expanded to best examine the topics of connectedness to a setting/place attachment and the things, people and/or events that play a significant role in their experience of place, and the movement between those places.

The second group, like the initial group, also comprised (2) newly diagnosed homosexual and (2) heterosexual HIV positive people, and (2) homosexual and (2) heterosexual HIV positive people who had been diagnosed three or more years prior. This group of respondents were each given a copy of the list of questions the initial group devised which were also read aloud, then they were asked to critique and explore why they might include, exclude or expand the questions that best examine the topics. This groups answers were also recorded and helped to further critique and inform the results.

These groups helped discern through the group process, the role of place and spaces in the lives of HIV+ people, and to identify trends and patterns in perceptions. We also explored how, if at all, people with HIV perceive their HIV diagnosis had influenced a physical or social transformation.

Semi-structured Interview

The second phase included (20) voice-recorded semi-structured interviews (See Appendix B) consisting of (19) questions designed to assess respondents sense and use of place, movement and evaluative and transformative perspectives which took approximately 30 minutes each. The respondents included (5) self-identified newly diagnosed HIV+ heterosexuals, (5) self-identified newly diagnosed HIV+ homosexuals, (5) self-identified HIV+ heterosexuals diagnosed three or more years prior, and (5) self-identified HIV+ homosexuals diagnosed three or more years prior.

The taped interviews were conducted on an individual basis and started by asking respondents about their gender, race, age, sexual preference, and education. The researcher then began exploring respondents experience of place prior to diagnosis, asking very broad questions about place, sense and use of place and movements between places perceived as significant, and continued with more specific questions to explore transformational dynamics. To explore their level of openness or constriction, I simply asked using a likert scale design, their ‘level of openness,’ pre and post diagnostically. (See Appendix B)

Cognitive Mapping

The cognitive mapping exercise (See Appendix A) was incorporated in the interviews where each respondent was asked specific questions about the places they frequented and then asked to note their physical settings, the ways they used, evaluated and perceived their movements and how they spent their time. This technique is useful in this study because cognitive mapping techniques aim to provide a tool for revealing peoples' subjective beliefs in a meaningful way so that they can be examined not only by the individual for whom the map is constructed, but also by other individuals and groups (Eden, 1992). It is a form of memory which is a series of psychological transformations by which an individual acquires, codes, stores, recalls and decodes information about the relative locations and attributes of phenomena in their everyday spatial environments. Cognitive mapping techniques reveal concepts that people hold to be important, but they vary in terms of the nature of the relationships among concepts that they identify. Therefore an advantage of the cognitive mapping technique in this particular study (over, say, simply asking someone what they think) is that it allows knowledge to be externalized in some sort of visual-spatial layout that is then open for critical reflection. In this way subjective knowledge can be to some extent 'objectified' and therefore discussed in a less daunting manner than direct questioning. These mental models are referred to, variously, as cognitive maps (Tolman, 1948).

In this task, I simply asked, as a part of the semi-structured interview (See Appendix B) respondents to list (3) current places they frequented during a ‘typical’ week, the purposes they served, and a follow-up question regarding their method of transportation to each of these (3) places. Further, and to clearly discern and specifically acknowledge the respondents movements, methods of transportation, use and purposes, I simply transcribed the (3) current places the respondents reported to frequent in the cognitive map section and asked, ‘Does this look like a typical day for you?’ I made additions, wherever necessary to the map as directed by the respondents in response to the question, ‘If not, where else do you go?’ noting approximate distance and time. The analysis of this data included noting all the cognitive mapping locations, purposes (use), and methods of transportation with approximate distance and travel time, and then correlating each with a number of variables, including connectedness to a setting/place attachment, physical surrounding with significant features inside and outside, significant people, groups, events, the respondents’ occupation, diagnosis date, and reported health status. Therefore using the cognitive mapping task, respondents reported on their movements, impressions and actions, and recorded other significant players involved, types of interactions, and situations and settings they signified as influential in their lives. Further, the measurement of mobility came through the subjects’ estimates of total distances traveled by various modes per week.

Through this task, the researcher was able to locate and note movements, actions, significant players, specific types of interactions, and differentiating situations and settings noted as influential in the lives of HIV+ people. All respondents were provided a statement of confidentiality along with the study disclosure (See Appendix C), and given a $10 CVS Gift Card for participation. Respondents were further informed that they could choose to discontinue the study at anytime without penalty.

Site Selection

Respondents were solicited by public flyer (See Appendix D) in key locations such as community based organizations and service centers serving HIV positive heterosexual, homosexual Black and White males. Specifically, programs like Harlem United which serve a diverse HIV+ population that includes heterosexual men, The Gay and Lesbian Community Center that has specialty services for the Gay, Lesbian and Transgender Population, and Housing Works that also services a diverse group of HIV positive people who are homeless in New York City. Each of these programs has community resource bulletin boards where public flyers were placed. The flyers (See Appendix D) included a specific statement about confidentiality that informed prospective participants that the contact number is a private, non-shared line and that any identifying information that might be left would be held in strict confidence and would not be shared by either the Principal Investigator or her advisor.

Respondents

For this study, the respondents were restricted to certain fixed variables to allow some uniformity among respondents for comparison. Specifically, all respondents were required to be: (1) residents of the New York City metropolitan area; (2) HIV +, diagnosed three or more years or diagnosed within 6 months; (3) male; and (4) English speaking. First, all respondents were residents of New York City not only because of accessibility, but to provide a common base of experiences via a common current "hometown." Exploring the environmental experiences of residents from one city makes it possible to examine the kinds of places that are important for urban dwellers living in the same city. Second, to explore the transformative dynamic of an HIV diagnosis, it was important to locate respondents based on a particular life event (becoming HIV +) to better discern the issues faced at this life stage. Third, we limited the perspective of race and gender to include only self-identified Black and White male respondents as our research and previous research suggests the stigmatizing nature of HIV, the varying perspective of experience, and one's sense of place may have some effect on perception of access to support and resources. Finally, it was required that all respondents be English speaking to minimize comprehension issues within the group setting or during the individual interview.

In contrast to the fixed variables described above, respondents were selected to include a range of demographic variables such as race (Black or White), marital status, sexual identity (Heterosexual or Homosexual), income, occupation, health status, and education. Each variable may have an impact on our experiences of places. For example, those with greater financial resources generally have access to more places than those with fewer resources. Conversely, it has been argued that poverty has its own location in space, most visibly in ghettos (Clark, 1989).

A total of 36 self-identified HIV+ male respondents--(9) newly diagnosed HIV+ heterosexuals, (9) newly diagnosed HIV+ homosexuals, (9) HIV+ heterosexuals diagnosed three or more years prior, and (9) HIV+ homosexuals diagnosed three or more years prior) who were at least 18 years old participated in the study. I obtained a population distribution of ages at the time of diagnosis with the highest proportion of diagnosis rates ranging between 27-57 years, with a mean of 45 years. Table 1 shows the interval distribution by respondent mean age or the average. The main advantage of the mean is that it takes all the ages into account and therefore makes it a sensitive measure of central tendency, in that it describes how the data cluster together around a central point (Patton, 1980).

Table 1.

AGE	Mean
25-34 (n=5)	32
35-44 (n=10)	41
45-54 (n=18)	48
55-64 (n=3)	58

As regards to race, sexual identity and diagnosis, there were (15) Black Heterosexual Men, (15) Black Homosexual Men, (3) White Heterosexual Men, (3) White Homosexual Men, of which (18) were newly diagnosed (diagnosed within 6 months of the interview or focus group), and (18) were diagnosed 3 years or more prior. Regarding marital status, (16) of the respondents reported being single, (2) were married, and (1) was separated and the other divorced.

Social position was determined by the respondents' declared income, education, geographical position based on zip code of residential neighborhood, self-reported health status, and openness toward interacting with others previously and post diagnostically.

This classification of the respondents revealed (13) of the respondents reported an income of less than $25,000 in the prior year, while (7) reported an income of $25-49,000 in the prior year. The respondents reported (14) had either a high school education or a graduate equivalency diploma (GED), while (6) had a grade school education, having never attended high school.

As for zip code of residential neighborhood, the respondents reported seven resided in Manhattan, most frequently within the 10030, and 10027 zip codes of the Central Harlem and Morningside Heights sections. Five respondents resided in the Borough of Brooklyn, most frequently within the 11212, and 11233 zip codes of Cypress Hills and Ocean Hill-Brownsville sections. Further, five respondents resided in the Bronx, and were more dispersed, residing within the 10463, 10472, 10467, 10452, and 10459 zip codes of the Soundview, Castle Hill, Jerome Park, Mount Eden, and Hunts Point sections. Two respondents resided in Queens, most frequently within the 11434 and 11432 zip codes of St. Albans, Springfield Gardens, South Jamaica and Hollis sections. And finally, one resided in Staten Island, the Stapleton section.

Findings

We have seen that place attachment develops to different degrees based on one's positioning and conditioning in social space. The groups yielded some interesting results. First, as we expected and in agreement with the results that prompted this study, respondents experienced constriction, as discussed earlier as a technique to maintain privacy about ones' HIV status, but that also discouraged social relations. (See Table 2 & 3)

Respondents, regardless of their group, meaning heterosexual or homosexual, newly diagnosed, or those diagnosed three years or more illustrated some level of constriction pre-diagnostically. Further, the Heterosexual respondent group reported less constriction post diagnostically, whereas, the Homosexual respondent group reported some level of increase constriction post diagnostically. Also, the older the respondent, the more likely they were to report higher levels of constriction regardless of whether they were reporting their pre-diagnostic perspective or their post-diagnostic perspective. Parental influence also had some congruent effects, in that respondents' who reported a Parental influence that encouraged sticking with one's own group had higher levels of constriction, while those who reported a Parental influence that encouraged seeking information outside of one's immediate support networks had lower levels of constriction. Those respondents' who reported less constriction pre-diagnostically reported higher levels of mobility in that their cognitive maps post-diagnostically reflected on average more places frequented, were communal in nature and that their use of these settings were used as a method to gather information and support. Further, levels of constriction affected education and income in that the lower a respondents' education and income, the higher their levels of constriction pre and post diagnostically. Further, respondents' who lived in high crime neighborhoods were more likely to go farther to seek this support.

Regarding health status, ten respondents reported their health status as average, while six said it was very good, and four said it was poor. There were seven respondents that reported their Level of Openness prior to being diagnosed as 'Very Open, seven said it was 'Somewhat Open,' and three respectively said it was either 'Somewhat Not Open,' or 'Not at all Open.' Post diagnostically, nine of the respondents reported their Level of Openness as 'Somewhat Open,' six said it was 'Very Open,' four reported it as 'Somewhat not Open,' and one as 'Not at all Open.' (See Table 2 & 3)

The findings illustrate, as noted earlier, their social conditioning and positioning prior to diagnosis appeared in some ways to 'arrange' their level of constriction post diagnostically, and lay the groundwork for their 'practical sense' social relations. (See Table 5)

Newly diagnosed Heterosexuals ‘The Go it Aloner’

The respondents who identified as newly diagnosed heterosexuals noted the highest levels of constriction pre-diagnostically. This group was more likely to report their ‘health statuses as ‘Average,’ and their ‘Level of Openness’ pre-diagnostically as ‘Not at All Open’ and post-diagnostically as ‘Somewhat Not Open.’ This group reported average age of 46 years old.

They reported conditioning that their parental influence was one of ‘sticking together,’ not seeking or utilizing support outside the immediate family structure’ or as one respondent noted, ‘we all we got.’ They were more likely to have not finished high school, more likely to have reported substance abuse, incarceration and high levels of unemployment prior to being diagnosed. They were more likely to note that they felt most ‘at home’ in one-on-one situations with their doctor or nurse at a program or private doctor’s office. These respondents reported the average time to start attending ‘regularly’ scheduled appointments (at least 1 time a month) with major HIV supports (Infectious Disease Doctor/Clinic, Virologist and/or Primary Care Provider and follow-up with blood work was approximately 5-6 months. This particular question emerged from the focus groups in which both groups noted the need to collect such information to capture their sense of space. Notably, they reported being linked to these supports through their initial testing source, but chose to change their providers to better suit their needs. Their responses from the focus groups revealed the most constriction with statements like:

> **‘Before I got diagnosed I used to look at HIV people like they was slime, dirt, people nobody wanted to be around…faggots, degenerates…But when God did it to me, I realized I had to be humble to people, God humbled me.’**

> **‘I was going back and forth to jail…using (drugs) made me not be around nobody too much.’**

> **‘I only go to my program and the clinic cause the people there are like me.’**

Here the respondent notes a sort of ‘arrangement’ by God seemingly indicating his unwitting ‘situatedness’ in a previously perceived undesirable position…HIV positive. The sheer vitriol by which he describes people living with HIV illustrates his complete disdain and therefore possible initial repugnant response about his own position. It’s clear he integrated a more positive position, but it could be imagined that if his beliefs were accurate with his statements, he would not or could not share his status initially for fear of being judged in the way that he had once judged. Further, and following this notion of ‘narrowing’ or ‘restriction’ of social interaction or confinement of social space, another respondent notes his use of drugs as a major factor for his self-imposed confinement. Finally another respondents’ emphasis on ‘I *only* go to my program…’ suggests the limited nature of this otherwise social activity.

This group noted questions that they thought important, and should be included when exploring the perspective of HIV positive people as it relates to their sense of place and surroundings:

> ***'How do you make sure your information is kept confidential?'***
>
> ***'How can I meet people just like me?'***
>
> ***'How do we inform others close to us so that they're not afraid?'***

These questions and the answers, particularly when exploring the perspective of one's sense of place and surroundings in the focus group, highlighted their disposition of 'high levels of constriction,' with questions that insured their status remained confidential, increased the likelihood of meeting other individuals that shared their status, and included instruction on how to maintain the support of loved ones. Their responses to these questions revealed this particular perspective.

> ***'Go to a clinic or office where you know you ain't gonna run into nobody you know'***
>
> ***'If you go to them groups sometimes you can hook-up or even at the program'***
>
> ***'If they HIV, and you HIV, then it's easier'***

Incidentally, and as mentioned earlier, this group specified they most felt ‘at home,’ in one-on-one situations with their healthcare providers at a program or private office which demonstrates the nature of one’s position and conditioning can be an imposing force in one’s everyday choices and dispositions.

Post diagnostically, their constriction was notably reduced but this group’s constriction still remained higher than any other group.

This group noted use of their physical environment pre-diagnostically as almost exclusively limited to their immediate neighborhood. They reported activities like: playing basketball, going to the movies, dating, going to bars and frequenting local hotels with sex workers, going to ‘Off Track Betting’ locations, doing odd jobs, going back and forth to jail, street hustling---drug dealing and committing petty crime like shoplifting, fare beating and other low level larcenous natured offenses. Regarding employment, their responses included working as a HVAC repairer and security work.

Post-diagnostically, this group reported significant places or spaces they deemed important like going to their doctors office and attending a daily drug or day program, attending program events like ‘Splish Splash,’ ‘Great Adventure,’ Washington D.C. for advocacy trips, attending program sponsored plays, skating in Central Park, and picnics/barbecues with the program. When asked some reasons for the places they frequent significance or importance in their lives, they reported statements like:

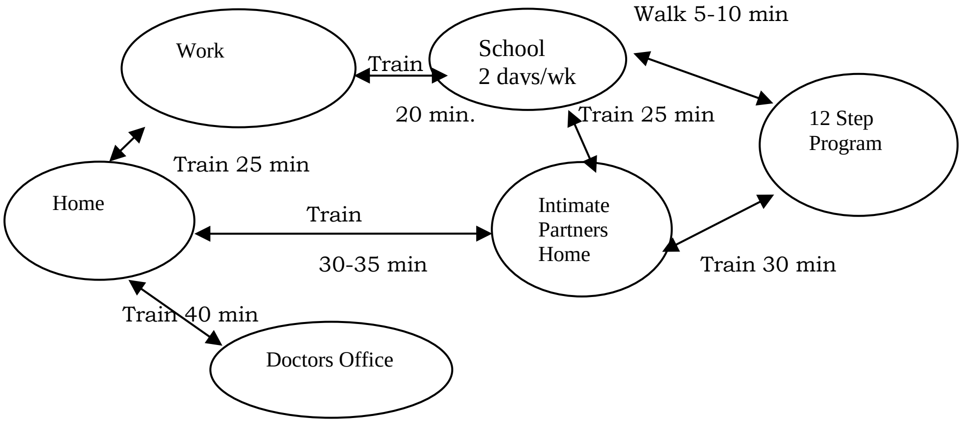
'My clinic is real private…it's like a regular doctor's office and my doctor I've been with since I was with my wife…so I'm ok telling him things.'

'It's Hillary, my counselor, because the people at the program are nosey.'

'I got to fix up my area.' (at work)

They also reported when living in community residences, going to the dayroom where programming like support groups and movie events happen, going bowling with the residence program, and when not in a residence, probation office meetings, food pantries and grocery stores, going to work, playing cards with friends, and 12 step meetings.

Their cognitive maps revealed they most frequented drug programs, medical providers and their intimate partners' or a relatives' home, most often using the train or walking to travel, and averaging about 30 minutes to get there. It should be noted this group were more likely to have to travel the farthest to receive support or treatment (see Table 2 & 5), hence 'longer cognitive maps.' Here is a 38 year old respondents' cognitive map: Figure2.



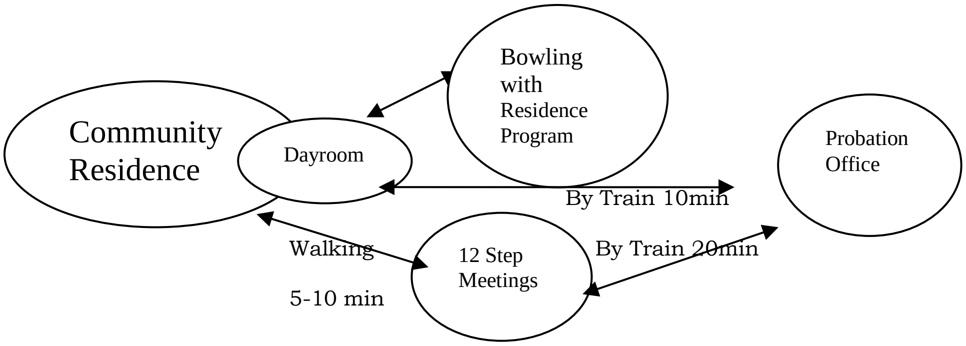
The diminishing nature of social space is rather pronounced in that the use of the physical space pre-diagnostically was almost completely limited to their immediate neighborhoods, but post diagnostically there appears to be a dynamic of what one might call ‘telescoping,’ where those that are accessed, are accessed in a most strategic manner taking care to guard closely their confidentiality by limiting the number of service providers and facilitated by meeting ‘one-on-one’ or going to only ‘private’ doctors’ offices versus large clinics. In this way, the information and services are ‘condensed’ and therefore likely not to offer the individual an opportunity to connect to other patients, outside community groups, peers, or even social services providers because of the sometimes ‘focused’ and other times ‘limited’ resources of private doctors’ offices. The implications for those patients who may have needs that require enhanced services, such as housing linkages, mental health referrals or drug use or abuse services may mean these needs go unaddressed. For example, a 46 year old participant noted,

> ***‘I can’t say nothing to nobody I know, cause ...I seen how they act when they think nobody ain’t looking—throwing out the fork the person used or spraying everything with bleach thinking they’re gonna catch something, that’s why I know I gotta keep this thing under wraps, that’s why I can’t say nothing...I seen it already when they find out and they don’t even know I got the virus.’***

> ***'I didn't tell them, because they…didn't need to know and some of them…you know look down on people…they treat people with HIV differently.'***

> ***'I don't speak on it because people are still very afraid, that's a lot of stress for me to tell.'***

Further, there is also evidence of relative expansion of their network, in that although likely to exclude their prior friends/or associates, includes primary care providers that in most cases, they did not have pre-diagnostically. More specifically, this groups constriction pre-diagnostically was more physically isolated but socially integrated in their very narrow prism of activities in their social space. So their expansion, although limited in its scope, post diagnostically was notable. Further, when the individual resided in a community residence or a 'supported' housing unit, they reportedly received information about other community activities and social supports they might otherwise not have found. Figure3.



I've included the following graphic and an ethnography of a respondent in this group and the following groups as an attempt to illustrate how the experience of these respondents might represent what the anthropologist Clifford Geertz (1973) called a 'web of meaning,' the cultural constructions in which they live and how the notion of 'doxa' or ones situatedness serves as an organizing function of thought and therefore action that can be acted out via 'practical sense.' Further, and most importantly, the point here is to unpack the notion of place and positioning to generate an understanding of the critical interaction between place, positioning and conditioning in social space from an 'insider's point of view.' The emphasis in this representation is to allow critical categories and meanings to emerge from the ethnographic encounters. Also, and in congruence with this tradition it will be necessary to visually depict the essential nature of the phenomena occurring in the lives of people living with HIV with the goal of locating the essential features of the experience pre and post diagnostically, thereby identifying the nature of the experience, the place(s) they happen, and their meanings and significance. This data was gathered during the individual interviews and focus groups where there were a number of open-ended questions that allowed the respondents to express their notions of their experience in a targeted way without being limited to pre-defined choices.

It was extremely important to be a participant observer, to develop an understanding of what it was like to live in the setting, but maintain the stance of an observer to assist in describing the experience with a measure of detachment. Specific data related to the nature of the setting were either photographed or described by the respondents and observer to better locate and understand the contextual artifacts embedded in the positioning and conditioning of the respondents.

Heterosexual Newly Diagnosed Respondent Ethnography

It's about 3:45pm on an early November evening in 2009. It's cold, about 48 degrees and the sidewalk in front of the Mission we are to meet has no foot traffic. The building is a whitish gray brick building that spans about a quarter of the block. It appears gloomy, partly because of the large tree and partly because of the color. It has a fenced in parking lot that's packed with about 25 cars, and two white commercial vans parked next to the entrance. The front door is propped open with a large stone and the there's an old coffee can filled with dirt acting as an ashtray. When I enter, I notice the lights aren't on, and it makes it hard to see. The hallway is short and you're quickly met by a double door which is also propped open, this time with a magazine folded in half and wedged between the door and the door stop. There is a small waiting area with four plastic yellow chairs, and the front desk is to the right. There are papers spread across the desk and a computer, with the computer screen saver on, the one that has the vertical and horizontal lines that morphs into multiple rectangular designs. The small receptionist chair is neatly tucked under the desk. No one is waiting and there is another set of double doors, this time, there is a sign written in all capital letters and in red print, NO ENTRANCE, PLEASE WAIT TO BE SEEN!!! I was immediately struck by this idea that I might sit for some time before anyone might come back to the desk. I sat for about a minute, and then went to the double doors and knocked… Hello? …I said…I need to speak to someone.' I waited about 5 minutes, and then repeated my statement. After about 5 minutes more I eventually got the attention of the maintenance person as he was walking downstairs, he was carrying a mop downstairs as I peered through the double doors. He waved at me and said he'd get someone. I could see an open bay of neatly made twin beds, all with standard gray wool blankets covering them. I counted about thirty beds. There was at least a six foot walk way between the two sections. They had white sheets and pillows and were lined up so that there were 5 beds per row. The room was circular and there were offices with yellow hospital doors, the kind that have the small rectangular window with the wire inside. Most had paper taped over the windows, but others didn't. It seemed devoid of human contact, the walls were a stark white painted over cinderblock, no pictures, no color with the exception of the occasional signage in all capital letters with red print, all with at least three exclamation points at the end.

It's only about 5 minutes more when a friendly Black woman, casually dressed came in, she had an earpiece in her ear that blinked a blue light, she told the person on the line to hold on. She quickly helped me locate the man I was there to meet, and told me to wait in the waiting room until he came in. The waiting room door was steps away from the Van Wyck Expressway so the intense sounds and even the rumble of the trucks as they zoomed by seemed especially poignant. The buzz of traffic, car horns, and commercial trucks made you feel like you weren't sitting in a waiting room alone, but more like sitting in traffic.

We're in Queens, off of Van Wyck Expressway (service road) between Linden Boulevard and 115 Avenue, 11420. The streetscape has commercial buildings on the same side of the street as the Mission, the other side is fenced, has no pedestrian sidewalk and shows a steep drop off to the Expressway. Next to the Mission, is another well-known drug program, its building is distinct with its red brick and circle drive way. It appears much busier than the Mission in that it has what appears to be a bustling medical clinic, with lots of foot traffic and Access-a Ride picking up and depositing people almost every 15-20 minutes.

The man I'm here to meet appears in the doorway and appears to brighten up when he remembers our meeting. He reminds me of the $10 CVS card, before I can say hello and I quickly begin to talk about and show him my consent form that he grabs quickly and shuttles me toward the door. "I'd feel more better If we talked outside.' We find a picnic table in the back of the parking lot under a huge shade tree next to a large privacy fence that lets in no light. We're outside, so the noise from the traffic masks our discussion in that even though we're only about 1-2 feet away from each other, we have to lean forward to hear one another.

He's a 49 year old man, who appears much older than his stated age. He's malnourished, with his cheekbones and eye sockets protruding and receding at the same time. He has brown wrinkled skin that resembles the texture of leather and he's shabbily dressed. He has on a white striped yellowing sports shirt with the collar stuck in one side of his shirt and the other bent backwards. He wears very loose, worn and soiled blue jeans that clearly have stains of paint, what looks and smells like motor oil and dirt on the pant legs. He appears eager to start and talks to me in a monotone voice that requires me to listen intensely for his words. He reports he moved from Jackson, South Carolina about twenty-five years ago, the early 80's. I shared with him that I had briefly lived there when I was in the Army, and he appeared to immediately warm up to me using more inflections in his voice and leaning forward to talk. He explained he moved for more work and that he'd been an auto mechanic, but was not able to find consistent work and heard there were more jobs in New York. 'I moved here without anything, a couple of dollars in my pocket and that's it.' He reports he lived in rooms and did odd jobs, painting, roofing, tiling until he got more steady work in Brooklyn. 'I've always been good with my hands,' he says with a smile and reveals multiple missing and discolored teeth. He reveals he was working regularly for a couple of years and then there was a recession and he ended up homeless, and moved to the shelter. He laughingly says, 'I missed and started messing around with this lady and we moved in together and that was it, next thing you know I'm marrying her…biggest mistake of my life.' He reports they lived modestly in a 1 bedroom apartment in Brooklyn in East Flatbush for about 8 years, but he states, 'she couldn't get pregnant,' and that broke them up. He blames himself for leaving her, 'I was just dumb and young, and I really wanted to have some kids.' He reports after leaving her, he had numerous relationships, and many sexual partners. 'I didn't want to settle down after that and I started to drink a lot more than I used to.' He reports he also started gambling at the track and started to 'loose more than I made.' He reports he did 'ok' financially for a while working as a mechanic, but when he started to gamble a lot more, his life started to get unmanageable. 'I couldn't pay my bills, my rent and I was messing with the wrong womens, they wasn't no good.' He reports soon he was living a very marginal lifestyle in Canarsie, Brooklyn. Canarsie is a middle class residential and commercial neighborhood in the southeastern portion of the borough of Brooklyn, in New York City, United States.

The respondent notes he did some light automobile repairs at the Canarsie Piers until the Park Police started to crack down. He reports he worked at this shop or that one, when the managers needed someone to fill in, but he explains his gambling made it hard to be consistent. 'Some days I just couldn't go to work, and they stopped wanting me to fill in.' He reports that's when things really took a turn for the worse. I started hustling and helping move some product. He notes he never sold drugs, but reveals at least 8 misdemeanor convictions for 'steering,' a common drug offense for being the middleman in a drug transaction.

Figure4.

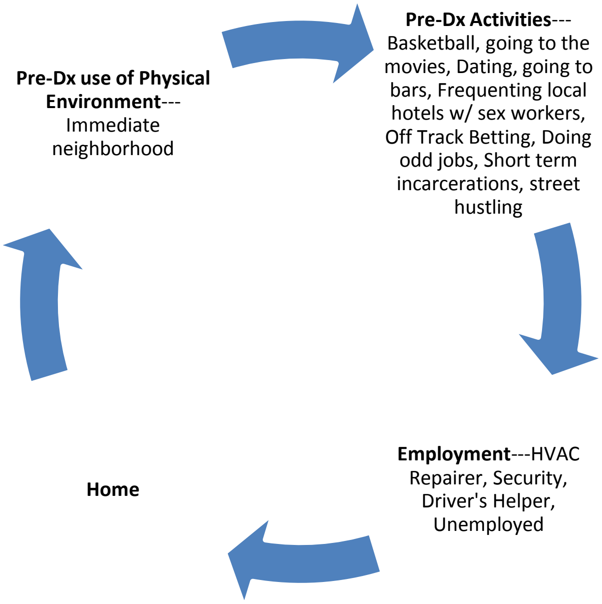
Bedell Lane. & E. 89 St. Canarsie, Brooklyn, NY

He reports using sex workers monthly and not using condoms. He admits the sex workers he frequented wanted to use condoms but did not insist on their use. ‘I know that’s how I got HIV. I know I was doing wrong, but I stopped giving a shit---you know I kinda gave up.’ He goes on to explain how he believes his gambling really made him depressed and winning on occasion made his problem worse---‘I thought if I could win the big one, all my problems would go away—you know, get my apartment, a job, and things would be different.’ But that unfortunately is not what happened---he reveals he eventually resorted to loan sharks and ‘when I couldn’t pay I would have to do favors and errands for them.’ He states after his last incarceration he insisted on a discharge other than the shelter. ‘That’s the only way I ended up here, and they gonna hook up my services for me so I can get my apartment.’ He states he was speaking to the nurse and the social worker and they got ‘places I’m eligible for.’ He reports, he tested positive while at Rikers Island, but chose not to start treatment. 'When I found out, I just couldn't deal with that in that place—those young boys was running around cutting people in the face with razors—it was crazy, I had to be focused.' He reports the nurse mentioned Jamaica Hospital because their program has a connection to them, but he suggests, 'I'll use them, but I really want something a little more private.' 'I just ain't one for hospital clinics—too many peoples there.'

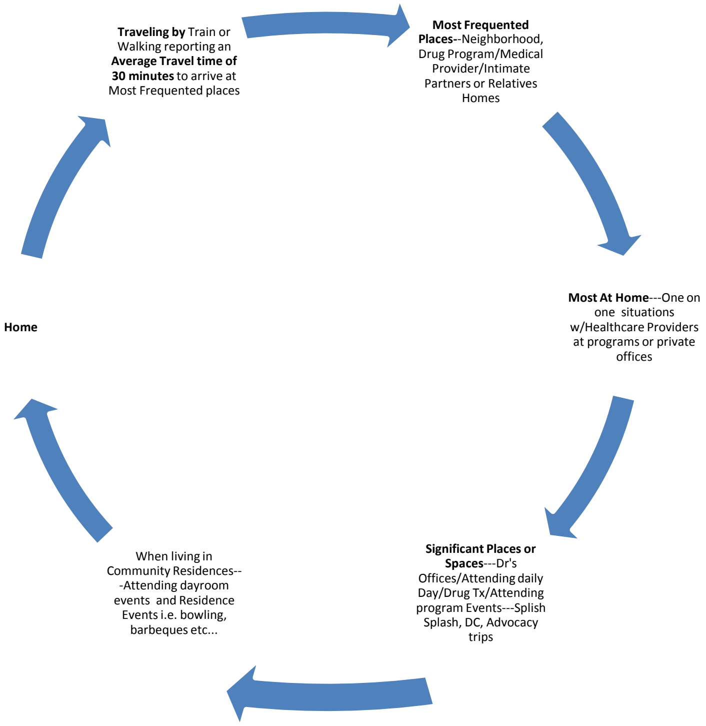
He reports having no real community ties—and he states he lost track of his ex-wife several years ago and offers, 'she probably wouldn't want to have anything to do with me.' He also notes some 1st and 2nd cousins back in South Carolina, but does not consider them a source of support or a resource. 'It's not like I could go to their house if I got sick or something.' And with that statement, he appears very alone, and left essentially to navigate this new world of HIV on his own. When asked how he'd found out about this study he reported the man laying adjacent to his bunk was looking for his birth certificate and had laid out all his important papers on his bunk, as well as flyers he'd collected. The respondent noted he read some of them and asked if he could get a copy—later on he found out the man regularly collected flyers for studies---Depression, Obesity, Prostate Health, Drug Abuse, Hepatitis C, and other health related research as a way to supplement his income. Further, the man had instructed him on where to locate such information—some he noted required days, and even weeks away in the hospital, but were well worth the time. 'You know, I'm only getting like $68.50 right now, how am I supposed to live on that? I gotta do something.'

Figure5.

Pre - diagnosis



Post diagnosis



Newly diagnosed Homosexuals ‘Social Butterfly with a Plan’

The respondents who identified as newly diagnosed homosexuals noted low levels of constriction pre-diagnostically, their level of openness pre-diagnostically was ‘Very Open,’ and post-diagnostically ‘Somewhat Open,’ and who as a group were more likely to note more ‘social’ oriented HIV services as a place that they signified ‘feeling at home’ in. Further, they were more likely to have reported parental influence encouraging social equality or a sense of community being the base of support, and also to report their ‘health status as ‘Average.’ This group had reported an average age of 36 years old, making them the youngest of the groups.

This group was more likely to have graduated from high school and to have attended either some college or a vocational school. They were more likely to note their HIV Service Center program as the place they signified as ‘feeling at home’ in. These respondents reported the average time to attend regularly scheduled appointments with major HIV supports and follow-up with blood work was approximately 2 weeks to 1 month, an amazingly short amount of time in comparison to the other groups. Fittingly, they reported being linked to these supports through their friends, associates and/or service providers. Their responses from the focus groups revealed this group not only appeared almost ‘ready’ for the challenge of HIV, but expectant of it. They repeatedly noted how their friends, lovers and family members had lived and died with HIV and they quote, ‘knew what to do.’ This dynamic was evident in statements like:

> **‘It (HIV Service Ctr.) was one of the first places I went after being diagnosed and they helped me get my apartment.’**
>
> **‘I go to groups and get carfare, tickets to plays and bowling and referrals to food pantries to supplement my income.’**
>
> **‘When my Medicaid got turned off, my assigned case manager helped get my fair hearing to get it back, and I continued to see my nurse and doctor, they never made me stop seeing them because of the benefits.’**

The researcher noted that their support pre-diagnostically was limited to a close-knit group of friends who shared their sexual identity and were likely to be HIV positive. Further, it was noted that although these relationships appeared prominent in their lives, they did not serve as a deterrent to HIV infection, but as a primer to a certain degree. There is an aspect of the experience here that has not been adequately explored as it relates to social positioning and conditioning that drives this group to be especially vulnerable to contracting HIV despite having some information and experience in relation to HIV disease in their everyday lives.

This group noted questions that would be important to be included when exploring the perspective of HIV positive people as it related to their sense of place and surroundings:

‘Do you have a doctor that’s on your train line?’

‘Are you seeking support from other HIV positive people?’

‘Do you have a case manager to help get and keep your benefits on?’

These questions, particularly when exploring the perspective of their sense of place and surroundings in the focus group, highlighted their disposition of relatively ‘low levels of constriction,’ based on the emphasis of seeking social support, and their ‘experience’ with the ‘practical’ needs of a person living with HIV with questions and later answers that underwrote the necessity of securing housing, supplementing their income through the use of special support services, and finally insuring the maintenance of these services by utilizing programs that provided advocacy services in the event they were discontinued. Their responses revealed this particular perspective.

‘Try to keep your appointments so you don’t have to be running around everywhere, less carfare’

‘Don’t isolate yourself, get out and get the services…it’s out there for you’

‘Make sure you keep your case open and having a ICM (intensive case manager) to advocate for you helps… otherwise HASA will just close your case for no reason’

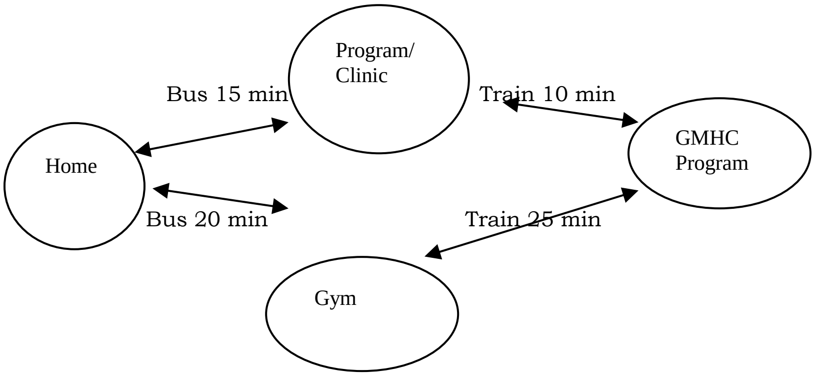
It’s important to note, this group reported the most familiarity with friends, family, and other associates who were HIV positive. It appears their 'primer' response as I call it embodied poor judgment. Yet even in this case, the groups' seemingly maladaptive response may not be necessarily irrational. Dewey (1922) notes that it is precisely this poor fit between habits and the agents environment that opens the door to the reconstruction of habits, adjustment, and a sense of 'an adaptation of the environment to the individual's needs and ends, and social change.' Perhaps, it is through and within the 'knowledge' or 'habitus' gained from the relations with other HIV positive people, services providers, self-help and community organizations that in fact mask changes that have led to a redefinition of the position in social space. Post-diagnostically, this group had the lowest level of constriction of the groups studied.

This group noted use of their physical environment pre-diagnostically as happening most often outside their immediate neighborhoods where they lived. This group reported activities like: going to the gym, hanging out in the clubs, rollerblading in the park, going to friend's house parties, meeting people on-line, hanging out at the pier in the village (Greenwich), and going to 'House Balls,' quasi fashion shows and dances. As it relates to employment, the respondents reported working in the retail, service and the fashion industries.

Post-diagnostically, these individuals most often reported attending day programs, Gay Men's groups and other supportive services in the community and work. When asked some reasons for the places they frequent significance or importance in their lives, they reported statements like:

> ***'The room is special, it's where the 'connecting' happens. Sometimes there's a room change and the group is just as powerful...I feel I can face the world when I leave.'***
>
> ***'Because it (day program) was the first place I went after being diagnosed and they helped me get my apartment'***
>
> ***'I get information and that's important to me, assistance with carfare and food vouchers.'***

Their cognitive maps revealed they most frequented places of employment, the gym, day programs, various support groups---Gay Men's, HIV etc..., drug stores and various shopping centers, their doctors office or clinic, and that they most often used the train, bus or walking to travel averaging about 20 minutes to get there (See Table 5). Here is a 34 year old respondents' cognitive map: Figure6.



It should be noted this group had the second longest cognitive maps of the groups, indicating they were, like the newly diagnosed heterosexuals, more likely to have to travel outside of their neighborhood to receive support or treatment. But more specifically, this group used a close-knit collection of friends, associates and providers. Further, their use of social space revealed their ‘practical sense’ as effective in that they were able to efficiently link with others, share information regarding housing, furniture vouchers, food pantries and other resources. This dynamic was evident in statements like:

> ***‘…think about it, sit home and get nothing…no food, no carfare, condoms, nothing, or go to Day Treatment and get all this stuff and I get to see the nurse or doctor, therapist, and have lunch!’***
>
> ***‘My clinic is in the same place…That’s why I like going…everything is right there so it cuts down on the carfare too so that’s an added plus too.’***
>
> ***‘I go to my day treatment program…say like if I’m sick and I got like a cold or something I might see the doctor, say about 2 or 3 times, but I see the nurse every morning to check-in, you see what I’m saying, so I can just see them when I need to and that’s a good thing because it helps me stay up with my medications and stuff so, so that’s also you know like a benefit.’***

Their lived social space expanded through the use of these close-knit cohorts to create ‘safe spaces’ that were adaptable and capable of allowing open and free exchange of information to an otherwise socially isolated population.

Homosexual Newly Diagnosed Respondent Ethnography

It’s about 2pm on an October afternoon in 2009. It’s cool, about 66 degrees and the sidewalk outside the Day Treatment Program we are to meet in is slightly damp from an earlier rain storm. We’re in Harlem, 126 Street and Lenox Avenue New York, NY 10027. The streetscape has commercial buildings on the same side of the street of the Day Treatment Program, the other side is lined with Brownstones so that if you look down the street the hand rails will almost look like one hand rail, but with new construction multiple dwellings interspersed throughout the block. The sidewalk on the Day Treatment side is wide and there is a wide vacant lot at the corner. Next to the Day Treatment Program there is a bustling medical clinic with Access-a Ride picking up and depositing people almost every 15-20 minutes. There are people of all nationalities coming in and out of the building, some with physical mobility limitations, children, older adults, men and women. The Day Treatment Center is much quieter. The door opens occasionally and a Black or Hispanic Male emerges or enters who appears in his late 30’s or 40’s. The receptionist appears to take frequent cigarette breaks and stands right outside the entrance. She has an earpiece that dangles from here ear as she checks her cellphone and smokes her cigarette. She says hello in a loud, friendly voice to everyone who comes in, adding a…. ‘how you doing?’ to those she appears to know more personally. The entrance is a simple steel door that’s has an awning above it with the Program name. There is a wide bay-like window with the shades drawn which looks like it would be more appropriate as a living room window. It is a four story red brick building that appears to be new construction relative to the clinic adjacent to it and the warehouse on its other side. It has the same style windows per floor. Once inside, there is an atrium and a receptionist desk with a friendly older looking Black woman to greet those that enter. She sits in front of a concave wall of privacy glass allowing light from the room behind her, but obscures those that are there. 'Hello, can I help you, she inquired?' Once I told her who I was supposed to be meeting she promptly asked me to be seated in the waiting room, buzzed the door for entrance, and suggested he'd be down soon. The waiting room was painted in a light tangerine color with several medium sized palm trees throughout the room, with about twenty fabric cushioned wood backed chairs and wooden end tables between them. The waiting room had large black and white pictures of people with statements at the bottom like…. "You're Not Alone," and "Help is Here."

He's a 28 year old Black man with a slight build, a neatly sculpted short cropped curly hair cut with a light goatee. He has a wry smile and a giggly laugh. He's neatly dressed in a long sleeved plaid collared shirt with dark blue jeans and dark brown leather uppers. He appears comfortable with himself and puts other at ease by his light, relaxed demeanor. We move into one of the group rooms with the same design as the waiting room with the black and white portraits, but the chairs are set up in a circle. We settled in and he explains he was raised by his maternal grandmother from the age of 3 years. Prior to that his mother raised him in Harlem, (137 St. & Lenox) until he moved to his Grandmother's home in Cypress Hills Brooklyn (Fulton & Hemlock, 11208)…a 3 story walk –up where he continues to live. It is a historically working class neighborhood residing in mostly multiple dwelling apartments. The main hub appears to be Fulton St. where small businesses line the street and attract much of the traffic flow. In a 1 block radius of his house, three barber shops, and five beauty shops are counted. There is a social security office next to the Chase Bank on the corner, a bakery, a 99¢ Store, A Capital One Bank on the opposite corner with a parking lot, a fast food place adjacent to that, another bakery, a laundry mat, and a Drycleaners across the street. Underneath this respondents building, there is a Multi-Purpose service center, offering everything from driving lessons, tax preparation, international telephone calls, notary services, making copies, and computer repair.

Figure7.

Fulton St. & Cypress Brooklyn, NY

Cypress Hills is a sub-section of the East New York neighborhood in Brooklyn, New York City, lying north of City Line and south of Cypress Hills Cemetery, in the far northeastern corner of Brooklyn.

The elevated J train curves around Fulton and snakes toward Cypress Hills Cemetery and adds a distinct sound in the air as it creeps toward the next stop. It is served by the Cleveland Street, Norwood Avenue, Crescent Street, Cypress Hills and 75th Street – Eldert Lane subway stations (J/Z trains) on the New York City Subway and Conduit Boulevard passes through the neighborhood.

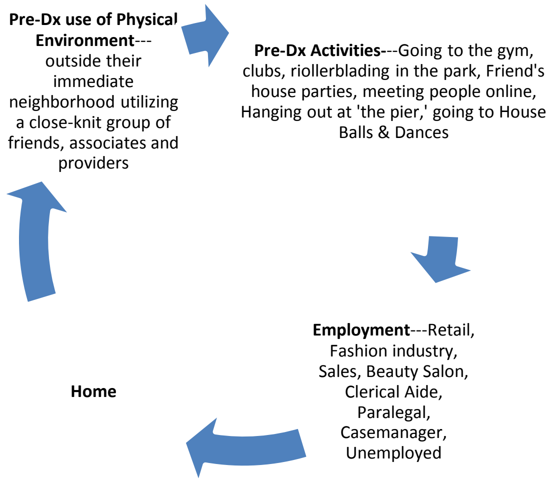
The entrance to the subway is constantly busy with a steady flow of people young and old going up and down the stairs and entering the subway. Every 10 to 15 minutes there is an explosion of pedestrians as they exit and go in all different directions, the taxi's and car services begin to blow their horns as they try to attract customers and then after a couple of minutes the pedestrian flow reduces again until you hear the rumble of the train approaching and a new batch of pedestrians are deposited. He explains growing up in Cypress Hills wasn't easy…even though he knew everyone and their families, he felt different, and as he got older he states he felt like he had a secret he couldn't tell anyone. He attended his Grandmother's church, St. Paul Apostle Church in Ocean-Hill Brownsville, and states listening to the Pastor, and his grandmother's friends during Bible Study let him know being Gay was 'not good.' "They would say stuff like, God created Adam and Eve not Adam and Steve.' Although he laughs while he's talking, I get the sense this topic of his childhood is difficult to talk about and he occasionally grimaces as he thinks back. Despite this feedback, he states he gravitated to the church often singing in the choir or performing in plays sponsored by the church. He reports spending most of his childhood until approximately 13 or 14 years old at the church for 3 to 4 hours at least 2-3 times a week after school. He describes the church as 'a creeky old place' with lots of leaks. He reports, 'they put patches over the patches.'

He notes he knew how to fit in with the other kids in the neighborhood. He describes his childhood as a 'typical city kid.' 'We played 'street hockey,' played in the Johnny pumps (fire hydrant) on hot days, and foot-raced each other in the streets.' He states he was always doing errands for his Grandmother and her friends and that kept him busy. In the winter, he said he didn't go out much and depended on school and church for recreation…"I watched a lot of reruns." He notes he didn't leave his neighborhood except for church on Sundays and wasn't allowed to go past the laundry mat on Fulton Street about one block away. "My Granny said she couldn't see me any further than that" from their apartment window where he reports she sat in a chair with a radio most of his childhood.

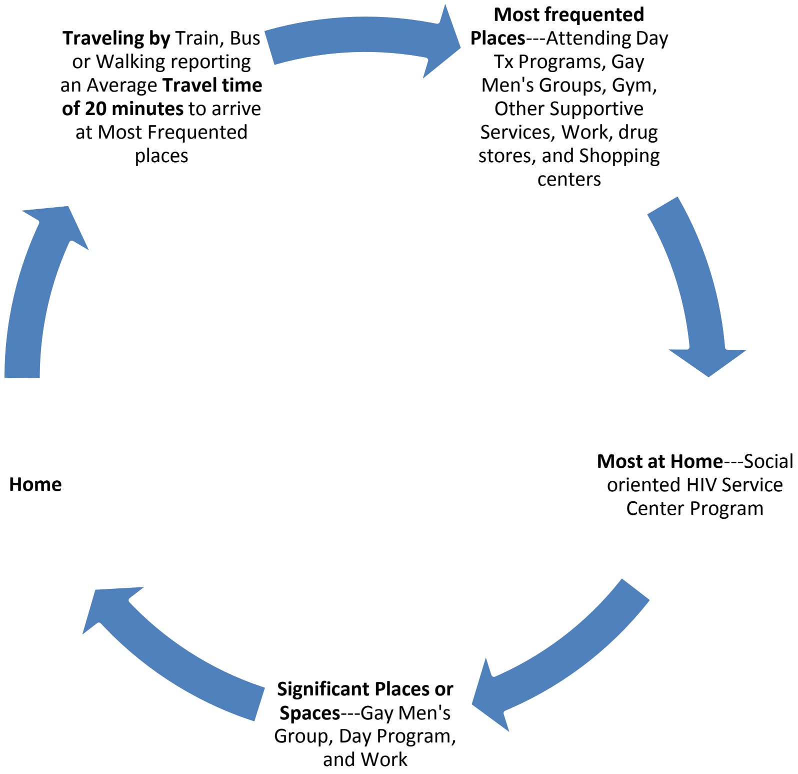
He completed the 7th grade, but got his GED when he was 19 years old through the adult learning program his grandmother told him about in the city. He reports when all of his friends were getting interested in girls, he didn't have those feelings. He said he got a girlfriend because his friends told him one of the girls liked him, but he didn't like kissing her. He reports finally just shying away from his childhood friends who he suggests 'probably didn't even notice because they were busy chasing girls around.' He reports starting to hang out in 'the village' after seeing on the news that's where the Gay people were. He gravitated toward 'the piers' or what is now a boardwalk for pedestrians, bikers and joggers. 'I had my first date right around there …he was an older guy, but they all seemed to be older than me and then I started meeting kids my own age.' He reports they 'schooled him' on responding to people who would come down to the village to Gay bash and he states he got good at responding with smart little quips that made people think twice about trying him. He said, and seems to take on a whole new persona when he does so, moving his head to the side and raising his voice, 'I might be Gay but I'm still a man and I can whoop you're mother---- a--.' He says having a 'viscous mouth' and 'tough skin' was a necessity to survival even among his friends. He reports, 'It got easier because the sneers, the laughing, the name calling could really get to you if you weren't ready for it.' He reports he felt more fortunate that most of his friends who he reports were runaways, throw-aways, or homeless children. 'I hung out with them, but I went home every night'. 'I was grateful for that because my grandmother was not thrilled with my lifestyle but she never once told me to leave.' He states he has three main supports---D'Anthony, Mark, and Nathaniel, and he reports meeting them at the pier in the Village (Greenwich Village) while hanging out about 2 ½ years ago. He reports he tested positive a couple of months ago, and was not surprised he'd gotten infected. He notes having 'hooked up' with a guy he met on-line who mentioned he'd never gotten tested. ‘I knew I was positive cause I got these really bad night sweats after that, the kind that wets the mattress.’ He continues, ‘I didn’t even wait to get tested, I told my friend and he brought me to the program for testing and services.’ Prior to becoming infected, he reports having an average social life with a number of good friends he’s met in school, around his neighborhood, at parties or on-line. He considers himself outgoing and states he does not have any difficulty making friends. He goes to the program every day, traveling approximately 25 minutes by train, and then either a train or bus downtown to his support groups at the ‘Center’ (Lesbian, Gay, Bisexual & Transgender Community Center) located at 208 W. 13 St. New York , NY 3-4 days/week. ‘They have everything, groups, social events, and services. I’m looking for a job or a sponsor cause a girls gotta eat,’ he says with a smile at the end of it.

Figure8.

Pre - diagnosis



Post diagnosis



Heterosexuals diagnosed 3 Years or more 'The Inspirational Journey'

The respondents who identified as heterosexuals who had been diagnosed three years or more noted more constriction pre-diagnostically, but less constriction than newly diagnosed heterosexuals. They were more likely to report parental influence as one of 'sticking together,' and not seeking or utilizing support outside the immediate family structure,' a salient quality also noted in newly diagnosed heterosexual respondents. This group was also more likely to report their 'health statuses as 'Very good,' and their 'Level of Openness' pre-diagnostically as 'Somewhat Not Open' and post-diagnostically as 'Somewhat Open.' This group had a reported average age of 52 years old, making them the oldest of the groups.

They were more likely to be enrolled or to have completed a vocational training program and more likely to note their place of employment or their family or intimate partners place of residence as the place they signify 'feeling at home' in. These respondents reported the average time to attend regularly scheduled appointments with major HIV supports and follow-up with blood work was approximately 5-6 months. This group was similar to their 'earlier selves,' or the newly diagnosed group in that although now called to act and use this experience of HIV as an inspirational moment were at an earlier time in their diagnosis reluctant to act. Their responses from the focus groups revealed this group had the most transformative experience in that although highly constricted when first diagnosed had used their diagnosis as an inspirational moment, a call to action in their lives and had since learned to embrace what life has to offer including experiencing anguish and internal struggles, for example in statements like:

> **'Now that I know that I'm positive and have been through the pain of acceptance, I can understand what you're going through, and accept the good and bad in me, I can accept you.'**

> **'I have a second chance at life, one where I get to ask questions, learn and be better. I never heard about the stuff I'm learning now... good food, medication and paying rent. It's new to me but I can see other people do it so I know I can too.'**

> **'I just want to live a life worth living, instead of just existing.'**

This group noted questions that would be important to be included when exploring the perspective of HIV positive people as it relates to their sense of place and surroundings:

> **'Do you think HIV was meant for you?**
> **'Can you explain what HIV is?**
> **'Don't say 'you're ok, don't worry about it'...guide them instead.'**

These questions, particularly when exploring the perspective of ones' sense of place and surroundings in the focus group, highlighted not only their disposition of relatively 'high levels of constriction,' but additionally this groups sense of gaining 'meaning' from this experience of becoming HIV positive with questions that specifically asked about their fate with HIV and its significance in their lives, the understanding of its nature, and a suggestion for providers working with HIV positive people to be a guide, and not be condescending and dismissive about their futures. Their responses to these questions revealed this particular perspective.

> **'I think I was meant to have a chance to face my maker and make peace with my life, it's like being able to have two lives in one.'**
>
> **'HIV introduced me to a whole new world as strange as that may sound.'**
>
> **'People always saying don't worry about this and don't worry about that…instead you need to help them find their way, guide them instead, that's better.'**

It appears possible that these socially situated, imperfectly knowledgeable agents stumble upon ways of doing things that are themselves produced and reproduced through their position and conditioning in social space that seem to work, make 'practical sense' and seem to fit with their other concerns. Their cognitive mapping illustrates a 'practical sense' of 'intimate,' 'confidential' and legitimizing environments most suited to their preferences.

'This group was more likely to have returned back to school, be employed and post-diagnostically to have experienced the greatest reduction in constriction than any other group.

This group noted use of their physical environment pre-diagnostically as most often limited to their immediate surroundings and neighborhood connections. This group reported activities like: going to their place of employment, going to bars and clubs, playing cards, staying in the neighborhood, and taking the kids to the park.

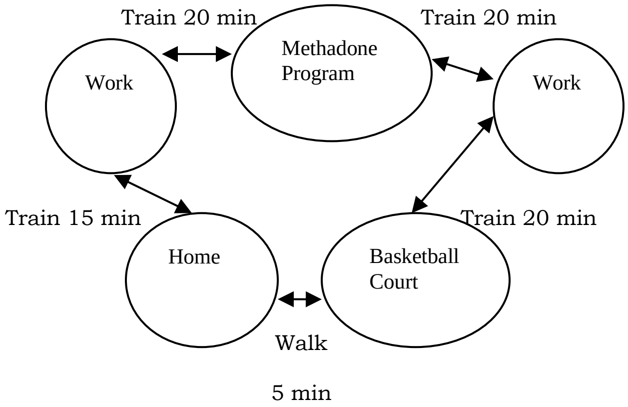
Post-diagnostically, these individuals most often reported their intimate partners' home, neighborhood and places of employment as a significant and important place for them. Further and following this, they were more likely than any other group, to signify their family or intimate partners place of residence as the place they signified 'feeling at home' in. Incidentally, they were also a group noted to have a strong 'parental influence' of 'sticking together' or not seeking or utilizing support outside the immediate family structure.

When asked some reasons for the places they frequent significance or importance in their lives, they reported statements like:

> ***'Because you know you're family is in that building…even if it's a dump…it's the love inside. The building could be falling down, but that's home…there was love there regardless of all that.'***
>
> ***'I have the freedom to work my shift without my boss behind me, they trust I'm gonna do my job.'***

> ***'I feel secure in myself cause if somebody said something I could take care of it without letting things getting out of hand…I know what people to avoid, so I just play (basketball).'***

Their cognitive maps revealed they most frequented their doctors' office or clinic including methadone programs, places of employment, law enforcement supervising agencies, i.e. probation, parole, and parks for local recreation. They reported most often using the train, walking or the bus to travel averaging about 10 minutes to get there (See Table 5). Here is a 34 year old respondents' cognitive map: Figure9.



There is a clear expansion in the respondents' use of lived space in that pre-diagnostically they too were almost exclusively limited to their immediate neighborhoods, but post diagnostically their cognitive maps illustrated an increased willingness to interact with higher educational activities, connect with their places of employment, a place they reported having a sense of 'authority' or ability to self-decision-make. This dynamic was illustrated by statements like:

> ***'The basement at work is real peaceful…I'm pretty much in charge…there's just one other guy above me and he never comes to work…so I take care of things.'***
>
> ***'My boss …he knows me for years, he's a good friend, he know if I got something to do, I'm gonna do it, but not before I've taken care of my business…so you never hear no complaints…because my work is done.'***
>
> ***'I would say at the school believe it or not I feel at home…because you know I tell the kids the way it is out there, and they give me that respect, you know what I mean.'***

Bourdieu notes, 'our dispositions or positions are adjusted to the constraints of the social surroundings in which they emerge, and the way we attach meaning, habitus, differs according to our conditioning within those positions.' It would appear this groups positioning may have leant a sense of 'legitimacy' to create and re-create a sense of edifying action by engaging more than any other group with 'legitimizing organizations,' like employment and educational institutions.

Heterosexuals Diagnosed 3 Years or more Respondent Ethnography

It's about 7:35pm on a November evening in 2010. Its 42 degrees and we're meeting in an East Harlem coffee shop—one of those new type of hip spots with big comfortable chairs and Billie Holiday music songs playing in the background. There is a strong smell of herbal tea in the air, and the walls are colorfully textured and soothing. It's a cozy place with friendly service and a young white woman with a colorful headscarf takes our order and quickly returns with two steaming cups.

The man I'm meeting is a 43 year old man with mixed gray hair in neatly manicured corn rolls. He wears a tan turtleneck on under a brown leather jacket and thick corded corduroy brown pants. He's short and stocky, about 5'6 and approximately 240 pounds, with a muscular physique that makes his leather jacket tight around his biceps. He's cleanly shaven with very white teeth, and smiles after he speaks. We sit in the far left corner close to the window and sit across from each other. I notice the tables are small and it takes us a moment to figure out how to situate our cups and saucers around the sugar bin and creamer on the table.

He speaks openly about his status and appears very comfortable with himself. 'I tell you, this being HIV thing has really changed my life.' He reports, 'I was lost but now I'm found,' and smiles again. 'No really, growing up in South Jamaica, Queens on 159 St. and 107 Avenue in the projects (South Jamaica Projects) was tough…I was the oldest so I had to look out for my brothers and sisters.' He reports having 3 siblings, 2 girls and a boy. Of the girls, one was 3 years, and the other 2 years younger than him. The boy was almost 5 years younger than him. He reports having a lot of responsibility around the house, keeping it clean, helping his sisters get the others off to school, and out of trouble. 'I was the enforcer, whatever my sister said, I enforced.' He reports not knowing his dad, and remembers his mother as a quiet, overwhelmed person---quick tempered and 'working all the time.' 'She was a home health aide raising four children with no father.' He continues, 'she barely even mentioned him except when she would drink and then she'd just cry.'

Figure10.

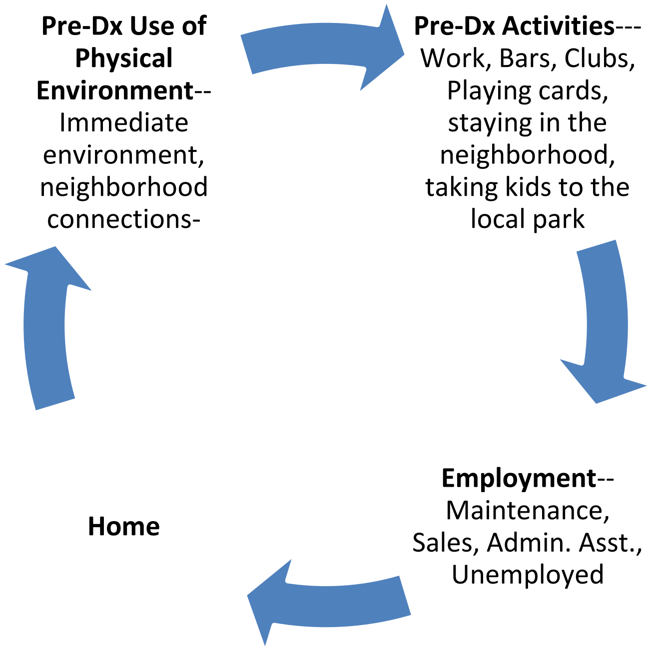
The respondent reports growing up in the area with a lot of gangs, and he had to protect his sisters from the local 'tough guys.' He reports---'that's why I got a reputation for being a fighter, not because I liked fighting, but because I wanted my sisters to be safe.' 'I started off in a gang and got into even more trouble…they all went to jail or ended up on house arrest…back in the day being in a gang was a way to keep the neighborhood safe, but we started robbing and slanging weed and coke and pretty soon everybody was just out for themselves.' He goes on to explain, 'I did a lot of things I'm not too proud of---but it was survival.'

He reports going to school sporadically and then finally dropping out because he reports, 'It didn't make no sense, I wasn't learning anything anyway.' He reports at around 10th grade going to juvenile detention and then eventually his crimes began to escalate into misdemeanors and felonies. 'I decided I was going to live a life of crime. I finally went up state on an assault charge and paid a high price.' He explains… 'I had to put in some work for my tribe.' He explains he had to do some assignment which involved a criminal act within the prison facility. 'Of course, I got more time cause the guy had to go to the hospital, but if I hadn't done it, they wouldn't did it to me.'

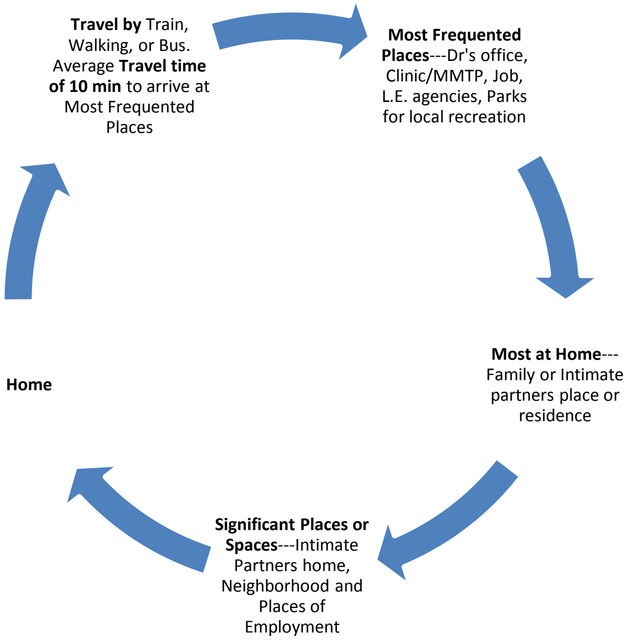
He reports not being able to adjust to civilian life once discharged from prison, and continued to hang out with people who committed crimes, serving several short stints in the local jail. 'I don't know when I made a decision to do the right thing, but I did—I just kept on trying.' He goes on to say… 'I started school once I found out I was positive. I got my doctors' appointments together from this girl I used to mess with, and now I'm straight.' He goes on to report getting a private doctor because he 'didn't want my business out in the street.' He continues, 'I'm not ashamed or nothing, if anybody asks me I'll tell them, but people can be stupid, and I don't wanna deal with that ignorance.' 'Me and my doctor are good…I'm on a (medication) regiment that works with my school and work schedule…it don't have a lot of side effects and I don't have that sluggish feeling like I did when I first started.' He goes on to report, 'I know I can live instead of just surviving...I got HIV, but for the first time in my life, I'm actually living and enjoying life as other people do.'

Figure11.

Pre - diagnosis



Post - diagnosis



Homosexuals diagnosed 3 Years or more ‘With Open Arms’

The respondents who identified as homosexuals who had been diagnosed 3 years or more were noted pre-diagnostically to have to lowest levels of constriction of all the groups. This group was more likely to report their ‘health statuses as ‘Very good,’ and their ‘Level of Openness’ pre-diagnostically as ‘Very Open,’ and post-diagnostically as ‘Somewhat Open.’ This group had a reported average age of 44 years old. Interestingly, they were slightly more likely, (3:2) to report their parental influence as one of ‘sticking together or staying within one’s own group,’ as opposed to having an orientation of social equality. These respondents reported the average time to start attending ‘regularly’ scheduled appointments (at least 1 time a month) with major HIV supports (Infectious Disease Doctor/Clinic, Virologist and/or Primary Care Provider and follow-up with blood work was approximately 1-2 months. This group also resembled their earlier selves, the newly diagnosed homosexuals, in that they appeared to act rather quickly to get into care once diagnosed. Perhaps the ‘primer’ experiences helped to facilitate this apparent confidence.

Their responses from the focus groups revealed the second least internalized constriction post diagnostically with statements like:

> **‘I work at a not-for-profit AIDS advocacy program, and my co-workers are like family now, they help me with doctors and specialists, give me advice about HIV medications, holistic meds and even dating.’**

> **'I go to work, my doctors' appointments and the gym. I also attend a few meetings (12 Step) at the Center (Lesbian, Gay, Bisexual and Transgender Community Center) a couple of nights a week...it's a social thing, but we talk about serious issues and then afterwards we go to dinner, walk around the village, go the pier, hang out.'**

> **'Everybody knows me there (HIV Services Ctr) and they tolerate and accept me...it's like an extended family without the baggage.'**

This group was extremely socially oriented in their perspectives and noted their place of employment where there were supportive networks of co-workers, 12 step fellowship friends, and HIV Services programs as the place(s) they signified 'feeling at home' in. Fittingly, they were more likely to have a wide variety of supportive connections in the community, day treatment programs, support groups, advocacy groups, and more likely to have reported having a good relationship with their doctors.

This group noted questions that would be important to be included when exploring the perspective of HIV positive people as it related to their sense of place and surroundings:

> **'Educate, Educate, Educate!'**
>
> **'What kind of mind-frame do you have to help you through this?'**

> **‘When you find out something useful, pass it on so others can benefit.’**

These questions, particularly when exploring the perspective of their sense of place and surroundings in the focus group, highlighted their disposition of ‘low levels of constriction,’ both pre and post diagnostically with statements to educate themselves about HIV disease, to assess their particular mind-set as a method of coping with all the dynamics of living with HIV, and lastly they highlighted passing on useful information to the next HIV positive person. Their responses to these questions revealed this particular perspective.

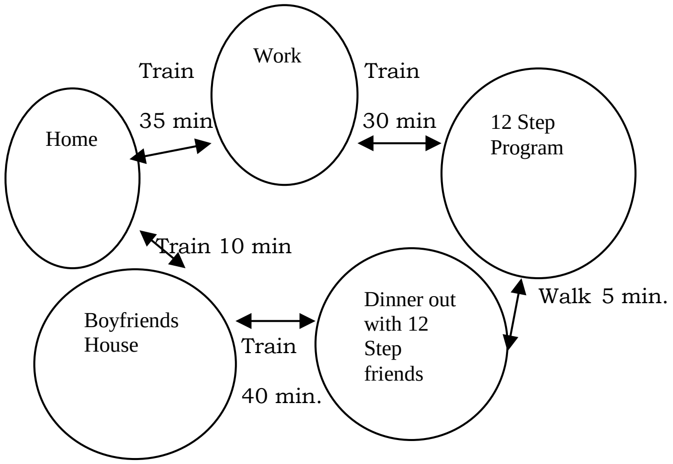
> **‘Try to soak up as much as you can’**
>
> **‘Embrace the spirit of surviving, and more than that growing’**
>
> **‘Don’t keep things to yourself, others could benefit from your experience, even the bad stuff.’**

This group noted use of their physical environment pre-diagnostically as most likely happening outside the neighborhood they lived in. This group reported activities like: going to clubs and parties, working, playing cards, and dating. Post-diagnostically, this group reported significant places or spaces they deemed important like their places of employment, 12 Step meetings, day programs and their own homes. When asked some reasons for the places they frequent significance or importance in their lives, they reported statements like:

> **'The meetings are like in church basements, community centers, and hospital conference rooms…It's where the people who have helped me be the person I've become and am becoming are…I'm still a work in progress. They helped me deal with things on my mind and some of them ain't never spoke to me.'**
>
> **'It's the fellowship of people who come together and give each other support…that's what makes the place special, that's where I get my other medicine.'**

> **'It's my place, I worked hard to get it, fixed it just right and I'm not letting anybody move in and take over.'**

Their cognitive maps revealed they most frequented supportive networks, medical providers and close friends homes, most often using the train or walking to travel, and averaging about 15 minutes to get there (See Table 5). Here is a 45 year old respondents' cognitive map: Figure12.



Their experience in social space with varied supportive networks, lack of constriction prior to diagnosis, and their seemingly full-on embracing of their lived experience as HIV positive people was something clearly noted in statements like:

> ***'I remember when I first started going to the meetings… the feeling in the room that I had when people was sharing …you know it's the fellowship that creates the specialness.'***
>
> ***'…the groups are really beneficial, we're able to open up in the groups and be able to express feelings and emotions. Like we had a group today called 'Beyond Trauma' and the person that runs that group…she's extremely good, extremely good, she's also the director of case management…of groups, and her groups are really intense.'***
>
> ***'My home group, my sponsor and my entire support network at the meetings. You know what's kind of funny…on a couple of occasions I've found myself at the 'Center' and I've gone to the room where my home group meets, and just sat in the room to get grounded or just feel better, and the room didn't really help. What I remember was the people and they hugs and words of encouragement. That's the hit right there (laugh).'***

Their statements also shed light on the notion of 'place attachment,' in that the affective bond between people and specific places has as an essential feature 'human connection' or to take this idea further 'human engagement,' in places they deem safe in accordance with one's conditioning and positioning in social space, and that this exchange of information has at its core, the appearance of unconditional positive regard where individuals can feel free to 'share their experiences,' and not be attacked, derided or ridiculed, but be inspired by the sharing of similar stories and how others dealt with life issues.

Homosexuals Diagnosed 3 Years or more Respondent Ethnography

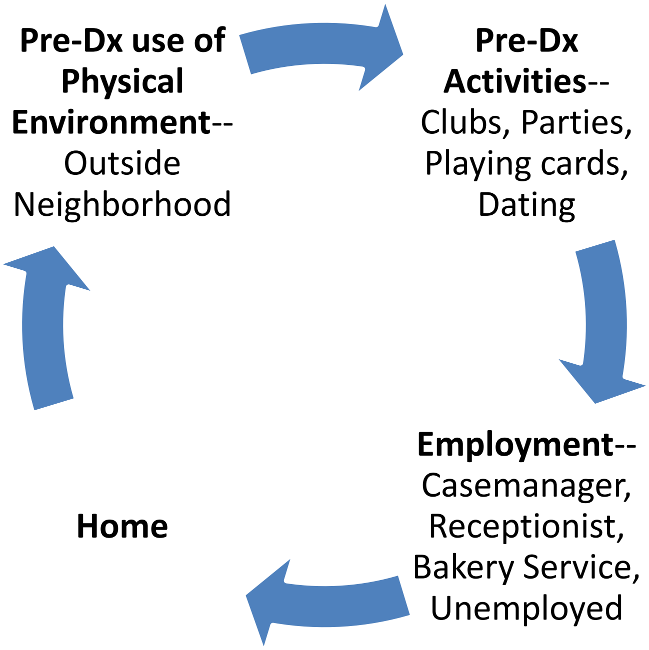
It's about 2:35pm on an October afternoon in 2011 in Chelsea, a section of Manhattan known to be gay friendly. It's a muggy 61 degrees and we're meeting in a coffee shop during his lunch hour. He's 20 minutes late, but called me twice to confirm that he was coming. 'I got hung up at work…sorry about that,' said this young looking black man…he had on a black slacks and tightly fitting white tailored shirt and a black scarf wrapped around his neck. He reports to be 47 years old, but clearly looks 10 years younger than that. He has piercing eyes and gives a warm hand shake as he sits down in the booth I selected. 'I live in Hell's Kitchen on 54 St. between 9th and 10th Avenue with my boyfriend.' 'It's a pretty neighborhoody place, once all the 'day people' leave.' He reports having HIV for almost 6 years now and that it has really changed his perspective. "I used to be a busy, busy bee…he laughs, but I've since calmed down. I have a lot of help from friends. To be honest I don't know what I would have done without them.' He reports growing up in Bedford-Stuyvesant, Brooklyn on Halsey between Marcy and Tompkins.

Halsey Street between Marcy and Tompkins Figure13.

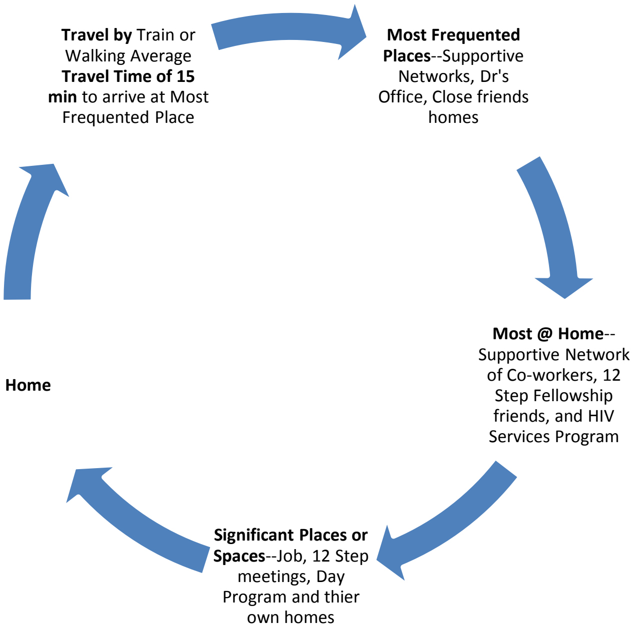
‘I was an only child…kinda nerdy if you want to know the truth about it. I wasn’t really into sports and I knew really early on, I was not like to other boys.’ ‘My Mom raised me well…she put me in Little League, I played tennis and she sent me to piano lessons cause she always wanted to learn how to play. But she’d be the first to call me finicky. I was just very particular about what I ate, what I wore and where I went.’ He goes on to say the kids in his neighborhood really didn’t pick on him, because ‘I was just another kid from down the street,’ but he reiterates… ‘I just was not interested in girls at all.’ He goes on to report that his mother did her best raising him, and eventually sent him to live with his father. ‘He thought if he ran me around the track enough, the man would come out of me, needless to say, one day I put on my running shorts, told my dad I was going for a run, and I ran to my aunties' house…I never went back. My mother kept trying to send me back…so I just stayed with my aunt till I was grown enough to get my own place.' He reports he graduated from high school pretty easily, and got a job with the telephone company…. 'honey you couldn't tell me nothing…I had arrived.' 'I got into clubs I shouldn't have, dated men I had no business dating and eventually got HIV…but that's not the end of the story…that's only the beginning.' He goes on to report that he got linked to a Virologist that his friend was using because he was very gay friendly and well known. 'I like him because he's a gay man with HIV and he's down to earth…he doesn't judge because he's been there….but he's tough…you can't just go up in there not serious and not ready to commit.' He continues he receives the majority of his information and support from other HIV positive individuals that are in his support network… 'we go to dinner, out to plays, movies…we travel together.' When asked about whether he feels more constricted since becoming HIV positive, he responds 'no,' but then adds… 'I'm still out and proud, but I just kind of stick to my close friends and that really works for me. Next semester I'm planning on going back to school, because my job has an administrative position I've got my eye on. We want to move and maybe buy a house somewhere. My boyfriend and I want to take things to the next level…yeah we live really well, I'm proud of who I've become, and I know my mother would be proud too.' He quips, 'she was not happy about me being gay at all, but she learned to live with it…I didn't flaunt it in her face, you know out of respect for her, she wasn't like super religious or nothing, but you know.' He goes on, 'I just know that things are getting better…when I first became HIV positive, I didn't panic, I felt like I had got played by the guy I was dating, but when I really sat down to think about it, I was just as responsible…more!' He continues… 'I choose to look at the glass half full, not empty…all I had to do was look at the hundreds of examples around me to know that I was going to be ok. It's about living and that's what we're doing!'

Figure14.

Pre - diagnosis



Post - diagnosis



CONCLUSIONS

The Impact of HIV as a Transformative process

The transformative nature of an HIV diagnosis is apparent in each of the groups and its degree of effect in their lives was very much dependent on their position in the social milieu and the ways in which that position conditioned them to respond to such an occurrence. They all experienced constriction in their interactions with their community, families and friends, but the strategies they used varied greatly and helped transport them through their social conditions.

This research highlights an important question of 'How does habitus happen?' It appears to be through the catalyst of 'engagement.' Through the act of being transported in one's thinking through these community networks of day treatment programs, 12 step meetings, trauma groups, and advocacy supports people with HIV assign highly intimate and personal meaning to these places which appear as mere conference rooms in their programs, nurse education rooms or old basement churches throughout the city but nevertheless are the conduits that allow them to be 'creative' and 'instructive' in their thinking and transform (change) their experience into meaningful inspirational stories that structure their lives around reparative support and act as substitute families in some instances.

'Habitus,' is therefore this way of knowing that can encompass not only reason but also emotion. Further, emotion is integrally woven into the context of 'place,' and guided and cultivated into life-context through a 'relational dialectic.' Meaning, that which is informed and infused with one's positioning and conditioning, like race, poverty, and exposure to high crime that colors our worldview and shapes our choices, our strategies and rationalities. The 'relational dialectic' enables or constrains by informing our schematic representations or 'doxa,' and in doing so alters 'habitus' which by definition produce and reproduce the 'practical sense' of an agent.

Emirbayer & Goldberg also utilized Bourdieu's sociological perspective when they explored transformational processes related to social movements when they noted it allows the agent to bring about changes of a broader sort, including the creation of a more open-minded and tolerant disposition (2005). What they call the 'democratic praxis,' I call and take further the notion of the 'relational dialectic' whereby the agents, from and through their social position and conditioning, capacity to communicate, listen, understand, and learn are cultivated, such that, for example they can argue, laugh, agree and share their experiences in these social spaces they feel 'most at home' in. It is here that the agent, Bourdieu notes, and the 'relation' of complicit domination granted to social institutions, like Day Treatment Programs, social service and medical providers as well as structural factors like poverty, racism and exposure to violence can be broken (2001[1998]). It should be noted here, as mentioned prior, these medical providers and social services institutions are a part of a network of governance and social ordering that are supported by other social institutions and social controls like racism and economic inequality respectively, and are grounded in specific configurations of cultural, civic and economic action. This ‘connection to such institutions,’ which I submit is just another spoke in the constantly revolving arm of the ‘relational dialectic,’ allows for correspondence between the past and the present, the scientific and the social, the ecological and the economic, the formal and informal governance, and are themselves transformed through these relationships. The dispositions of ‘habitus’ predispose agents to select forms of conduct that are most likely to succeed in light of their resources and past experience (Swartz, 1997, pp. 105-106), thereby allowing intersections between organizations, constituencies, and social and economic forces and in doing so creating a precisely knitted social network that does not dispense with hierarchies, but works within them and ensures when disruptions occur, all parts of the social system are invested, linked, and can talk to one another. There is fluidity in these systems, a ‘strategic looseness,’ that allows ‘instructive, creative engagement.’ Therefore, the ‘relational dialectic’ is not clearly delineated mostly because it interacts with the other parts of itself that are specific to the positioning and conditioning of that particular individual to produce multiplicative or even exponential effects upon the individual. Broader still, this idea is relevant in any forum, from employer-employee relations, to traffic patterns in response to major detours. That individuals, from their positioning and conditioning in social space, their connectedness to a setting/place attachment, their ‘situatedness,’ emerges ‘practical sense,’ a method by which to incorporate ones’ knowledge (doxa) in an ever changing world of possibilities to inform and guide behavior.

The Influence of Positioning & Conditioning as a Transformative process, The Journey of AIDS

Newly diagnosed heterosexual respondents most noticeably experienced a journey where they were conditioned and positioned in such a way that led them to experience the highest levels of constriction pre-diagnostically, and that this particular 'habitus' informed their 'practical sense' of the spaces and the methods of engagement they felt most attached, like very private locations with their healthcare providers. Further, and although highly constricted, these respondents describe an emergence of a new configuration…a reconfigured complex of interlocking structures and strategies that are themselves composed of old and new elements, the old revised and re-oriented by a new operational context, and the newer elements modified by the continuing influence of working practices and modes of thought dating from an earlier period.

The ethnographic study in this group illustrates the notion of doxa or how the group attaches meaning, and that this meaning or habitus is grounded in their social conditioning. I call the respondents in this group 'The Go it Aloner' and the individual in the ethnography illustrates this method quite succinctly. He notes an extremely marginalized life prior to becoming HIV positive---marred with chronic unemployment, addictive behaviors as it relates to his gambling, use of sex workers, and criminal behavior. He notes being disconnected from his familial supports, and is therefore left to navigate this world of HIV on his own, a method clearly of his choosing and most particularly located in his conditioning of minimal, almost non-existent support prior to diagnosis, and minimal support post diagnosis. He demonstrates a constricted nature opting to share his information with only the service providers required. Even the constricted nature of the place he sought treatment reflects this ‘situatedness,’ as evidenced by the lack of information shared outside the treatment rooms and offices, and the stark lackluster physical space with signage that reminds those that occupy it of the boundaries and limits it enforces. His decision to delay treatment because of his incarceration and possible fear of disclosure, clearly illustrate how he attaches meaning to his particular ‘situatedness,’ and adjusted his practices and strategies to reflect it. An example of this is noted when he accidentally and out of his own curiosity noticed his fellow bunk-mates’ flyers for research participants. Through this accidental encounter he actually generates a new method to gain information and supplement his income.

The journey of newly diagnosed homosexual respondents who unlike the prior group were conditioned and positioned to experience low levels of constriction pre-diagnostically, were and in accordance with their historical perspective congruently more ‘social’ in their method of interaction. This perspective post diagnostically situated them to experience the lowest level of constriction of all the groups which through their ‘doxa’ ‘conditioned and positioned’ them to share, participate and contribute to and in the embedded cultural wisdom this group repeatedly engaged in.

The ethnographic study in this group illustrates the notion of doxa or how the group attaches meaning, and that this meaning or habitus is grounded in their social conditioning. I call this group 'Social Butterfly with a Plan' and the individual in this ethnography clearly reflects this stylized configuration. He notes being very socially oriented prior to becoming HIV positive, for example going to Greenwich Village and hanging out on the piers with other young gay men. He describes learning from their experiences regarding coping with being gay, dating, and becoming HIV positive. He notably and in keeping with the findings of this group was not surprised when he contracted HIV. He reacted quickly, and within 2 weeks was linked through HIV positive friends to a medical doctor and HIV supports. His conditioned lack of constriction pre-diagnostically appears to be translated to his post diagnosis self. For example, he adopted a strategy ripe with socially oriented service providers and specialized service centers. The service center which he attends has bright colored walls and comfortable accommodations, friendly accessible providers, and hopeful signage illustrating the message of open information sharing. This orientation clearly illustrates how this respondent attaches meaning to his particular 'situatedness,' thereby allowing his practice of 'communal learning' as illustrated by the numerous support groups and programs he attends to generate a method where he continually gains new information, and is seamlessly connected to a myriad of providers.

Additionally, the journey of respondents who were heterosexuals diagnosed 3 years or more were positioned and conditioned in such a way as to experience high levels of constriction pre-diagnostically and who like other groups correspondingly experienced somewhat less constriction post diagnostically, were still indeed ‘situated’ in their conditioning and who fittingly and through their ‘doxa’ preferred more private settings where their confidentiality and their particular and unique experiences would be safeguarded.

The ethnographic study in this group illustrates the notion of doxa or how the group attaches meaning, and that this meaning or habitus is grounded in their social conditioning. I call this group ‘The Inspirational Journey,’ and the individual in this ethnography illustrates this description. He notes having an upbringing filled with violence--real and imagined, repeated prison terms, and an orientation that discouraged seeking information or support outside the immediate family structure. This particular respondent clearly illustrates this notion of social isolation in that he describes a life of very minimal support with very little sense of community other than his immediate family and describes his neighborhood as a tough place. Post diagnostically, his particular disposition seems to become re-oriented when for example he describes feeling lost and found. Notably, this individual chose a solitary friend to disclose his HIV status, and she in turn linked him to a very private clinician. Again, the method by which this very clear re-orientation has ‘old and new’ elements clearly grounded in the social conditioning characteristic of his particular position in social space whereby he is strategically allowed to access care, although muted, while involving the least amount of support.

This phenomenon was also illustrated in the last group of homosexuals diagnosed 3 years or more who reported the second lowest levels of constriction, and who incidentally illustrated a willingness to interact with their peers, supportive services and primary care providers in a number of different forums, in groups, formal symposiums, and individually.

The ethnographic study in this group illustrates the notion of doxa or how the group attaches meaning, and that this meaning or habitus is grounded in their social conditioning. I call this group 'With Open Arms,' and the individual in this ethnography illustrates this method of thought. He notes his upbringing was one of social orientation, and describes it as an average upbringing. Further he reports graduating from high school, and being employed, a feature found typical for this respondent group. He notes being very social post diagnostically as well, and reportedly attends multiple services in a variety of forums, such as service centers, advocacy and social supports, and which includes a physician who he located from and through these varied social interactions. This is significant because it illustrates how this particular individual through his 'situatedness' of being socially oriented used the very practices and strategies embedded in the social conditioning characteristic of that particular position in social space to interface with varying sources to access information, services and fulfill other important needs.

This group really hallmarked Bourdieu's notion of 'practical sense,' in that their habits were just 'common sense' routines that were embedded in the precedents of the social group. They served as organizing functions that allowed them to quickly take action and enact change in their everyday lives.

Further, these strategies indicate elements of continuity and discontinuity as the person is transformed through 'habitus,' in that this particular group although showing salience in their ability to 'feel at home' in a wide variety of supportive network settings continued to experience slightly higher levels of constriction post diagnostically. Is it possible that this groups transformation, similar to the others, but in particular as men who identify as homosexual, was both an expansion and a constriction based on the circumstances and context of their everyday lives. This flexibility of practicality and durability provided an adjustment to render their world coherent and meaningful, and to give some otherwise odious systemic social realities acknowledgment.

Bourdieu clarifies, 'individuals do not move about social space in a random way, partly because they are subject to the forces which structure this space, and partly because they resist the forces of the field with their specific inertia, that is, their properties, which may exist in embodied form, as dispositions, or in objectified form, in goods, qualifications etc.' (1984). He goes on to explain…To a given volume of inherited capital there corresponds a band of more or less equally probable trajectories leading to more or less equivalent positions (this is the field of the possible objectively offered to a given actor), and the shift from one trajectory to another often depends on collective events----wars, crises etc.---individual events---encounters, affairs, benefactors etc.---which are usually described as (fortunate or unfortunate) accidents, although they themselves depend on the position and disposition of those whom they befall (pp. 110).

Habitus, Practical Sense and its link to Physical Mobility

If ‘habitus’ is simply the knowledge gained through our dispositions in social space, the interface between the past and present experiences in social space, then ‘habitus’ reflects the adjustments of the agent and the spaces in which they take place. If we consider Lows’ definition of ‘place attachment’ as ‘an individual’s cognitive or emotional connection to a particular setting or milieu (1992),’ and the interplay of a ‘dialectic practice’ which Bourdieu suggests is the mediator that a person comes to form ‘habitus,’ or attach meaning to their positioning and conditioning in social space, then we can be led to believe these transpersonal ties, bonds and relations discussed earlier are collectively designed, adapted and adjusted to the very settings or milieu’s in which they take place.

The respondents who identified as newly diagnosed heterosexuals use of their physical environment pre-diagnostically was almost exclusively limited to their immediate neighborhood, and their cognitive maps revealed they remained most connected to their intimate partners’ or a relative’s home, but that they sought information and HIV support the farthest from those they reported as ‘most connected to.’ This phenomenon might be explicated from the ‘relational dialectic,’ meaning the interchange of the past and present life stories of the respondents. Clearly, this groups’ journey to support and HIV care took the longest and this could conceivably reflect the transaction between their positioning in social space and their transformation to a more expansive existence.

The ethnographic study illustrated how ‘routinized’ the practices are in their everyday lives. For example, the strategy adopted to utilize research announcements as a method to supplement ones income while maintaining a sense of distance and privacy that are absolutely embedded in the disposition or positions and conditions that create and re-create this network of personal governance.

It is clear that the respondents in this group are clearly responding to the power relations embedded in their everyday lives and have sought to re-channel or reconfigure it through individualized, corrective measures carefully adapted to their specific issues or concerns.

The respondents who identified as newly diagnosed homosexuals use of their physical environment pre-diagnostically revealed most often happened outside their immediate neighborhoods. Their cognitive maps revealed post diagnostically a multitude of social venues that they felt most connected to and seemed to access almost immediately after being diagnosed. These social venues allowed for HIV support and care.

The ethnographic study illustrated how these ‘everyday practices’ are embedded in his particular position and conditioning in that, for example the strategies adopted utilized his social oriented upbringing while also providing a method by which to interact, learn, and share his experience in physical spaces that encourages such free flowing information.

This group illustrated a great sense of reflex-ability and expansion in that they responded quite handedly to a social apparatus (day programs and community organizations geared to the same-sex populations) giving them access to greater social provisions than their current social position and conditioning could. An apparatus in place and enforced by the very power relations that created it, but capable of giving access to legitimate routes of upward social mobility.

The respondents' who identified as heterosexual diagnosed 3 years or more use of their physical environment pre-diagnostically was most often limited to their immediate surroundings and neighborhood connections. Their cognitive maps revealed they had the largest reduction in constriction and therefore most transformation to expansiveness although highly constricted when initially diagnosed. It's conceivable, their conditioning and positioning, in that they were incidentally the oldest group, helped them gain or re-gain some sense of legitimacy or accretion. Further, it should be noted, like their 'earlier selves,' it took this group considerably longer to actually access care and HIV support.

The ethnographic study illustrated how 'practical sense' becomes a normalized and continual method of behavior. An example of this routinized behavior is demonstrated in the strategy adopted to utilize a sole individual as an in-road toward linkage to medical care. Further and more specifically, this care is provided in a private manner that takes care to insure his confidentiality is maintained.

The phenomenon illustrated in this group may have its catalyst in the everyday social controls imposed by the law enforcement communities, families, workplaces and communities that together create an everyday environment of norms and sanctions that may underpin the actions of the respondents in this group and may also explain its rather robust response to social controls. Meaning the combination of this initial constriction and the subsequent 'call to action,' and its corresponding connection to law enforcement supervising agencies, i.e. parole, probation, educational institutions and employment that may have galvanized the transformation illustrated here. Simply, I believe the 'relational dialectic' acted out in the 'practical sense' of the agents based on their conditioning and positioning in social space is at work here.

The respondents who identified as homosexual diagnosed 3 years or more use of their physical environment pre-diagnostically most likely happened outside the neighborhood they lived in and their cognitive maps revealed they felt 'most connected' to supportive networks, medical providers and close friends homes that like their 'earlier selves,' were almost immediately accessed after diagnosis.

The ethnographic study illustrated how these routine notions of thought are 'acted out' in our everyday lives through 'practical sense.' For example, the strategy adopted to locate a clinician, or the multiple ways this particular individual gathers, shares, and accesses information are all characteristic of his particular ‘situatedness.’ This means the very social and varied methods of information gathering exerts its influence on this individual’s personal evaluation, use and actions in the physical environment.

This group’s ability to engage with persons and systems through the ‘relational dialectic’ along with a resilient attitude and a close-knit supportive community may explain this groups measured transformation.

Transformational Themes

Transformational themes that seemed to transcend the respondent groups were levels of constriction, age, parental influence, education, income, high crime neighborhoods and mobility.

Perhaps an HIV diagnosis allows those living with HIV to seek networks that encourage a newly forming self through the dialectic of one’s positioning and conditioning, and sense of place, but transcribed through the prism of economic and social disadvantage.

This analysis illustrates no omnipotent strategist, no system or all–seeing agent with perfect knowledge and unlimited insight. It appears from the respondent groups that every solution or ‘group theme’ was based on a situated perception of the problem it needed to address, the interests that were at stake and the values that guided their ‘practical sense’ and movement in social space. It was illustrated in the cognitive maps quite clearly that one’s positioning and conditioning in social space greatly influenced the decisions acted out in ‘practical sense’ habits by the respondent, and this ‘practical sense' was formed, molded and adapted to the respondents everyday experiences and then inscribed in their very movements in social space. Therefore, it appears the ideas that were thus selected were those that fit with the respondent dominant group theme and the specific cultures and/or position and conditioning that supported it. Further, the interactions, transpersonal ties, bonds, and relations arise between respondents and their contextual realities in social space.

Ones' social positioning and conditioning in social space coupled with economic, racial and geographic positioning determinants of the world certainly can affect conduct and behavior through the gradual reshaping of the rules of thought, but are not held constant by them. This gradual reshaping of thoughts, routines, and one's 'practical sense,' appears connected to 'embedded cultural wisdom' imparted through shared rituals like group meetings, educational forums, barbecues, and advocacy trips. Further, social institutions like Day Treatment Programs, Support Groups and Community organizations that allow, promote and include such forums have the ability to knit together different constituencies and institutions—brokering relationships across the different levels of political, economic, and social divide. For example, the advocacy groups that finance sometimes quarterly trips to Washington to lobby a particular political player regarding an issue such as healthcare reform, or access to an increased variety of drugs not only empowers the individual and his or her community, but leaves a lasting impression on that political player. It brings a real face to the issues and impacts on the political process by encouraging policymakers to take a second look at the issues and their impacts on their constituents, by allowing the respondent who at first used the support groups as a financial tool, to actually participate in an environment that encouraged self-transformation and in the process helped him imagine another type of existence far greater than the metrocard at the end of the 45 minute session. Or maybe it's the individual who although positioned and conditioned to guard himself from those who would share his HIV status and create havoc in his life, heard from someone sitting next to him in a waiting room, about a study, a program, an organization that provided some essential service that allowed him to participate. This is the 'relational dialectic,' that entity that powers itself through itself, and everything around it. It all counts. I've included a visual depiction of this idea in Figure 1. That through the 'relational dialectic' of engagement that allows for creative and instructive thinking one can be transformed in their experience of becoming HIV positive and experience expansion in their everyday lives.

This is not to say that to some degree, the normal developmental process by which we as adults mature and therefore begin to 'know' and 'embrace' our true selves, our community, our spiritual selves isn't at play here as well. But it cannot be stressed enough that this 'coming to know…' is prefaced by the 'place' and the attachments thereof that facilitate these 'collective experiences' and in effect act as the platform for re-organizing one's social positionality.

The sense of place and place attachment continue to be an important part of human existence, and this in itself is fascinating.

Research Implications

This research was explicitly qualitative in nature and was an attempt at describing the experiences, perspectives and dispositions of those living with HIV within the context of racism, homophobia and poverty and how the interactions between these dynamics can affect behavior, HIV transmission, one's feeling of connectedness to a setting/place attachment, and mobility.

The respondents it should be noted included self-identified $N_{\text{Black Males}}=33$ and $N_{\text{White Males}}=3$ and therefore had very little White perspective and no female perspective that although discussed in the paper was used to highlight the research intent. Further, the exploration of the cognitive mapping of the respondents did not closely examine the individual experience of exposure to high crime activities, personal experience of victimization or how the amount of time they'd lived in these neighborhoods played a role in their sense of place attachment other than to link the respondents' neighborhood to their cognitive mapping and explore the constrictive dynamics linked to these places.

Concluding remarks

The vast literature on place attachment includes very few studies driven by a specific theory or meant to test specific hypotheses as this study attempts. Sense of place and place attachment continue to be an important part of human existence, and this in and of itself is the main reasoning for this study. With that said, the task of reconciling our need for close emotional ties to specific places with the fluidity of the contemporary world is a real challenge (Lewicka, 2011). Therefore studying the exact nature of the process through which time-space routines are formed, and which conditions must be fulfilled in order to make it successful seemed extremely relevant to adding to our understanding of this process-oriented phenomena.

Appendix A

Research Instruments

Focus Group Script (1)

In this study, we are interested in asking questions about people living with HIV and their use and sense of place, surroundings, the people and events associated with these places and why these places are significant in their lives. Further, you have been given a copy of the specific objectives (we will read these objectives aloud) we wish to explore, but we would like you to share with us some of the things that you think we may need to add, delete, or expand as objectives.

Focus Group Script (2)

In this research we have assembled and asked a group similar to you to look at the objectives of our study in exploring places, use and sense of place, surroundings, people and events that they think are significant in their lives. We asked them to suggest questions that they might want to add, delete or expand. In this group, we have given you a list of questions the initial group devised (we will read these questions aloud), and we would like you to help us critique these questions and explore why you feel they may have included some questions while excluding others.

Cognitive Mapping Script

Does this look like a typical day for you? If not, where else do you go?

What is your method of transportation? Note: Approximate distance/time

Appendix B

Gender: 00Male

Date of Birth: __________ /____________

MMM YYYY

Sexual Identity: 00 Heterosexual

01 Homosexual

Zip Code: ________________________

Marital Status: Single☐ Married☐ Domestic Partner☐ Separated☐ Divorced☐

Cohabiting☐ Widowed☐

Race:

0 White Amer 1 Black/African Amer

Education:

1 elementary school
2 junior high school
3 some high school
4 high school graduate
5 vocational school
6 some college
7 associates degree
8 bachelors degree
9 some graduate school
10 masters degree
11 jd
12 md
13 phd
14 other advanced degree

Household Income ($ US):

1 < $25,000
2 $25,000 - 49,999
3 $50,000 - 74,999
4 $75,000 - 149,999
5 >$150,000
6 Don’t know

Occupation: What do you do in terms of occupation?

____

1Adminsitrative Support
2Arts/Design/Entertainment/Sports-Arts and Design
3Business-Business Operations
4Computer/Math-Computer
5Construction/Extraction
6Education
7Engineers/Architects- Surveyors, Cartographers
8Farming, Fishing, Forestry
9Healthcare-Diagnosing and Treating Practitioner (MD, Dentist, etc..)
10Homemaker or Parenting
11Legal-Lawyers, Judges, and Related Workers
12Maintenance-Buildings and Grounds
13Management
14Military
15Production
16Protective Service
17Repair/Installation
18Retired
19Sales
20Science
21Service and Personal Care
22Social Service-Counselors, Social Workers, Community Specialists
23Transportation
24Unemployed

Diagnosis Date: __________ /____________

MMM YYYY

How long have you lived in the NYC Metropolitan area?

____

Health Status: 1 Very good 2 Good 3 Average 4 Poor 5 Very poor 6 Don't know

Questions:

1. **Tell me about your life prior to your diagnosis?** **Lfprdx(#)**
   LifepriorDX
   What were you doing in terms of work?
   What places did you frequent and what activities did you do while there?
   Who did you associate with and where had you met them?
   What types of leisure activities did you participate in, and where did you participate?

   ____

   ____

   ____

   ____

   ____

2. **When considering your level of open-ness with others, which would you say best describes you <u>prior to your diagnosis</u>**? **Openness PreDX**
   (1) not at all open
   (2) somewhat not open
   (3) not sure
   (4) somewhat open
   (5) very open

3. **When considering your upbringing, which one of the following would most closely describe the place where you were raised?** **Place Raised**
   (1) Urban (metropolitan city)
   (2) Suburban (outskirts or within close proximity to a metropolitan city)
   (3) Rural (village)

4. **Thinking back to your childhood, what places do you believe were significant influences in your upbringing?** **Sgplinup(#)**
   List some reasons for their significance to you
   SignificantPlaceInfluenceUpbring

   ____

   ____

   ____

5. **Are there things about the spaces of these places or the physical surroundings that helped them to be significant for you?** **RSPlPhU(#)**
   ReasonSignifPlacePhysUpbring

   ____

   ____

____

____

6. Did you feel at home in these places? Why or why not? Fe@hmup(#)

FeelathomeUpbring

____

____

____

7. With as much detail as you can remember; Defotup(#)

A) Describe each of these places as if you were looking at it <u>from the outside</u>

DescribefromoutsideUpbring

____

____

____

____

____

With as much detail as you can remember; Defidup(#)

B) Describe each of these places as if you were looking at it <u>from the inside</u>

DescribefrominsideUpbring

____

____

____

____

____

8. Are there any people, groups, &/or events associated with these places that helped them to be significant for you---if so, who &/or what were they?

List some reasons for their significance. **Pgpevup(#)**

PeoplegroupevUpbring

____

____

9. **Would you say your parents or those that raised you emphasized things like 'social equality' or a 'philosophy of diversity' or would you describe their philosophy as being more related to the need for people from the same group (family, religion, community, race, or other group) to 'stick together'?**

00 Social equality/Philosophy of diversity **Parental Influence**

01 Same group 'sticks together'

So switching gears a little…

10. **Tell me about how, if at all, your life has changed since your diagnosis?**

What places do you frequent and what activities do you do while there? **Lfaftdx(#)**
Who do you associate with and where have you met them? **LifeafterDX**
What types of leisure activities do you participate in, and where do you participate?

11. **When considering your level of open-ness with others, which would you say best describes you <u>since your diagnosis</u>?** **Openness Post Dx**

(1) not at all open
(2) somewhat not open
(3) not sure
(4) somewhat open
(5) very open

12. **List (3) '<u>current</u>' places you frequent during a 'typical' week (i.e. drug stores, support services centers, doctor's office, schools, gym), and what purposes they serve for you. Exclude your personal residence** **Plfqcur(#)**

Placesfrequented Current

13. **What is your method of transportation to each of these (3) places? Note: approximate distance/time** **MethodofTransportation** **MetTran(#)**

<u>Cognitive map</u>: **Cognitive Map** **CogMap(#)**

Does this look like a typical day for you? If not, where else do you go?
What is your method of transportation? Note: Approximate distance/time

14. **Of the (3) 'current' places you frequent during a typical week, do you feel at home in these places? Why or why not?** **Fe@hmCu(#)**
FeelathomeCurrent

15. **What would you say are the most significant places for you?**
List some reasons for their significance. **SigPlCu(#)**
SignificantPlaceCurrent

16. **Are there things about the spaces of these places or the physical surroundings that help them to be significant for you?** **SigPlPCu(#)**
ReasonsSignificantPlacePhysicalCurrent

17. With as much detail as you can; **Describefromoutsidecurrent** **DeFotcu(#)**
A) Describe each of these places as if you were looking at it from the outside

B) Describe each of these places as if you were looking at it from the inside

Describefrominsidecurrent **Defidcu(#)**

18. Are there any people, groups, &/or events associated with these places that help them to be significant for you ---If so who &/or what are they?
List some reasons for their significance. **PeoplegroupeventCurrent** **Pgpevcu(#)**

19. Do you feel your heterosexuality/homosexuality influenced your views, if so, how? **HomoHeteroInfluenceviews** **HoHeInV(#)**

Appendix C

Informed Consent Form

My name is Libby Black and I am a doctoral candidate in the Environmental Psychology Ph.D. Department at the Graduate School and University Center at the City University of New York (CUNY), and Principle investigator of this project, entitled "Place Attachment and Mobility in the lives of HIV positive people." This is a research study of place attachment and physical mobility in the lives of people living with HIV exploring experiences, perceptions, and movements. The study is expected to explore how if at all our physical movements are influenced by our experiences and surroundings. I would like your permission to complete either a voice-recorded individual interview or participate in a focus group where you will answer questions about your experiences and perceptions. Specifically, you will be asked to either answer 19 questions in the individual voice recorded interview or participate in a voice recorded focus group consisting of 6-8 respondents.

The interview and the focus groups will take approximately 30 minutes respectively. For your participation you will be given a $10 CVS Gift Card whether you choose to finish or not. **At any time you can refuse to answer any questions or to end the interview or focus group without penalty. Taking part is completely voluntary.**

With your permission, I would like to audio-tape the interview or the focus group so I can record the details accurately. The tapes will only be heard by me and my advisors. All information gathered, including telephone messages, will be kept strictly confidential, and will be stored in a locked file cabinet, to which only I and my advisor, will have access. The data will be kept for a period of no more than three years, at which time it will be shredded by me.

Because of the nature of the study, many of the questions are sensitive. The risk involved in this study, is that you may experience some discomfort in answering questions pertaining to your experiences. The risks from participating in this study are no more than encountered in everyday life. The benefit of your participation is that in the future there will be more information to help people living with HIV. There will be approximately 36 participants taking part in this study.

I may publish results of this study, but names of people, affiliations, or any identifying characteristics will not be used in any of the publications. If you would like a copy of the study, please provide me with your address and I will send you a copy in an unmarked envelope in the future.

If you have any questions about this research, you can contact me at (212) 365-8742 or blacklibby@hotmail.com or my advisor Dr. Saegert at (212) 817-1886 or ssaegert@gc.cuny.edu. If you have any questions about your rights as a participant in this study, you can contact Kay Powell, IRB Administrator, The Graduate Center/City University of New York, (212) 817-7525, kpowell@gc.cuny.edu. Thank you for your cooperation or interest in the study. I will give you a copy of this form to take with you.

I agree to participate in the [check one]: ☐ interview ☐ focus group

I agree to have this interview or focus group audio-taped please [check one]:

☐ Yes ☐ No

________________________ _______ __________________________________ _______

Participant's signature Date Investigator's signature Date

Appendix D

Attention
Participants Needed!!!!

Hello! My name is Libby Black and I am an Environmental Psychology doctoral candidate at the City University. I'm conducting voice recorded interviews in an effort to understand better how we become attached to particular settings, the things we connect to, what we might signify as important in a particular setting, and the ways we travel and move in our social surroundings. Your contribution to this work will be very useful in broadening the dialogue around place attachment and physical mobility.

The interview will take approximately 30 minutes. There are two components—either a self-report voice recorded interview or a focus group. **No names or faces are recorded** and a write-up of the study will not reveal individual identities or affiliations. Call now to set-up an interview. I will gladly make available the interview questions to anyone who is interested. I can be reached directly at my private, non-shared number 212 365-8742.

In order to participate, respondents must be:

- HIV positive, diagnosed within 6 months
- Heterosexual
- Male
- English-speaking
- New York City resident

Please note:
Any identifying information you might share will be held in strict confidence and will not be shared by either the Principal Investigator or her advisor.

Your interviews would be greatly appreciated!

Attention
Participants Needed!!!!

Hello! My name is Libby Black and I am an Environmental Psychology doctoral candidate at the City University. I'm conducting voice recorded interviews in an effort to understand better how we become attached to particular settings, the things we connect to, what we might signify as important in a particular setting, and the ways we travel and move in our social surroundings. Your contribution to this work will be very useful in broadening the dialogue around place attachment and physical mobility.

The interview will take approximately 30 minutes. There are two components—either a self-report voice recorded interview or a focus group. **No names or faces are recorded** and a write-up of the study will not reveal individual identities or affiliations. Call now to set-up an interview. I will gladly make available the interview questions to anyone who is interested. I can be reached directly at my private, non-shared number 212 365-8742.

In order to participate, respondents must be:

- HIV positive, diagnosed 3 or more years prior
- Heterosexual
- Male
- English-speaking
- New York City resident

Please note:
Any identifying information you might share will be held in strict confidence and will not be shared by either the Principal Investigator or her advisor.

Your interviews would be greatly appreciated!

Attention
Participants Needed!!!!

Hello! My name is Libby Black and I am an Environmental Psychology doctoral candidate at the City University. I'm conducting voice recorded interviews in an effort to understand better how we become attached to particular settings, the things we connect to, what we might signify as important in a particular setting, and the ways we travel and move in our social surroundings. Your contribution to this work will be very useful in broadening the dialogue around place attachment and physical mobility.

The interview will take approximately 30 minutes. There are two components—either a self-report voice recorded interview or a focus group. **No names or faces are recorded** and a write-up of the study will not reveal individual identities or affiliations. Call now to set-up an interview. I will gladly make available the interview questions to anyone who is interested. I can be reached directly at my private, non-shared number 212 365-8742.

In order to participate, respondents must be:

- HIV positive, diagnosed within 6 months
- Homosexual
- Male
- English-speaking
- New York City resident
-

Please note:
Any identifying information you might share will be held in strict confidence and will not be shared by either the Principal Investigator or her advisor.

Your interviews would be greatly appreciated!

Attention
Participants Needed!!!!

Hello! My name is Libby Black and I am an Environmental Psychology doctoral candidate at the City University. I'm conducting voice recorded interviews in an effort to understand better how we become attached to particular settings, the things we connect to, what we might signify as important in a particular setting, and the ways we travel and move in our social surroundings. Your contribution to this work will be very useful in broadening the dialogue around place attachment and physical mobility.

The interview will take approximately 30 minutes. There are two components—either a self-report voice recorded interview or a focus group. **No names or faces are recorded** and a write-up of the study will not reveal individual identities or affiliations. Call now to set-up an interview. I will gladly make available the interview questions to anyone who is interested. I can be reached directly at my private, non-shared number 212 365-8742.

In order to participate, respondents must be:

- HIV positive, diagnosed 3 or more years prior
- Homosexual
- Male
- English-speaking
- New York City resident

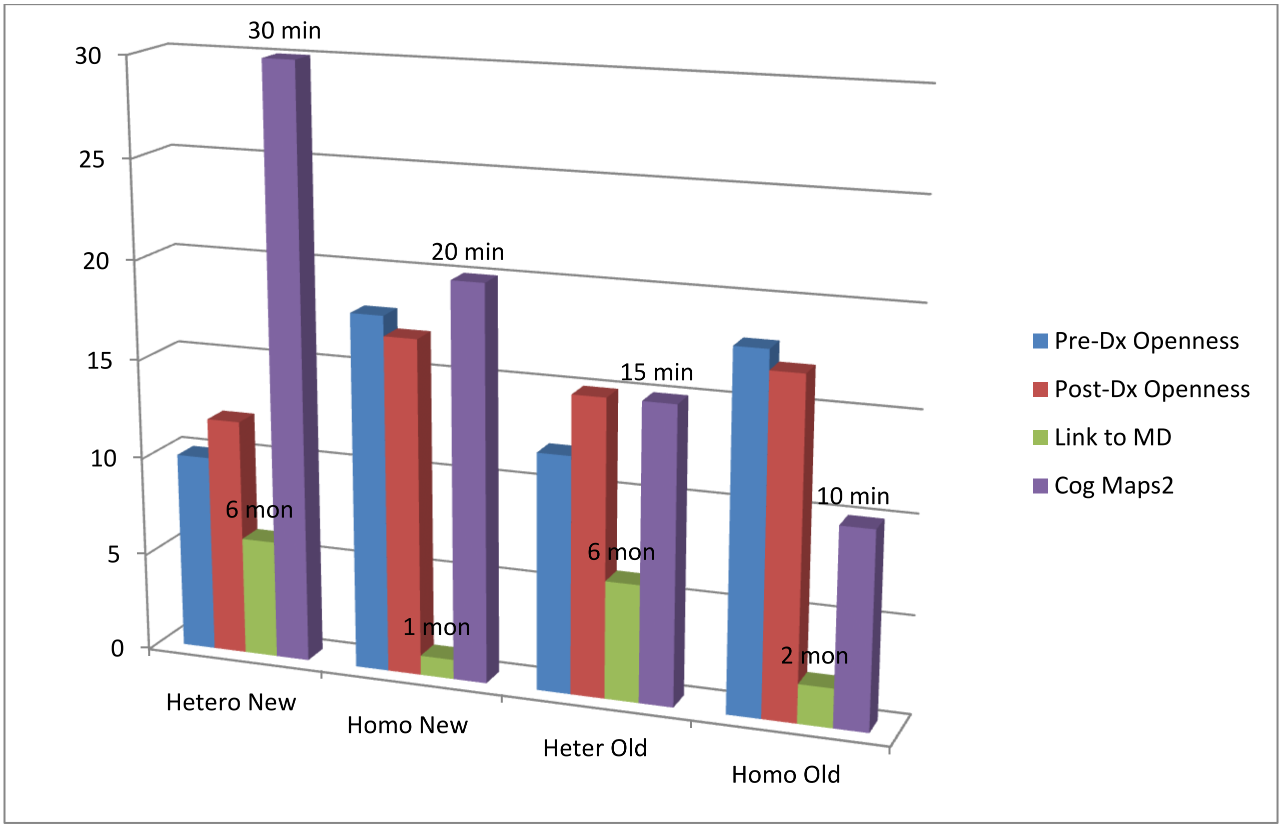
Please note:
Any identifying information you might share will be held in strict confidence and will not be shared by either the Principal Investigator or her advisor.

Your interviews would be greatly appreciated!

Table 2.

Respondent Group	Hetero New	Homo New	Hetero 3 +	Homo 3 +
Constriction (Pre-diagnosis)	**Highest**	**Low**	**High**	**Lowest**
Constriction (Post Diagnosis)	Highest	Lowest	High	Low
Openness (Pre Diagnosis)	**Not at all Open**	**Very Open**	**Somewhat Not Open**	**Very Open**
Openness (Post-Diagnosis)	Somewhat Not Open	Somewhat Open	Somewhat Open	Somewhat Open
Average Age	**46**	**36**	**52**	**44**
Most at home	One-on-One situations with doctor/nurse at a program or private doctor's office	HIV Service Center Program	Place of employment family or intimate partners' place of residence	Place of Employment w/supportive friends 12 Step Fellowship HIV Services Program
Use of Physical Environment (Pre Diagnosis)	**Immediate Neighborhood**	**Outside Immediate Neighborhood/using close knit group of friends**	**Immediate Neighborhood, neighborhood connections**	**Outside Neighborhood**
Average Time to start MD regularly	5-6 months	2 weeks- 1 month	5-6 months	1-2 months
Significant Places (Post Diagnosis)	**MD's Office, Drug Program/Day Program Advocacy Trips**	**Day Programs, Gay Men's Group, Other Supports in Community, Places of Employment**	**Intimate Partner's Home, Neighborhood, Places of Employment**	**12 Fellowships friends, HIV Service Program/Day Program, Own home**
Significant Place Reasons	Privacy	Getting Information, Carfare/ Vouchers	The freedom /power to self-direct	To assist with coping
Most Frequented	**Neighborhood, Drug Program, MD, Intimate Partners home**	**Outside Neighborhood, Employment, Gym, Day Program, Groups, Drug stores, shopping centers, MD clinic/office**	**Neighborhood, MD office, MMTP, Employ, L.E. agencies, Parks**	**Outside Neighborhood, MD clinic/office, Close friends, Supportive networks**
Mode of Transport/Average time	30 min Train/Walk	20 min Train/Bus/Walk	10min Train/Bus	15 min Train/Walk
Cognitive Map	**Longest**	**Long**	**Shortest**	**Short**

Table 3



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Hetero New
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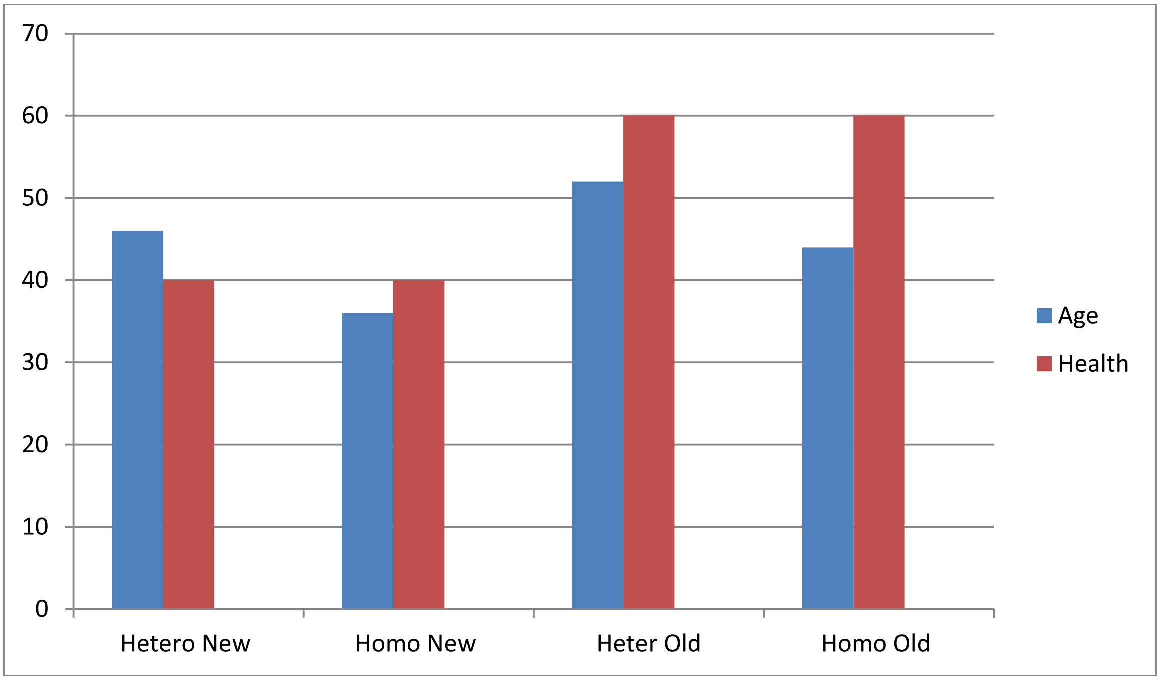
Homo Old
Pre-Dx Openness
Post-Dx Openness
Link to MD
Cog Maps2

Table 4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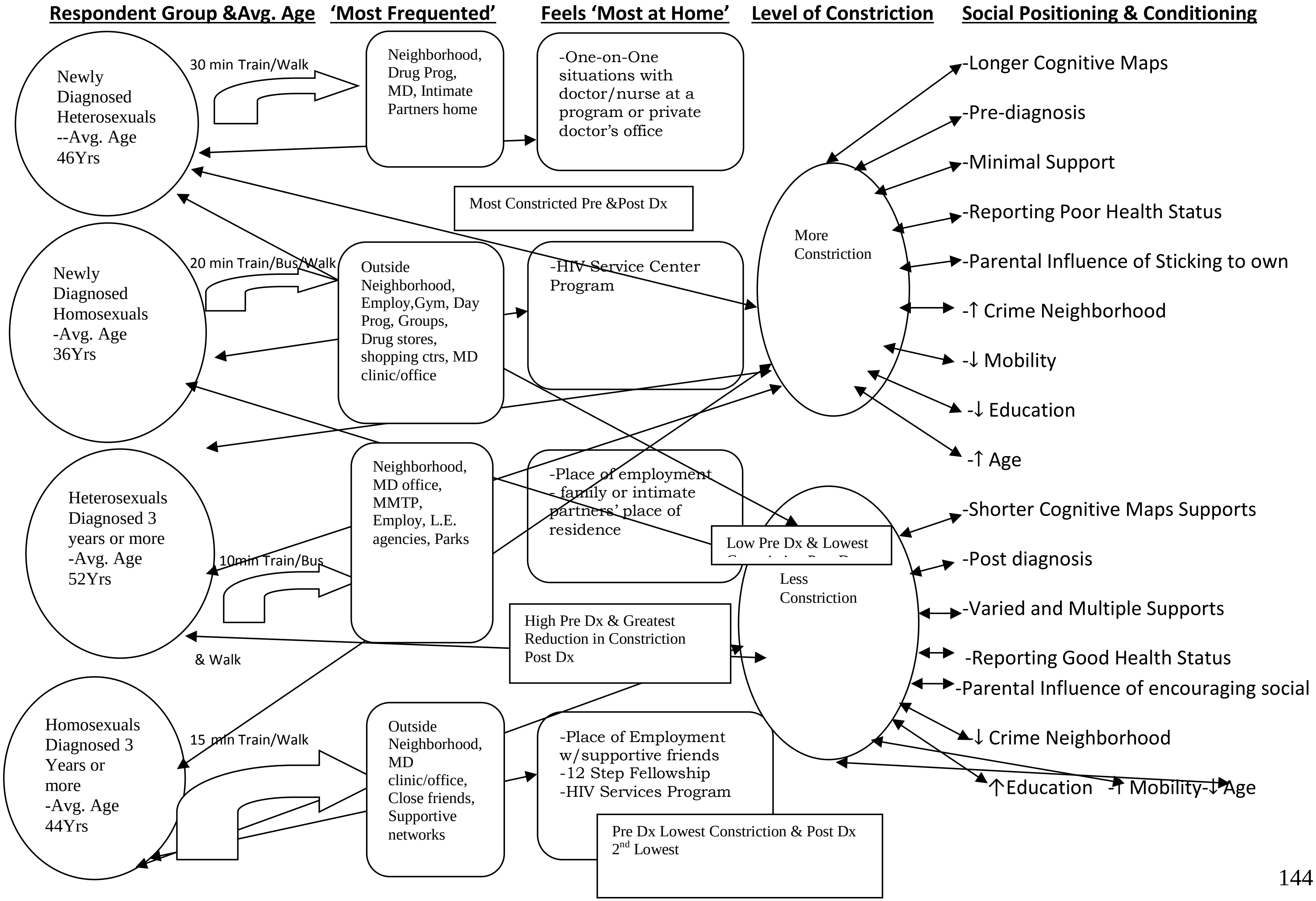
Heter Old
Homo Old
Age
Health

Table 5


Respondent Group &Avg. Age
'Most Frequented'
Feels 'Most at Home'
Level of Constriction
Social Positioning & Conditioning
Newly Diagnosed Heterosexuals --Avg. Age 46Yrs
30 min Train/Walk
Neighborhood, Drug Prog, MD, Intimate Partners home
-One-on-One situations with doctor/nurse at a program or private doctor's office
Most Constricted Pre &Post Dx
Newly Diagnosed Homosexuals -Avg. Age 36Yrs
20 min Train/Bus/Walk
Outside Neighborhood, Employ,Gym, Day Prog, Groups, Drug stores, shopping ctrs, MD clinic/office
-HIV Service Center Program
More Constriction
-Longer Cognitive Maps
-Pre-diagnosis
-Minimal Support
-Reporting Poor Health Status
-Parental Influence of Sticking to own
-↑ Crime Neighborhood
-↓ Mobility
-↓ Education
-↑ Age
Heterosexuals Diagnosed 3 years or more -Avg. Age 52Yrs
10min Train/Bus
& Walk
Neighborhood, MD office, MMTP, Employ, L.E. agencies, Parks
-Place of employment - family or intimate partners' place of residence
Low Pre Dx & Lowest
Less Constriction
High Pre Dx & Greatest Reduction in Constriction Post Dx
-Shorter Cognitive Maps Supports
-Post diagnosis
-Varied and Multiple Supports
-Reporting Good Health Status
-Parental Influence of encouraging social
-↓ Crime Neighborhood
↑Education
-↑ Mobility-↓ Age
Homosexuals Diagnosed 3 Years or more -Avg. Age 44Yrs
15 min Train/Walk
Outside Neighborhood, MD clinic/office, Close friends, Supportive networks
-Place of Employment w/supportive friends -12 Step Fellowship -HIV Services Program
Pre Dx Lowest Constriction & Post Dx 2nd Lowest

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