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"Biographical Ruptures" in the narratives of gay men coexisting with HIV: Disruptions, stigma, and the reinvention of masculinities in Brazil

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EN **Abstract:** This article examines how gay men living with HIV construct meanings and healthcare practices shaped by biographical ruptures, stigma, and structural inequalities. Biographical rupture is understood here as a disruptive event that reconfigures life trajectories, identities, and everyday practices. Grounded in a qualitative, ethnographically informed approach, the study was conducted as part of the postdoctoral project "Masculinities, Life Course, and Care". It draws on semi-structured interviews and field observations with 11 cisgender gay men from diverse racial, generational, and class backgrounds. Data were analyzed through a hermeneutic perspective to interpret the meanings of living with HIV in contexts marked by precariousness, violence, and resistance. Findings indicate that an HIV diagnosis operates as a rupture, prompting self-reinvention, reconfigurations of masculinity, and transformations in relationships. These processes are shaped by intersecting factors such as race, generation, and class, which affect access to healthcare, experiences of stigma, and possibilities for care. "Coexisting" underscores the relational and insurgent character of living with HIV, involving support networks and everyday resistance. Participants challenge biomedical and normative discourses, producing embodied knowledge about life with HIV and redefining masculinities beyond heteronormative frameworks. The study advocates for culturally situated public policies.
Keywords: Masculinities; health; HIV; AIDS; care.

ES "Rupturas biográficas" en los relatos de hombres gais que conviven con el VIH: trastornos, estigma y la reinvención de las masculinidades en Brasil

ES **Resumen:** Este artículo examina cómo los hombres homosexuales que viven con VIH construyen significados y prácticas de atención médica moldeadas por rupturas biográficas, estigmas y desigualdades estructurales. La ruptura biográfica se entiende aquí como un evento disruptivo que reconfigura trayectorias de vida, identidades y prácticas cotidianas. Basado en un enfoque cualitativo y etnográficamente fundamentado, el estudio se llevó a cabo dentro del proyecto postdoctoral "Masculinidades, curso de vida y atención". Se basa en entrevistas semiestructuradas y observaciones de campo con 11 hombres homosexuales cisgénero de diversos orígenes raciales, generacionales y de clase. Los datos fueron analizados a través de una perspectiva hermenéutica para interpretar los significados de vivir con VIH en contextos marcados por la precariedad, la violencia y la resistencia. Los hallazgos indican que un diagnóstico de VIH opera como una ruptura, lo que provoca auto-reinvención, reconfiguraciones de la masculinidad y transformaciones en las relaciones. Estos procesos están moldeados por factores interseccionales como la raza, la generación y la clase, que afectan el acceso a la atención médica, las experiencias de estigma y las posibilidades de atención. "Coexistir" subraya el carácter relacional e insurgente de vivir con VIH, que involucra redes de apoyo y resistencia cotidiana. Los participantes desafían los discursos biomédicos y normativos, produciendo conocimientos corporales sobre la vida con VIH y redefiniendo las masculinidades más allá de los marcos heteronormativos. El estudio aboga por políticas públicas culturalmente situadas.
Palabras clave: Masculinidades; salud; VIH; SIDA; cuidado.

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1. Introduction

HIV/AIDS remains a central public health issue, extending beyond biomedical dimensions to encompass social, cultural, and political processes (Seffner & Parker, 2016; Perlongher, 1987). In Brazil, responses to the epidemic have combined important biomedical advances — such as universal access to antiretroviral therapy through the Unified Health System (SUS) — with persistent structural challenges related to stigma, inequality, and moralizing discourses (Silva Junior, Brigeiro, and Monteiro, 2023; Calazans, Parker, and Terto Junior, 2022; Cueto and Lopes, 2022). Historically marked by strong civil society mobilization and internationally recognized for its rights-based approach (Parker, 1994; Galvão, 2002), the Brazilian response has, in recent years, faced setbacks associated with political and economic crises and the rise of conservative forces, which have weakened public policies and intensified inequalities (Maksud et al., 2022; Agostini et al, 2019).

Within this context, the experience of living with HIV cannot be understood solely in clinical terms, but rather as a socially situated process shaped by power relations, cultural representations, and unequal access to care. Among gay men, HIV intersects with broader dynamics involving sexuality, stigma, and the production of masculinities, as well as with regimes of visibility and representation that circulate in media and public discourse. Cultural and media narratives (from early representations of AIDS as a "moral disease" to more recent biomedical framings centered on treatment and prevention) play a key role in shaping how HIV is experienced, interpreted, and negotiated in everyday life, influencing expectations around risk, responsibility, and normality (Silva et al, 2024; Mora & Monteiro, 2025).

To understand these processes, this article draws on studies of masculinities, a field consolidated by authors such as Raewyn Connell (1995) and Michael Kimmel (1987, 1998), who highlight how gender norms are socially constructed and hierarchically organized. The concept of hegemonic masculinity (Connell, 1995) underscores how certain models of masculinity are privileged, producing inequalities and shaping men's relationships with health, including resistance to care and engagement in risk practices (Tramontano & Nascimento, 2025; Ragonesse, Shand & Barker, 2019; Rocha & Zucchi, 2025). These dynamics are further complicated by intersectional factors such as race, class, and generation (Couto, Venturi & Machin, 2019; Vigoya, 2018), which structure differential access to healthcare and exposure to stigma.

Central to this article is the concept of biographical rupture, originally proposed by Michael Bury (2011), which refers to the disruption of taken-for-granted life trajectories caused by chronic illness, requiring individuals to reinterpret their identities, relationships, and everyday practices. In the context of HIV, this rupture is not only a personal turning point but also a socially mediated process, shaped by stigma, biomedical regimes, and structural inequalities. Rather than representing a purely negative break, biographical rupture may also open up possibilities for re-signification, resistance, and the reconfiguration of masculinities.

In Brazil, where HIV/AIDS has historically been marked by processes of moralization and exclusion (Daniel & Parker, 2018; Grangeiro et al., 2023), this rupture unfolds within a broader landscape of tensions between biomedicalization and rights-based approaches. The growing emphasis on biomedical prevention strategies, while crucial, has often been accompanied by a weakening of community participation and activist engagement, contributing to a more individualized and less politicized understanding of the epidemic (Cueto & Lopes, 2022; Grangeiro et al., 2023). This shift risks obscuring the social determinants of health and the collective dimensions of care.

Against this backdrop, this article examines how gay men living with HIV construct meanings and healthcare practices in contexts marked by precariousness, stigma, and inequality. Drawing on an ethnographically informed qualitative approach, it explores how biographical rupture is experienced and negotiated at the intersection of masculinities, social markers of difference (particularly race, class, and generation), and broader sociocultural and political dynamics (Ferrari & Nascimento, 2021; Oliveira & Nascimento, 2026). By doing so, the study seeks to contribute to debates on HIV/AIDS, masculinities, and health by foregrounding lived experience as a key site for understanding both the persistence of inequalities and the emergence of everyday forms of resistance and care.

2. Research design and methods

This was a qualitative, ethnographic study linked to the postdoctoral project "Masculinities, Life Course, and Care: Navigating Narratives, Experiences, and Practices of Men Living with HIV", conducted within the Graduate Program in Women's and Children's Health at the Fernandes Figueira Institute (IFF/Fiocruz). The research was based on semi-structured interviews and field notes, prioritizing the listening and understanding of the life trajectories of 11 cisgender gay men living with HIV, whose profiles reflect diversity in terms of age, race, and social class, enabling an expanded intersectional lens. Data were processed through a hermeneutic perspective (Geertz, 1989), to understand the meanings attributed to care, health-related relationships, and the experience of being a gay man coping with the virus. Intersectionalities were analyzed through the framework of the micropolitics of care, highlighting how the notion of care manifests in participants' everyday experiences (Longhi, 2015; Henning, 2020).

Regarding the hermeneutic methodological perspective we adopted, drawing on Clifford Geertz (1989), we began with the premise that culture should be understood as a system of shared meanings, with the researcher's role being to interpret these meanings through individuals' social practices. This methodology challenges us to engage in a dense, contextualized reading of social phenomena, attentive to capturing the perspectives of the subjects studied and the meanings they attribute to their actions. Therefore, by adopting Geertz's (1989) hermeneutics as a methodological foundation, the article is grounded in an approach that prioritizes interpreting meanings emerging from participants' own narratives and experiences within their respective backgrounds and particularities. This perspective highlights the significance of ethnography as a qualitative research method, not only for documenting social practices but for deciphering the meanings that underpin them, while considering the multiplicity of voices and experiences that constitute the studied reality.

Field research was conducted in the city of Rio de Janeiro, with access to participants facilitated through the researcher's engagement with an NGO historically committed to HIV/AIDS activism since the late 1980s: Group for the Valuation, Integration, and Dignity of People Living with AIDS (*Grupo Pela Vidda – Grupo pela Valorização, Integração e Dignidade do Doente de AIDS*) (Valle, 2015, 2018). Although this article does not specifically focus on the work of this NGO, it is important to acknowledge from the outset that its actions and dynamics, developed since its foundation in 1989 in Rio de Janeiro, have played a pivotal role, alongside the work of other NGOs and associations, in the fight for recognition and the safeguarding of fundamental rights for people living with HIV (Valle, 2018; Oliveira, Nolasco & Nascimento, 2024; Oliveira & Nascimento, 2026).

Data collection occurred between August and December 2024. At the beginning of the fieldwork, the leading author began attending the monthly meetings organized by the NGO, which brought together a small group of individuals, some living with HIV. Through these meetings, a bond was created between the researcher and several members of the organization, enabling access to a key informant. From this initial contact, a broad network of interlocutors was established using a snowball sampling technique, which, in turn, facilitated access to participants outside the primary research site. Of the 11 individuals interviewed, nine were from or lived in the state of Rio de Janeiro. As for the remaining two, one was from Belo Horizonte, Minas Gerais, and the other from Vitória, Espírito Santo. Intentionally, we only draw on the accounts of participants who were either native to the state or residing there at the time of the research.

Data collection involved participant observation, with information recorded in a field diary, and semi-structured individual interviews, which were recorded with the consent of all participants. The interlocutors were offered the option to conduct the interviews either in person or remotely. Of the 11 participants, 10 chose remote interviews, either for privacy concerns or logistical reasons (such as distance). In addition to the recordings, the field diary was an essential tool for the subsequent data analysis. Interviews followed a predefined guide designed by the authors for this study. The focus of the interviews included topics such as: biographical and life trajectories; the context of diagnosis; concepts of care; the interrelation between masculinity and HIV/AIDS; activism; and the meanings of life. Each interview lasted between 30 minutes and 2 hours and 16 minutes.

Regarding ethical clearance, the study was approved by the Research Ethics Committee of the IFF/Fiocruz, under the Certificate of Ethical Consideration (CAAE) No. 83821524.0.0000.5269 and Opinion No. 7.181.225, in compliance with the ethical guidelines established by Resolution No. 510/2016 of the National Health Council, which governs ethical standards in research within the Human and Social Sciences.

3. Findings

The research involved the participation of 11 interlocutors, all cisgender men who self-identified as gay, "bicha" (an emic term), or homosexual. Although this article focuses on the narratives and trajectories of only nine participants, it is important to present the sociodemographic profile of the entire group (Table 1). Regarding age, the predominant group was between 29 and 40 years old (n=8), while a smaller group fell between 48 and 61 years old (n=3).

In terms of racial identity (self-declaration), most participants identified as Black or Mixed-race (n =8)[1], with three identifying as White. As for education, with the exception of two participants, one with only a high school diploma and the other with a technical course, the remaining had completed higher education. When it comes to occupation, most participants were employed under formal employment contracts, either in the private sector or in the public service, with only one being unemployed. On the other hand, one participant was a person with a disability (PWD), had completed high school, and was unemployed (interlocutor 9). About religion, two participants were affiliated with Afro-Brazilian religions (interlocutors 1 and 3), one identified as evangelical (interlocutor 9), and another as Catholic (interlocutor 10). The remaining participants did not report any religious affiliation.

[1] In Brazil, according to the official parameter of the Brazilian Institute of Geography and Statistics (IBGE), Black and Mixed-race people constitute a unified category.

Table 1. Sociodemographic profile of the research interlocutors, Rio de Janeiro, Brazil, 2024

Interlocutor, age	Racial Identity	Schooling	Occupation	Religion
1, aged 46	Mixed-race	College	Artist	Afro-Brazilian
2, aged 35	Mixed-race	College	Student	Uninformed
3, aged 29	Black	College	Student	Afro-Brazilian
4, aged 40	Black	High School	Lab Technician	Uninformed
5, aged 40	Mixed-race	College	Professor	Uninformed
6, aged 61	White	College	Retired Advertising Professional	Uninformed
7, aged 48	Mixed-race	College	Biomedical Scientist	Uninformed
8, aged 30	White	College	Advertising Professional	Uninformed
9, aged 29	Black	High School	Unemployed	Evangelical
10, aged 35	Black	College	Social Worker	Catholicism
11, aged 34	White	College	Accountant	Uninformed

Source: Posdoctoral Research (2024).

Throughout the interviews, several recurring themes emerged, including: the experience of receiving an HIV diagnosis, understandings and interpretations of masculinity, and processes of healing and the production of care.

3.1. Biographical disruptions and HIV

This section analyzes the narratives and biographical trajectories of the participants through the lens of biographical rupture, mobilized here not merely as a descriptive concept but as an analytical operator that enables the interpretation of how living with HIV reorganizes subjectivities, social relations, and practices of care. Following Michael Bury (2011), chronic illness is understood not simply as a biomedical condition, but as a disruptive event that destabilizes taken-for-granted assumptions, interrupts life trajectories, and compels individuals to actively reconstruct meanings, identities, and everyday routines.

In the context of HIV, this rupture acquires specific contours, as it is mediated by historically sedimented stigmas, moral discourses, and unequal structures of access to care. Rather than constituting a singular moment, rupture unfolds as a process, permeating different temporalities of experience — from the moment of diagnosis to the ongoing negotiation of living with the virus. As such, it operates simultaneously on existential, relational, and socio-political levels, challenging interlocutors to rearticulate their positions as gay men within fields marked by heteronormativity, biomedicalization, and structural inequalities (Parker & Aggleton, 2024; Nolasco, 2024; Oliveira & Nascimento, 2026).

By approaching the empirical material through this framework, the narratives presented here are not treated as isolated or merely descriptive accounts. Instead, they are read as situated productions of meaning that reveal how participants interpret, negotiate, and at times resist the conditions imposed by HIV. This perspective allows us to apprehend how biographical rupture is unevenly experienced, being shaped by the intersection of social markers such as race, class, and generation, which modulate access to healthcare, exposure to stigma, and possibilities of care.

Thus, the interlocutions analyzed in this section illuminate how HIV not only affects physical health but also reconfigures emotional, social, and symbolic dimensions of life. The accounts that follow, therefore, should be understood as expressions of a broader socio-historical process, in which individual trajectories intersect with collective histories of marginalization, activism, and resistance (Henning, 2020). Through them, we seek to demonstrate how living with HIV involves not only disruption, but also the ongoing work of self-reinvention and the production of new meanings of being and caring as gay men (co)living with the virus.

3.1.1. Biographical rupture and the experience of diagnosis: temporality, shock, and moral reconfiguration

As we said earlier, rather than a punctual event, the HIV diagnosis emerges in the narratives as a biographical rupture that reorganizes temporalities, moral frameworks, and perceptions of self. In line with Michael Bury's (2011) formulation, rupture is not limited to the moment of diagnosis, but unfolds as a process that destabilizes taken-for-granted assumptions and compels subjects to reinterpret their trajectories and futures.

For some interlocutors, this rupture is marked by an abrupt confrontation with finitude and vulnerability. As **Interlocutor 1** states, the diagnosis serves as a moment when "a veil is lifted," producing an acute awareness of mortality and triggering a moral re-evaluation of life itself.

"It was a difficult moment. Because it's a moment when a veil is lifted, right? You come face-to-face with your own mortality. With the idea that one day you will die. And that triggers several alarms, doesn't it? About

life, about... trying to be less arrogant, about seeking to be less arrogant. Beyond that, you start thinking about eating properly, taking care of yourself, right? (...). There are things that only someone living with HIV knows. And only they have the experience. Because, beyond physical death, there's social death, you know?"

This experience illustrates how rupture operates not only as disruption, but also as a reflexive turning point, in which values, behaviors, and self-perceptions are reconfigured — here expressed in the effort to "be less arrogant" and to engage in practices of self-care. At the same time, the narrative introduces a central tension: alongside the threat of physical death, there is the anticipation of a "social death," revealing how stigma is constitutive of the rupture experience.

In other cases, rupture is experienced through intense affective disorganization, closely tied to the conditions under which the diagnosis is delivered. **Interlocution 2**, for instance, describes the moment of diagnosis during the COVID-19 pandemic as a scene of sensory and emotional fragmentation — "bright lights," "white walls," and an "echo" that produces a lasting sense of emptiness.

"The week before my birthday, in the midst of the long Covid-19 pandemic, I took a rapid test, which I had only decided to do casually, since I was there to treat a possible penile candidiasis. The doctor told me, 'Your test result came back positive for HIV!' (...) I was completely floored. I was terrified, terrified of stigma, of shame, of anxiety, of pain, of shortness of breath. I remember the bright lights, the white walls, the doctor in his white coat, and a persistent sound, an echo that reflected in an emptiness that has since remained constant within me. I can barely remember how long it lasted; it seemed like an eternity. I don't know how I crossed the wall, the corridors, the reception area full of people who were looking at me, while trying to hide their presence in that place."

Here, rupture is not only cognitive but also embodied and atmospheric, shaped by clinical settings and institutional interactions. Similarly, **Interlocutor 10** emphasizes that what marked him most was not the diagnosis itself, but the way it was communicated, highlighting how healthcare practices mediate the experience of rupture and can intensify its traumatic dimension:

"These processes were quite early for me, you know? It was in 2012. 2012 was a year of several milestones. It was the year I started my undergraduate degree, the year I came out to my family as gay, and the year HIV entered my life. At the time, I was in a monogamous relationship. I didn't really understand it. There was never any direct discussion about these things at home or in other spaces. In fact, I realize now that my adolescence and youth were really lacking in this area, in terms of addressing sexuality, prevention, and so on. So, when this information reached me, it was a bit late. I didn't have access to the knowledge I have now. And, initially, it didn't exactly terrify me, but it did make me anxious. What was worse for me, though, was the way I found out. It wasn't just the diagnosis itself, but the way the result was delivered to me, which was quite heavy. It came from a urologist I had been seeing because I was dealing with physical symptoms. You go to the doctor because something is happening to your body. I was having some bleeding, and that's when I did the tests. I didn't even know that he had requested STI tests, including HIV. When I went back for the results, I was given the news in a very bad way, you know? It was harsh for me. That experience really left a mark. Of course, today I have a different perspective on it, but at that moment, it was a really heavy time for me."

The temporal dimension of rupture also varies across trajectories. For **Interlocutor 5**, the diagnosis is associated with a prolonged period of disorientation, extending over a year, marked by the anticipation of imminent death and the absence of adequate institutional support.

"In 2008, a friend of mine who worked at Fiocruz, in the Iprex project, invited me to take part in a study on the early stages of PrEP. So, I went there and decided to participate. I went to do the exams to start PrEP, but then I found out I couldn't join, because it was already too late, if you know what I mean. That was in 2008. And, to make matters worse, it was on my birthday. Well, not exactly on the day, a bit before my birthday, I went in for the tests, and the results came some time later, you know? They called me in to give me the results on my birthday. You see? That was on 29 October 2008. They called me, gave me the result, and I was devastated. I wanted to throw myself away... I just couldn't accept it. At that time, the psychologist, a bit of a mess, really... not mad, just not competent, didn't even invite me to talk. He just said, 'It's this and that, that's it, alright?' and left. Didn't say another word. I was completely lost for a whole year, you know? I kept working, but I didn't know what to do. I thought I was going to die three days later, you know? So, a year later, Fiocruz called me again to do more exams and start follow-up care with them, you see?"

The lack of psychological care at the moment of diagnosis exacerbates the rupture, transforming it into a period of suspension and uncertainty. In contrast, **Interlocutor 6** articulates a narrative of continuity, in which the diagnosis is incorporated into everyday life through a pragmatic decision to "carry on."

"Well, what I vaguely remember about it is something like this: people used to say, 'You have to take the test.' So, I did it the first time, then the second time, and nothing. Then, the third time I took it, the result came back positive. The doctors came, and I was afraid to think about it too much, you know... But I'll admit to you, where I found out was a hospital, I don't even know if it still exists, that used to be on Presidente Vargas Avenue. And between the gate, the pavement, and the street, there's a bit of a quiet spot. I didn't think for a moment, 'Oh, I'm going to throw myself in front of something!' The only thing I thought was, 'I have to go to work' So, you know... I got the diagnosis and made a decision: I'm going to carry on, I'm going to keep living my life.

Then they sent me to another hospital, told me to do a test at a private laboratory. I did it, and they called me in again. 'So, what happened?' they asked. And I said, 'No, I already know.' And then I was referred to a clinic for further exams and treatment, where I met Dr. M., an amazing guy. So, I began my treatment with a private doctor, and I've been with him for 28 years now. It's a love–hate relationship, he tells me off. I accept it; he has his reasons, and I just keep going. That's part of the treatment, of course."

This does not imply the absence of rupture, but rather a different mode of engaging with it— one that foregrounds endurance and the normalization of living with HIV over time.

These differences indicate that biographical rupture is not experienced uniformly; rather, it is mediated by social positions, previous knowledge, and access to care. **Interlocutor 7**, for example, mobilizes biomedical knowledge to interpret bodily signs and respond to the diagnosis without shock, yet his narrative reveals a persistent concern with social rejection, reinforcing the centrality of stigma even in contexts of informational familiarity.

"When I found out, it was quite a funny thing. I had no symptoms, nothing at all, but I had never had gingivitis before, never. Then, I got gingivitis. I thought, 'What's going on?' I went to the dentist, and they said: 'Do this, do that, treatment, all sorted.' My gingivitis improved. Fifteen days later, it came back. I thought, 'This isn't normal. This isn't right. I eat healthily; I take care of myself. This is not normal.' So, I said to myself, 'This is unusual. Two bouts of gingivitis in such a short period, this is not normal.' That's when it clicked, I needed to go and get tested.

So, I went to the lab. Since I work in a lab, I did the test, a rapid test. And the rapid test came back positive for both hepatitis B and HIV. I hadn't done a test for syphilis because I had already been diagnosed with syphilis, hepatitis B, and HIV. You know, you might ask, 'How did you react?' Normal, I guess. I wasn't in shock. My whole concern was about rejection... How can I put it? Rejection by people and society, because nowadays, there's still this prejudice, this idea that HIV is like an Ebola virus or something."

Likewise, **Interlocutor 4** explicitly situates his experience within an intersectional framework, linking the impact of the diagnosis to being Black, overweight, and affectively marginalized.

"(Self-identified as bicha). I discovered my HIV status in a relationship that I considered monogamous. About 15 years ago, I was in a relationship that I thought was monogamous, at least on my part it was. I ended up finding out about my serology, getting really sick, and needing surgery. The doctor suspected it was cancer. Actually, I had a gastrointestinal issue, and he suspected rectal cancer. We did all the tests, biopsies, and nothing came up; everything was inconclusive. Then, when he asked about my serology, in my mind, everything was fine; we hadn't tested for a while. So, we did the tests, and all of them were negative except for the HIV test. And I immediately figured it out, since I'm from a lab background. When the private lab called me asking me to see a doctor for a 'Wester Blood' request, which is the confirmatory test, I knew. I knew something was up. And then, my world just spiraled, right? It was complicated. At that point, all the intersectional factors came into play: being Black and being overweight. So, I had all these intersections; I'd had very few affectionate relationships, mostly sexual ones rather than emotional. Always seeking affection through the more sexual side of things. And when I found out, it just hit me. It felt like, well, if they didn't want me before, now with HIV, they'll want me even less. I actually thought these things a few times."

In this case, rupture intensifies pre-existing experiences of exclusion, particularly in the field of desire and affectivity, where HIV is perceived as further reducing already limited possibilities of recognition.

Finally, the narratives also reveal how rupture is mediated by cultural repertoire and prior representations of HIV. **Interlocutor 9**, diagnosed at a young age, refers to a storyline from a popular television program as a reference that shaped his expectations about the disease.

"It's been 12 years since my HIV diagnosis. I was 16 at the time. I wasn't living with my parents, but I lived on the same street. Back then, I was living with someone, and I always took great care of myself. I was the kind of person who used moisturizers, face creams, all that sort of thing, a bit vain, you know?

I remember it was during Carnival. I was getting ready to go to Rio das Ostras, and while I was there, I think it was because of the drinking, the heavy food, the prawns, and all that, my lips started to crack. I thought it was strange because, as I said, I was very particular about my appearance. So, when I got back to Rio [de Janeiro], I told the person I was living with that I wanted a full blood test, the full panel, everything.

At the time, I was still underage, so I couldn't even collect my own test results. Since I was a minor, my mother had to go and get them for me. And I think it was around the same time that Malhação [a popular Brazilian TV series] had started to address this issue, there was a storyline about a mother and her son, who was HIV-positive. That really stuck with me.

So, ever since then, I had it in my head that if I ever tested positive, it wouldn't affect me as much as it might others. I used to think there were worse things that could happen. But, in the end, the way I found out was almost ironic.

As I said, my lips were cracked, and I had already taken the test. Then I turned to my mother and said: 'Mum, I've got HIV, and you didn't say anything.' There was this silence. And then she said to me: 'I couldn't tell you that you had it.' But I had already noticed she was acting differently, withdrawn, kind of sad."

This suggests that rupture is not experienced in a vacuum, but is informed by circulating meanings that anticipate, frame, and sometimes mitigate its effects.

Taken together, these accounts demonstrate that biographical rupture, in the context of HIV, is a multi-layered and processual phenomenon, encompassing existential shock, moral reconfiguration, embodied experience, and social positioning. Rather than a singular break, it constitutes an ongoing negotiation between disruption and continuity, in which subjects mobilize different resources (affective, social, and symbolic) to reconstruct their lives.

4. Discussion

As Michael Bury (2011) points out, the Illness is not merely a medical event; it represents a pivotal moment that unravels future plans, undermines one's sense of self, and transforms social relationships; it creates a

profound discontinuity between the "before" and the "after", necessitating a re-interpretation of one's personal biography.

In some of the accounts, HIV appears as such a dividing line. Not by chance, Interlocutor 1 speaks of a "veil falling" and confronting his finitude. The diagnosis triggers an existential reconfiguration that leads him to revisit his values and self-care practices: "to try to be less arrogant", "to eat well", "to take care of myself". For Interlocutor 2, the experience is described as a sensory and subjective collapse: "an echo reflected in an emptiness that became present." His biography is interrupted, "I was left on the ground", and time seems suspended. Meanwhile, Interlocutor 4 reveals an abrupt shift in self-perception: "my world flipped". The revelation of his HIV status involves reconsidering his romantic past, his affections, and the value of his body in the eyes of others.

It is worth reflecting on how the biographical rupture is intertwined with processes of social vulnerability (Ayres et al., 2009; Butler, 2015). In the case of Interlocutor 4, when he shares, "Then there were all these intersections of having had very few affectionate relationships, or many more sexual ones than affectionate", he reveals a significant divide between affection and sexuality in the experiences of young gay men. This points to the difficulty in forming deep emotional bonds within a context shaped by multiple social intersections, an experience that becomes even more pronounced for individuals coping with HIV. Furthermore, this observation aligns with the analyses of Wendell Ferrari and Marcos Nascimento (2021), who illustrate how the masculine socialization of these young men is deeply rooted in masculinities that valorize heterosexuality and reinforce a model of the "real man", which is inherently incompatible with homoaffective expressions.

These authors emphasize that such pedagogies not only marginalize dissident masculinities but also structure the affective-sexual experiences of young men in an unequal manner. In this context, eroticism is often dissociated from affection, and the experience of sexuality occurs in environments marked by insecurities, discrimination, and silencing (Ferrari & Nascimento, 2021). The emphasis on predominantly sexual relationships, as highlighted in the excerpt above, can be understood as a direct consequence of the internalization of gender and sexuality norms that fail to recognize homoaffective desire as legitimate or deserving of care. Of note, these trajectories are shaped by markers such as class, race, and gender expression, which reinforce inequalities within the gay community itself. Young men who fall outside the hegemonic ideal, often racialized, masculinized, and economically privileged, tend to be even more vulnerable, both in their sexual experiences and in their ability to form secure and reciprocal emotional bonds (Ferrari & Nascimento, 2021).

The news of an HIV diagnosis reorganizes the meanings attached to life, the body, and relationships. The diagnosis is less a clinical fact than a narrative disruption, one that demands new meanings for the individual's own story. These meanings are constructed from the trajectories and experiences of each person living with HIV. After all, what role does experience play in these processes of "biographical rupture"? The Spanish philosopher Larrosa Bondía (2002) proposes that experience is not merely something that happens to us, but rather something that crosses us and transforms us. Unlike objective knowledge, the "knowledge of experience" is embodied, subjective, and singular. In these accounts, HIV is less a "disease" in the biomedical sense and more a transformative experience, one that can only be fully understood by those who live through it.

Let us delve into the following examples. Interlocutor 1 expresses this distinction clearly: "There are things that only someone living with HIV knows." Here lies the core of *experiential knowledge*, a form of knowledge not learned from books or medicine but embedded in lived experience with the virus. Meanwhile, Interlocutor 7 speaks "naturally" about the diagnosis, but his account centers on social stigma, which is where the true trauma lies. The illness is not only in the body but in the gaze of others, in the rejection (Daniel & Parker, 2018). In the case of Interlocutor 10, it is made explicit that the greatest impact was not the virus itself but the manner in which the information was delivered. This reveals how medical knowledge can be indifferent to subjective experience, reinforcing symbolic violence that exacerbates suffering (Ferrari et al., 2021; Ferreira & Bonan, 2021).

Therefore, HIV is experienced not only as a clinical condition but also as a marker of profound experiences that intersect the body, time, identity, and social relationships (Nolasco & Bernardes, 2023; Côrrea Junior, 2023). Not surprisingly, studies on HIV/AIDS have historically highlighted not only the biomedical challenges of the epidemic but also the complex intersections between health, stigma, and social inequalities (Parker, 2013; Daniel and Parker, 2018). The trajectories of gay men living with HIV are shaped by dynamics of discrimination, institutional abandonment, and vulnerabilities in support networks, creating experiences that transcend the diagnosis and are rooted in a context of symbolic and social violence (Ferrari & Nascimento, 2021; Oliveira & Nascimento, 2026).

One of the aspects that emerges from these trajectories is the impact of stigma on the construction of a sense of identity and belonging (Parker & Aggleton, 2021). The statement from Interlocutor 1 illustrates how the diagnosis marks a "moment when a veil falls", highlighting the social death imposed by prejudice. Larissa Pelúcio and Richard Miskolci (2009) discuss how the stigma surrounding HIV/AIDS is not confined to the biomedical dimension but is intertwined with historical forms of oppression, particularly when associated with homosexuality. This intersection becomes even more pronounced when other categories of difference, such as race, disability, and class, are involved.

The account of Interlocutor 4, for example, expresses how HIV intersects with other marginalizations: being a Black, overweight person with a history of affective relationships marked by rejection intensifies the sense of not belonging. Herbert Daniel (2021) highlighted how the social experience of living with HIV often reactivates pre-existing forms of violence, denying those living with the virus a dignified place within society. Similarly, research by Paulo Victor Avelino Monteiro et al. (2024) demonstrates how the experience of being a

gay man with HIV, in the context of precarious affectivities, reinforces the construction of vulnerabilities, both in terms of access to diagnosis and in relation to treatment and adherence.

Another key point lies in the relationship between access to healthcare and the unequal forms of reception/shelter (Ayres et al., 2009). Interlocutor 5 recounts an episode of negligence in which they received their diagnosis in a blunt manner, without the appropriate professional support. This situation is recurring in the accounts of individuals living with HIV and/or those belonging to sexual minorities, highlighting structural failures within the healthcare system (Ferrari et al., 2021; Ferreira & Bonan, 2021). The inadequacy of professionals in addressing the humanization of care reflects institutional dynamics that perpetuate the dehumanization of certain bodies. As Gabriel Luis Pereira Nolasco (2024) notes, HIV/AIDS is still permeated by a moralizing discourse within healthcare services, complicating access to treatment and proper ongoing care.

The vulnerability generated by a lack of information is also a recurring factor. Interlocutor 10 recounts that the diagnosis arrived at a time of limited understanding of prevention and sexuality, reflecting deficiencies in sexual education. Herbert Daniel and Richard Parker (2018) argue that HIV/AIDS is also a pedagogical phenomenon, wherein gaps in its understanding and depathologization perpetuate vulnerabilities. In this line of thinking, Alexandre Grangeiro et al. (2022), when analyzing the trends and challenges in the response to the HIV epidemic among adolescents and young people, pose that the persistence of these vulnerabilities is linked to a disconnection between public policies and generational transformations in how sexuality, gender, and affection are experienced. Despite biomedical advances and a diverse range of preventive technologies, such as PrEP, the lack of an appropriate dialogue with the experiences and needs of new generations, often characterized by non-normative performances and the pursuit of greater autonomy in sexual practices, contributes to the prolongation of the epidemic. The authors contend that this gap is exacerbated in scenarios where political conservatism internalizes stigma in governmental actions, thus hindering an intersectional and participatory response (Daniel & Parker, 2018). Consequently, HIV/AIDS remains a reflection of the pedagogical and political insufficiencies that shape the lives of young individuals, particularly those whose trajectories lie on the margins of normative standards.

Even through adversity, some trajectories also reveal the strength of support networks and the potential to re-signify life with HIV (Côrrea Junior, 2023). For instance, Interlocutor 6 underscores continuity and resilience in his life, highlighting that HIV can be integrated without becoming an existential constraint. This experience aligns with the arguments by Gabriel Nolasco and Anita Bernardes (2023) and Salvador Côrrea Junior (2023) on processes of subjectivation and care networks, which are fundamental to the well-being of people living with HIV. Thus, the discourses analyzed demonstrate how the trajectories of gay men living with HIV are shaped by structural violence, stigma, and institutional fragilities, but also by forms of resistance and the creation of new possibilities for existence. A political and social commitment is crucial to strengthening support networks, de-stigmatizing HIV, and fostering a less exclusionary and more inclusive society.

It is worth noting that the narratives analyzed here are notably rich and point to a wide range of dimensions that traverse the experience of living with HIV, including processes of rejection, corporeality, marginalization, vulnerability, and the constitution of support networks. While these elements emerge consistently across the interlocutors' accounts, offering important insights into the complexity of everyday life with HIV, a comprehensive exploration of each axis exceeds the analytical scope and editorial limits of the present article. In this sense, the focus on biographical rupture serves as a strategic lens through which we can apprehend how these dimensions are articulated in the reconfiguration of life trajectories. Future analyses may further develop these aspects, deepening the understanding of how such processes unfold in specific contexts and social positions.

5. Conclusion

Throughout this article, we have underscored how the trajectories of gay men living with HIV illuminate experiences shaped by profound biographical ruptures, as conceptualized by Michael Bury (2011) and further elaborated in life course and health studies (Henning, 2020). The diagnosis, more than merely a clinical event, emerges as a critical turning point that disrupts the continuity of life and compels individuals to reinterpret their identities, their masculinities, and their ways of inhabiting the world. In this sense, our findings are consistent with a well-established body of literature that frames chronic illness as a moment of disruption and re-signification (Canesqui, 2007). However, by situating rupture within the specific context of HIV among gay men in Brazil, this study advances the debate by demonstrating how such processes are not only existential but also deeply shaped by stigma, moral discourses, and structural inequalities.

In dialogue with studies on masculinities — particularly those developed by Raewyn Connell (1995) and Michael Kimmel (1987, 1998) — our findings reinforce the idea that hegemonic masculinity continues to operate as a normative framework that constrains men's engagement with care, emotional expression, and vulnerability. As widely documented in the literature, such norms are associated with resistance to healthcare, delayed diagnosis, and risk-taking behaviors (Gomes, 2011; Ragonesse, Shand & Barker, 2019; Rocha & Zucchi, 2025). At the same time, the narratives analyzed here suggest that living with HIV can destabilize these norms, opening up possibilities for the reconfiguration of masculinities through practices of self-care, affective expression, and engagement in support networks. In this regard, our results not only corroborate existing studies but also highlight HIV as a potential site of tension and transformation within masculine subjectivities (Nolasco, 2024).

Furthermore, in line with intersectional approaches (Couto, Venturi & Machin, 2019; Vigoya, 2018; Duque, 2021), this study confirms that experiences of HIV are unevenly distributed and mediated by race, class, and

generation. Similar to findings in the broader literature on vulnerability and health (Ayres et al., 2009; Butler, 2015), our analysis demonstrates how structural inequalities shape both access to care and exposure to stigma. However, our empirical material also nuances this perspective by showing how such conditions are actively negotiated in everyday life, through strategies of resistance, meaning-making, and the construction of support networks.

The wordplay in the title "coexisting" thus gains analytical density: it reflects not only the condition of living with HIV, but also the relational and political dimensions of this experience. Coexisting entails navigating tensions among biomedical regimes and lived realities, stigma and belonging, and historical narratives of death and contemporary possibilities of life. This resonates with a growing body of literature that critiques the biomedicalization of HIV while emphasizing the importance of social participation, activism, and community-based care (Seffner & Parker, 2016; Cueto & Lopes, 2022). Our findings reinforce this perspective by demonstrating that support networks and activist spaces function as crucial sites for the re-elaboration of identities and the production of care.

Ultimately, this study contributes to the field of HIV/AIDS and masculinities by advancing an interpretive framework that integrates biographical rupture, intersectionality, and the sociocultural dimensions of health. By foregrounding the lived experiences of gay men in Brazil, it highlights not only the persistence of structural inequalities but also the creative and insurgent ways through which individuals reconstruct their lives. These findings underscore the need for culturally situated public policies that move beyond strictly biomedical approaches and engage with the social determinants of health, recognizing lives lived with HIV not as deviations, but as legitimate expressions of human diversity. To coexist with HIV, as the narratives suggest, is not only to endure, but to transform, resist, and persist with dignity, desire, and agency (Oliveira, Nascimento, Côrrea & Junior, 2025; Oliveira & Nascimento, 2026).

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