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Michelle Varraveto Date

# Community Perceptions of Mental Health Care among Young, Black Gay and Bisexual Men Who Have Sex with Men Living with HIV in Atlanta, Georgia

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# Community Perceptions of Mental Health Care among Young, Black Gay and Bisexual Men Who Have Sex with Men Living with HIV in Atlanta, Georgia

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Santa Clara University

2015

Thesis Committee Chair: Sophia A. Hussen, MD, MPH

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An abstract of

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## Abstract

# Community Perceptions of Mental Health Care among Young, Black Gay and Bisexual Men Who Have Sex with Men Living with HIV in Atlanta, Georgia

By Michelle Varraveto

**Background:** Young, Black, gay, bisexual, and other men who have sex with men (YB-GBMSM) are disproportionately affected by HIV in Atlanta. With YB-GBMSM being at high risk for disengagement on the HIV Care Continuum (HIV-CoC) and being less likely to be aware of their HIV diagnoses, they are also less likely to receive the benefits of the Care Continuum, including treatment and access to resources. However, little is known about how mental health (MH) symptoms and disorders impact the MH of YB-GBMSM specifically. This issue is complicated by racial and sexual identity and the subsequent stigmas and stereotypes that come with being Black and gay in America. Within this framework, we sought to explore community perceptions of seeking MH care among YB-GBMSM living with HIV in Atlanta.

**Methods:** 40 in-depth qualitative interviews were conducted with YB-GBMSM (ages 18-29) living with HIV in Atlanta. Participants were recruited through street outreach, clinic-based recruitment, and social media efforts. Domains of the interview guide included: (1) descriptive/narrative context questions, (2) phenomenon clarification questions, and (3) questions structured around domains of Andersen's model of health service utilization: predisposing factors, enabling factors, and need. A thematic analysis approach was used for coding and qualitative analysis.

**Results:** Most participants expressed a desire to seek out MH care, but several mentioned the lack of knowledge around MH resources. Out of 40 participants, only 2 discussed their positive experiences with utilizing MH resources. Participants cited stigma as a major influence on why people living with HIV are hesitant to openly discuss their MH issues or receive treatment. Some participants felt that there was more stigma attached to being Black and gay, especially when compared to other races and genders. Another major influences included cultural norms within families that discouraged seeking professional MH care. Further, Participants stated how having a social support system through family, friends, or a positive community positively impacted their MH. Finally, the majority of participants discussed how their racial and sexual identities impacted the way they handled their MH issues.

**Conclusion:** Many YB-GBMSM living with HIV in Atlanta are interested in MH care. Our findings support continued investment in YB-GBMSM MH. This research could serve to mitigate these barriers and assist them in both accessing and utilizing health care resources, like therapy, to deal with MH issues.

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# Acknowledgements

This thesis would not have been possible without the help of so many people. First and foremost, I would like to thank my thesis chair and professor, Dr. Sophia Hussen. Your work has been an inspiration for me, and I appreciate all the time you've given me throughout this past year. Thank you for constantly pushing me to be the best writer I can be, guiding me through the thesis process, and for never failing to brighten my day. This work was made possible due to your detailed and thoughtful edits and guidance that helped elevate the paper to what it is now. Thank you for allowing me to join your research team and utilizing your qualitative data for my thesis. I would next like to thank Marxavian Jones. Thank you for sharing the codebook with me and helping me solidify my thesis topic and focus. Your guidance was so helpful, especially in the beginning of the thesis process and working through the data. 40 participants involved in this study without whom this thesis would not have been possible. Further, I would like to thank the I would also like to thank my friends and family for their constant and unwavering support. To my Rollins family, Nikki Warren, Enneye Makonnen, and Taren McGray, thank you so much for our thesis work sessions and for answering my questions. I so appreciate all your help and support, and for all the laughs along the way.

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## List of Abbreviations

HIV-CoC: HIV Continuum of Care

IDI: In-Depth Interview

MH: Mental Health

MSM: Men who have Sex with Men

PLWH: People living with HIV

YB-GBMSM: Young, Black, Gay and other Men who have Sex with Me

# Chapter 1: Introduction

## 1.1 Introduction and Rationale

Gay and other men who have sex with men (MSM) in Atlanta are particularly at risk for acquiring HIV infection, with a prevalence of 69%.[1] Young people are also at elevated risk for HIV acquisition, making up 35.7% of new infections in 2019.[2] The CDC's estimates show that from 2008 to 2014, there was no decline in HIV incidence among MSM with men in the United States (US)[3]. More specifically, HIV continues to disproportionately affect young Black gay, bisexual and other men who have sex with men (YB-GBMSM) in the United States; one study estimates that 40% of this population will be living with HIV by the age of 30.[4] Studies show that just over a third (36%) of young Black GBMSM diagnosed with HIV were aged between 13-24, while 39% of the same population were aged 25-34.[5] YB-GBMSM remain at high risk for disengagement across the HIV Continuum of Care (HIV-CoC)[6], a public health model outlining the stages that people living with HIV (PLWH) go through from receiving diagnosis to achieving and maintaining viral load (VL) suppression[7]. Viral suppression occurs when there is a very low or undetectable amount of HIV in the blood; therefore, disengagement across the HIV-CoC would lead to lower rates of VL suppression among YB-GBMSM.[8]

The HIV-CoC is an important measure because it provides a population-level framework for analyzing the proportion of PLWH in specific populations who are engaged in each successive step of the continuum.[9] Ideally, the HIV-CoC could then be used to help service providers more accurately identity where gaps in services might exist. A major gap in services exist within the US South which accounts for more than 50% of total HIV diagnoses.[10] In order for the HIV-CoC to effectively help PLWH achieve and maintain VL suppression, individuals must first be aware of their status. In addition to the high prevalence of HIV diagnoses, PLWH in the South are also less likely to be knowledgeable of their HIV status. This lack of knowledge means that this population are subsequently more likely to die of AIDS-related complications.[11] Within the South, Atlanta is known as a "Black Gay Mecca,"[12,13] a relatively liberal destination for YB-GBMSM migrating from other parts; however, Atlanta is an HIV epicenter, in which YB-GBMSM have the highest incidence rates.[14] With YB-GBMSM being at high risk for disengagement on the HIV-CoC and being less likely to be aware of their HIV diagnoses, they are also less likely to receive the benefits of the Care Continuum, including treatment and access to resources.

Identifying YB-GBMSM in Atlanta as an HIV epicenter is vital to knowing how to intervene to break the cycle of HIV transmission. One critical determinant is MH symptoms and disorders which can lead to negatively impacts on HIV-CoC outcomes. YB-GBMSM report high levels of depression, trauma, and anxiety,[15] which is significant because these MH-related symptoms impact HIV-CoC outcomes among PLWH. However, anxiety and trauma's specific impact on YB-GBMSM are comparatively understudied. Further research is needed to understand their effect on the care continuum and how MH care can address the level of disengagement among this population.[16]

Research that has been conducted on the link between MH and HIV has shown that MH treatment can improve HIV-CoC outcomes. One retrospective study showed that retention in care was observed in conjunction with increasing MH service utilization. Results of the study implied that MH service utilization should be considered to improve retention for PLWH newly engaged in care.[17] In another randomized, multi-site, controlled trial, cognitive behavioral therapy improved antiretroviral adherence; however, more robust effects may require a more intense intervention that combines ongoing adherence monitoring.[18] The results of the studies that have been conducted focused on MH symptoms therefore represent an addressable "target" for future interventions whose aims are to improve YB-GBMSM's engagement across the HIV-CoC.[19]

### 1.2 Problem Statement

Studies have shown that PLWH and gay individuals are desiring of having access to MH care resources but the intention and act of carrying out that desire are often affected by their familial and cultural backgrounds. Investigating these topics and the socio-contextual factors that influence them will allow clinicians, policy makers, and other public health practitioners to better assist gay men living with HIV to engage with MH care.

### 1.3 Statement of Purpose

Community perceptions surrounding seeking MH care among YB-GBMSM living with HIV in Atlanta are influenced by factors including MH and HIV stigmas, and sexual orientation. These are further influenced by family dynamics and social support received from their family, friends, and communities. Qualitative analysis of in-depth interviews is a useful method of exploring common themes regarding how these intersecting factors affect the way YB-GBMSM living with HIV navigate their willingness and/or ability to seek out MH resources. This research aims to investigate (i) the attitudes surrounding seeking MH care among YB-GBMSM living with HIV, (ii) YB-GBMSM living with HIV's thoughts on the resources available for them to work through MH issues and (iii) barriers YB-GBMSM living with HIV see in seeking MH care. This research will add to the existing knowledge about the socio-contextual factors that shape the life course of YB-GBMSM living with HIV and inform future interventions to mitigate barriers this population faces in living out lives of quality.

### 1.4 Research Questions

To improve the understanding of how YB-GBMSM living with HIV in Atlanta build their understanding of MH care, this exploratory qualitative study aims to investigate the research questions:

- What are the attitudes surrounding seeking MH care among YB-GBMSM living with HIV?
- What are YB-GBMSM living with HIV's thoughts on the resources available for them to work through MH issues?
- What are the barriers YB-GBMSM living with HIV face in seeking MH care?

### 1.5 Significance Statement

YB-GBMSM continue to be disproportionately affected by the HIV/AIDS pandemic, which affects millions of people worldwide. The topic of MH has often been neglected among YB-GBMSM living with HIV, who face challenges due to compounding marginalized identities hindering their ability to live openly with HIV. Research examining the experiences of YB-GBMSM can help identify barriers and facilitators these individuals face in seeking and utilizing MH care and inform how to best target interventions to help improve the quality of their MH and HIV-CoC outcomes.

## Chapter 2: Literature Review:

### I. Epidemiology of HIV in Atlanta and YB-GBMSM

HIV-related illness is the second leading cause of death among people aged 10-24.[20] In 2019, the rate was highest for persons aged 25-34, at 30.1% of total HIV cases in the US.[21] There were 37,244 people living with HIV in Atlanta[22] and 59.2% of people living with HIV were virally suppressed in 2019. In Atlanta, 80.4% of people living with HIV are male,[23] while 70.4% of people living with HIV are Black. Further, the rate of Black males living with an HIV diagnosis is 5.6 times that of White males.[24] One crucial key population is MSM.

Black MSM accounted for 26% of new HIV diagnoses and 37.9% of diagnoses among all MSM in the US in 2019.[25] Even though this population is at high risk for negative health outcomes, young gay Black, bisexual, and other men who have sex with men (YB-GBMSM) are underrepresented in the health literature. An extensive literature review of health-related peer-reviewed articles published between 1988-2013 that specifically targeted YB-GBMSM[26] found that the vast majority focused exclusively on sexual health, including HIV: out of fifty-four articles, fifty articles addressing sexual health were reviewed, (N = 50; 92.6%). Only a few of the reviewed articles included content on psychosocial functioning, including racial/ethnic identity and beliefs. Important sociostructural factors, including sexual networks and race-based discrimination, were under-addressed among these studies. Data on socio-structural factors that would influence access to care, including health care delivery, health insurance, tobacco use, and substance abuse were similarly under-addressed.. The other limitation to this research was a deficit of qualitative research exploring intersectional identity and health. Many studies on YB-GBMSM health reviewed during this period prioritize sex over other critical health domains.[27]

More research is needed on the diverse health issues of a vulnerable and underexamined population.

## II. HIV and Racial Disparities

For MSM in the United States, each step of the HIV care continuum[28] is marked by racial disparities. A multisite clinical study found that Black YLWH were less likely than non-Black YLWH to receive MH care or medications.[29] Additionally, the results from the Community Perceptions part of the study I will be working on showed that YB-GBMSM were less likely than other young GBMSM to have accessed counseling or MH treatment.

Black MSM living with HIV are reported to have worse care outcomes than other MSM. A 2021 study was conducted to identify and explain disparities in HIV viral suppression among Black compared to White MSM living with HIV in Atlanta.[30] Health disparities for Black MSM were hypothesized to be driven by structural racism and barriers to receiving quality care. Therefore, observational studies are important to document and quantify the specific factors within the socioecological framework that account for disparities in viral suppression.[31]

## III. Barriers to Mental Health and HIV Treatment

Barriers of MH and HIV service treatment and utilization for YB-GBMSM are culturally specific, including poverty, limited healthcare access, and conservative and/or religious ideologies that enable HIV stigma.[32] Further, MH attitudes among Black Americans include factors such as stigmatizing attitudes towards MH treatment,[33,34] religious influences,[35] high effort coping[36] and masculinity norms (e.g., hypermasculinity)[37]. For Black men in particular, there is a tendency to delay health help-seeking which is largely attributed to masculinity.[38]

Masculinity norms influence Black men's identities which[39,40] theoretically encourage men to avoid help-seeking, display emotional toughness, cope autonomously, and maintain a high sense of control even in the face of negative life experiences.[41]

Other barriers for YB-GBMSM that are known to deter sustained HIV care engagement and contribute to compromised health outcomes include structural factors such as systemic racism, and conservative cultural norms that promote pervasive stigma against sexual minorities and/or people living with HIV.[42,43] These factors prevent Black Americans from seeking professional counseling or other MH treatment. Social support systems including family and friends are the preferred methods of dealing with MH issues for many YB-GBMSM instead of seeking out formal medical services.[44] Facilitators of engagement in MH and HIV care are similarly culturally influenced, which collectively confirm the importance of cultural factors in understanding MH service use among YB-GBMSM.

## IV. Mental Health Risks Among YB-GBMSM

A retrospective cohort study among YB-GBMSM showed that depressive symptoms were the most common concerns identified, followed by substance use, anxiety, and trauma.[45] Results of this study also showed significant gaps in engagement from MH care referral to retention in formal MH care. One study showed that that Black youth who reported depressive symptoms at baseline would report inconsistent condom use at six-month follow-up; moreover, this result was approximately four times greater than that of their peers who did not report depressive symptoms.[46] This study concluded that prevention interventions addressing depression could have a significant impact on later HIV sexual risk behaviors. Prior studies of depression including Blacks are less likely to seek help for their depressive symptoms.[47] Therefore, further research focused specifically on YB-GBMSM is still needed to understand the effect of depressive symptoms on sexual risk to examine the potential cultural forces that affect this relationship.

A more commonly studied MH risk among YB-GBMSM is substance abuse, with several studies finding detrimental effects on HIV-CoC outcomes among heavy users.[48] One study found that substance use mediated the relationship between psychological distress and HIV risk behaviors.[49] This eight-year longitudinal study[50] used growth curve modeling to show the association between greater psychological distress and increased sexual intercourse frequency, decreased condom use, and increased number of partners. Another study highlighted the need for regular screening for substance use in HIV care settings in order to improve access to and delivery of culturally competent substance use prevention and treatment service.[51] MH conditions can also have interrelated impacts on HIV-related outcomes.

## V. Community Perceptions around Mental Health Care

Racial and sexual minority youth underutilize MH services. Studies including YB-GBMSM living with HIV typically focus on Youth Living with HIV (YLWH) or sexual minority youth more broadly, which is a limitation of the studies that have been previously conducted.[52] The emphasis on YLWH highlights the dearth of literature focused specifically on YB-GBMSM. A 2018 study acknowledged that improving Black MSM MH was a priority and described feeling anxiety and depression at multiple points throughout their live. These feelings were due in part to the stigma surrounding PLWH.[53] Participants reported difficulties in accessing MH services, including identifying competent providers, insurance coverage, and cost. Additionally, participants stressed that access to MH services needed to be prioritized during healthcare visits.

The National Mental Health Association conducted a survey that found that 63% of Blacks believed depression was a personal weakness.[54] Similarly, one study found older Black adults believed depression was a sign of weakness and lack of inner strength.[55] Another study found that Black men believed MH problems were a lack of motivation.[56] Additional research focused on Black American mental illness has been increasing, though few researchers have addressed differences in beliefs, attitudes, and coping strategies. Results from a 2013 survey showed that depression was the most common mental illness. Participants in the survey believed they were aware of some of the causal factors of their mental illness.[57] Results also suggested that participants were not opened to acknowledging mental illness, were concerned about stigma associated with mental illness, but were somewhat open to seeking MH services.

Studies to examine Black American beliefs about mental illness and attitudes toward seeking MH services have shown mixed results. Several studies have shown that Black Americans view mental illness as highly stigmatizing, resulting in low treatment-seeking.[58],[59] Similarly, a recent study of attitudes and beliefs about MH among older Black adults revealed that participants viewed mental illness, particularly depression, as a weakness.[60]

In contrast, Black Americans have been found to have positive beliefs and attitudes toward seeking MH services, but these positive beliefs and attitudes do not translate to seeking treatment. In one study of racial differences in beliefs concerning the relationship between the natural course of mental health and perceptions of treatment effectiveness, Black men were more likely than White men to believe that MH professionals could help individuals with mental illness. However, Black men were also more likely to believe that MH problems could improve on their own.[61] The belief that MH problems can resolve on their own seemed to inhibit use of MH services as a coping strategy. Similar results were obtained in another study of racial differences in attitudes toward professional MH care and use of services; Black men had more positive attitudes toward seeking MH services than White men but were less likely to use services. Having a positive attitude toward seeking MH services did not result in use of MH services.[62]

## Chapter 3: Manuscript

### Student Contribution

I am the primary author of this research paper. Dr. Hussen and Marxavian Jones assisted in finalizing the research topic and provided the data used in the methods and results sections. Dr. Hussen provided guidance on the entirety of the written thesis through her role as Thesis Committee Chair.

# Title: Community Perceptions of Mental Health Care among Young, Black Gay and Bisexual Men Who Have Sex with Men Living with HIV in Atlanta, Georgia

**Authors:** Michelle Varraveto

[1]Hubert Department of Global Health, Emory University Rollins School of Public Health, Atlanta, GA, USA

**Background:** Young, Black, gay, bisexual, and other men who have sex with men (YB-GBMSM) are disproportionately affected by HIV in Atlanta. With YB-GBMSM being at high risk for disengagement on the HIV Care Continuum (HIV-CoC) and being less likely to be aware of their HIV diagnoses, they are also less likely to receive the benefits of the Care Continuum, including treatment and access to resources. However, little is known about how MH symptoms and disorders impact the MH of YB-GBMSM specifically. This issue is complicated by racial and sexual identity and the subsequent stigmas and stereotypes that come with being Black and gay in America. Within this framework, we sought to explore community perceptions of seeking MH care among YB-GBMSM living with HIV in Atlanta.

**Methods:** 40 in-depth qualitative interviews were conducted with YB-GBMSM (ages 18-29) living with HIV in Atlanta. Participants were recruited through street outreach, clinic-based recruitment, and social media efforts. Domains of the interview guide included: (1) descriptive/narrative context questions, (2) phenomenon clarification questions, and (3) questions structured around domains of Andersen's model of health service utilization: predisposing factors, enabling factors, and need. A thematic analysis approach was used for coding and qualitative analysis.

**Results:** Most participants expressed a desire to seek out MH care, but several mentioned the lack of knowledge around MH resources. Out of 40 participants, only 2 discussed their positive experiences with utilizing MH resources. Participants cited stigma as a major influence on why people living with HIV are hesitant to openly discuss their MH issues or receive treatment. Some participants felt that there was more stigma attached to being Black and gay, especially when compared to other races and genders. Another major influences included cultural norms within families that discouraged seeking professional MH care. Further, Participants stated how having a social support system through family, friends, or a positive community positively impacted their MH. Finally, the majority of participants discussed how their racial and sexual identities impacted the way they handled their MH issues.

**Conclusion:** Many YB-GBMSM living with HIV in Atlanta are interested in MH care. Our findings support continued investment in YB-GBMSM MH. This research could serve to mitigate these barriers and assist them in both accessing and utilizing health care resources, like therapy, to deal with MH issues.

## Introduction

Gay and other MSM in Atlanta are particularly at risk for acquiring HIV infection, with a prevalence of 69%.[63] Young people are also at elevated risk for HIV acquisition, making up 35.7% of new infections in 2019.[64] The CDC's estimates show that from 2008 to 2014, there was no decline in HIV incidence among MSM in the US[65]. More specifically, HIV continues to disproportionately affect YB-GBMSM in the United States; one c study estimates that 40% of this population will be living with HIV by the age of 30.[66] Studies show that just over a third (36%) of YB- GBMSM diagnosed with HIV were aged between 13-24, while 39% of the same population were aged 25-34.[67] YB-GBMSM remain at high risk for disengagement across the HIV Continuum of Care (HIV-CoC)[68], a public health model outlining the stages that people living with HIV (PLWH) go through from receiving diagnosis to achieving and maintaining viral load (VL) suppression[69]. Viral suppression occurs when there is a very low or undetectable amount of HIV in the blood; therefore, disengagement across the HIV-CoC would lead to lower rates of VL suppression among YB-GBMSM.[70]

The HIV-CoC is an important measure because it provides a population-level framework for analyzing the proportion of PLWH in specific populations who are engaged in each successive step of the continuum.[71] Ideally, the HIV-CoC could then be used to help service providers more accurately identity where gaps in services might exist. A major gap in services exist within the US South which accounts for more than 50% of total HIV diagnoses.[72] In order for the HIV-CoC to effectively help PLWH achieve and maintain VL suppression, individuals must first be aware of their status. In addition to the high prevalence of HIV diagnoses, PLWH in the South are also less likely to be knowledgeable of their HIV status. This lack of knowledge means that this population are subsequently more likely to die of AIDS-related complications.[73] Within the South, Atlanta is known as a "Black Gay Mecca,"[74,75] a relatively liberal destination for YB-

GBMSM migrating from other parts; however, Atlanta is an HIV epicenter, in which YB-GBMSM have the highest incidence rates.[76]. With YB-GBMSM being at high risk for disengagement on the HIV-CoC and being less likely to be aware of their HIV diagnoses, they are also less likely to receive the benefits of the Care Continuum, including treatment and access to resources.

Identifying YB-GBMSM in Atlanta as an HIV epicenter is vital to knowing how to intervene to break the cycle of HIV transmission. One critical determinant is MH symptoms and disorders which can lead to negatively impacts on HIV-CoC outcomes. YB-GBMSM report high levels of depression, trauma, and anxiety,[77] which is significant because these MH-related symptoms impact HIV-CoC outcomes among PLWH. However, anxiety and trauma's specific impact on YB-GBMSM are comparatively understudied. Further research is needed to understand their effect on the care continuum and how MH care can address the level of disengagement among this population.[78]

Research that has been conducted on the link between MH and HIV has shown that MH treatment can improve HIV-CoC outcomes. One retrospective study showed that retention in care was observed in conjunction with increasing MH service utilization. Results of the study implied that MH service utilization should be considered to improve retention for PLWH newly engaged in care.[79] In another randomized, multi-site, controlled trial, cognitive behavioral therapy improved antiretroviral adherence; however, more robust effects may require a more intense intervention that combines ongoing adherence monitoring.[80] The results of the studies that have been conducted focused on MH symptoms therefore represent an addressable "target" for future interventions whose aims are to improve YB-GBMSM's engagement across the HIV-CoC.[81]

## Methods:

We utilized an interpretive phenomenological framework which focused on describing what a group of people have in common as they experienced a particular phenomenon, while allowing for patterns, themes, and categories to emerge from the data.[82] This approach allowed the research team to learn about culturally circumscribed behaviors, language, and roles among YB-GBMSM, including individual and shared experiences and meanings related to MH and HIV.

### *Participant and Sampling:*

Qualitative interviews (n=40) were conducted with YB-GBMSM living with HIV (ages 18-29) in Atlanta, USA. A multi-pronged strategy was used to target and recruit YB-GBMSM at varying levels of engagement with HIV and MH Care. Participants were recruited through several strategies including street outreach (information tables at LGBT-focused events), clinic-based recruitment (at a large comprehensive HIV center) and social media efforts. The main clinical recruitment site was the Grady Infectious Disease Program clinic (IDP) located in downtown Atlanta. Screening surveys were conducted at relevant community events and locations including nightclubs and Black Gay Pride festivals. The research team also collaborated with Atlanta CBOs focused specifically on Black GBMSM living with HIV. Additionally, participants were contacted from the research team's prior studies who had indicated interesting being contacted in the future.

### *Procedures:*

First, the research team developed a semi-structured interview guide for in-depth interviews (IDIs). The interview guide provide topical area questions and probes to ensure the same basic lines of inquiry were pursued for all participants in the study. The interview guide was designed to encourage explorations of participants' experiences with MH. The guide was grounded in phenomenological and constructivist frameworks, requiring participants to provide their own understanding of terms and phrases based on their experiences. The guide included a mixture of descriptive/narrative context questions, phenomenon clarification questions, and questions structured around domains of Andersen's model of health service utilization: predisposing factors, enabling factors, and need.

### *Instruments:*

The in-depth-interviews were conducted by the study staff, including a coordinator and two graduate research assistants (GRAs). Members of the study staff have been trained in qualitative interview techniques and cultural humility and share various social identities with the participants. Some IDIs were conducted in quiet, private, mutually convenient locations within the collaborating clinic; however, most were conducted over Zoom in the context of COVID-19 related social distancing requirements. Verbal informed consent was obtained prior to each IDI, and participants received a $50 gift card upon completion. Interviewers recorded field notes and documented salient themes to be explored in subsequent IDIs. All IDIs were digitally recorded, professionally transcribed verbatim, and de-identified.

### *Data Analysis:*

Next, transcripts were coded using a team approach. All interview transcripts were first read by team members to increase familiarity with the data before being re-read to create pattern codes that connect concepts together. Data analysis included aspects of deductive analysis by creating a priori codes to represent constructs found through the IDIs. A codebook was created to organize the codes that were created through the data analysis process. To ensure uniform coding methods throughout the data analysis process, transcripts were coded by multiple team members in parallel, using MAXQDA qualitative data management software. Discrepancies in coding or interpretation were resolved through consensus.

The first step upon receiving the 'Community Perception' data from the codebook was familiarizing myself with the data and thoroughly understanding the contents of that code. To help with this step, memos were used to document ideas within the 'Community Perception' code. These memos provided an organized key to develop detailed themes within the category. Once all memos were created, the next step was to review the themes and identify any subthemes that come from the data. Next, I defined and named the specific themes identified. In order to properly interpret the themes, I analyzed quotes from the participants that would best support each theme. Thick descriptions were then written to further describe each theme and subtheme, but also to add details to record the meanings behind participant responses. I then requested data feedback from the research team before initiating the writing of this thesis.

### *Ethical Considerations:*

The study protocol was submitted and approved by the Institutional Review Boards of Emory University and Grady Hospital System in Atlanta.

## Results:

Many participants described stigma against MH in the wider Black community as being considered “crazy”. Participants described additional contributors to the lack of MH care including fear of speaking out, race and family dynamics, religion, and physical health being more a priority over MH, particularly within the gay community.

*Mental Health Stigma:* Many participants stated that MH is not normalized within the Black community, with people who struggle with MH issues being labeled as “crazy” or “mentally unstable”.

> *"Most of the time they call them crazy. I feel like they look at them as like when you're dealing with mental - the Black community has got this whole thing, like if you're dealing with mental health stuff, like they feel like you're crazy or you're weak, you know." (P6)*

Many participants associated mental health with personal weakness. Being vulnerable about MH issues were seen through a negative connotation. Within the Black community, there is a stigma that MH does not exist due to a common belief that mental health is for white communities or that one lacks mental toughness. Many participants described MH care as being a low priority for Black gay communities. One participant mentioned his perception that Black culture is hyper-masculinized. Hyper-masculinity norms encourage men to avoid seeking professional MH care and display emotional toughness even in the face of negative life experiences.[83]

*Stigma:* Some participants described the stigma in many Black communities around being gay or having HIV. Even though there is already discrimination against people who are Black and gay, adding HIV would add further stigma. Some participants addressed age and how some younger

Black men accept HIV medication regardless of stigma, whereas older gay men may place more emphasis on the stigma.

> *"They don't care about the stigma because they feel like the medicine is good and they can do whatever they want to do still. I feel like the older gays, they're more seasoned and they understand the value of life and your health and trying to deal with society because those are the guys that really had to be in the closet." (P54)*

Additionally, some participants described the stigma of being Black and being both Black and gay, and the stereotypes placed on the communities.

> *"I feel like even society and the public is more open and accepting of the LGBT community when it's not a Black person or they're more understanding when it's not a Black person as opposed to seeing a Black gay male or a Black gay woman. It kind of puts a stigma on you or it places you as a statistic as opposed to being a human being, I guess." (P29)*

Some participants felt that there was more stigma attached to being Black and gay, especially when compared to other races and genders.

*Race:* Participants described many challenges associated with just being Black. Some participants described the Black experience in America to be characterized by trauma and violence that impacts MH of both younger and older generations.

> *"Whether society at large wants to admit it, as a Black person you already have a strike against you. As a gay person you already have a strike against you. So three strikes and you're out, and when you're already starting with two strikes, you don't have the time to worry about why you're sad all the time."*

Some participants described living in a state of fear. Participants expressed having to process individual trauma, particularly from childhood, in addition to mass traumas from grief, police brutality, and racial stereotyping adds compounding layers of complexity for individuals to responsibly manage.

> *"I am pretty self-sufficient and I can handle myself, but I've never felt so alone or afraid. You turn on the TV and as a white person, as a Caucasian person, you guys,*

> *it's viewed objectively and you're not living it. But you turn on the TV and see the latest, that could be me. That could be my friend. It's a constant - you live in a constant state of fear." (P3)*

Participants also discussed ways in which socioeconomic status was linked to MH. Participants discussed how people who are impoverished or have substance use problems are at higher risk for poor MH. One participant described how watching parents deal with drug or alcohol abuse growing up caused MH issues later in life.

> *"You can say drugs and drugs can be defined as different things, so promiscuous sexual behavior, of course reckless sexual behavior and not knowing partners or not knowing their status before you decide to have sex with them. Um, egregious behavior." (P8)*

Participants described cultural norms within Black families as an important influence on MH care seeking. Participants described a common belief that MH care is for white people.

> *"It's not advertised in the Black community as such so, I mean like growing up, I remember like people telling me, 'Oh, you need to go seek counseling cause you do that white people stuff.'" (P74)*

Many participants elaborated that their families had never sought therapy or professional care for MH issues. Further, many families do not discuss personal issues outside of the household if they feel that nothing is wrong. Some families believe that mental struggles can be attributed towards oneself, and one just needs to deal with the problem alone and move on.

*Support Systems:* Support systems, or lack thereof, played a key role in how participants responded to and dealt with MH issues surrounding testing positive for HIV. Participants discussed how having a social support system through family, friends, or a positive community positively impacted their mental health. Support systems for Black and gay individuals often included individuals who were also part of the same community that could relate to similar MH struggles. Participants without a positive family dynamic due to a lack of acceptance or fear of disclosing their HIV status reported feelings of isolation and fear.

> *"So your upbringing kind of associates kind of how you handle things differently and what you take on today. I take it differently because my immediate family – they weren't as supportive and so I didn't care because I knew that this is the battle that I have to fight by myself." (P86)*

Such participants held a fear of being judged for having MH issues which prevented them from reaching out to friends or family. Homophobic traditions or religion made it difficult for some participants to come out to family members or disclose their HIV status.

> *"I'm trying to find new words to use, but again the sense of isolation, doing this by myself. It can lead to very weird, bad, timid feelings and I've got to do this on my own. You may not know that it contributes negatively, that feeling of being in a community but having a feeling like you don't have a community." (P4)*

Some participants described going outside of the family to seek out other young Black gay individuals that understand both their race and sexuality.

*Lack of Knowledge:* Participants described how prioritizing other concerns seemed to limit knowledge of resources available for MH care and treatment options.

> *"You don't have the time as a gay Black person. You just don't have the mental time. You don't have the freedom to have the mental time." (P3)*

> *"I don't think people are actually able to sit down and take the time to sit down to spend time with themselves, to face their problems and to seek how they can deal with it." (P5)*

Within the Black community, participants elaborated that there is a general lack of education that impacts the accessibility of resources available. Not only is there a lack of knowledge, but there is also the challenge of not being able to "research something you don't know". One participant described feeling ignorant due to not being given information and resources.

> *"I guess it's a lack of research, but you can't research something you don't know, so that would be a hard topic." (P19)*

Furthermore, the lack of education translates into members of the Black community not being able to use the resources known to be available. Participants described how accessing resources presented challenges that affected their mental health. Furthermore, some participants described how Black people may not read MH resources because they will not take the time for it.

> *"Those challenges always being resources. Um, lack of resources and then lack of education. A lot of the times, even if you have the resources, a lot of the times Black communities just don't know how to use it." (P12)*

Participants who were able to seek out and use resources indicated better MH than those who either were afraid to seek support or could not access known resources. Some participants described how there are known resources, but the Black community overall do not take advantage of them to their full benefits.

> *"If it wasn't for Grady, I wouldn't know half of the things that I know. It's always better and helpful to have somebody that can point you in the right direction of where you need to go, who you need to see, talk to, yeah." (P11)*

> *"I'm here alone. I have been here eight years and I think that most people in, I wouldn't say, the community and more than likely my circle, they have someone to reach out to or a family member to help them with certain things and I'm just kinda trying to figure out everything on my own here. So that's why I say if not better, they have better resources; they have better chances to obtain the help that they need." (P25)*

Within the gay Black community, not only is there a lack of information but the added factor of not wanting to seek out MH resources. Participants described this factor as being connected to the negative connotation of seeking MH care in traditional Black families. For some participants, not wanting to seek out resources stemmed from not having strong support systems to ask questions to.

> *"In my view I just see people not wanting to know or not wanting to - well first let's start off with the lack of information then the lack of not wanting to know. I guess it would be that." (P19)*

For some participants, functional accessibility affected participant access to MH resources and care, even if the behavioral desire was in place. Financial instability often influenced whether individuals would be able to afford care options like therapy or healthcare treatment centers, like Grady. Participants described how the lack of adequate transportation may discourage individuals from pursuing MH care.

> *"Some people may not go simply because you know, for lack of transportation discourages them from pursuing it or they may not necessarily have the money to be able to catch the bus to go." (P77)*

*Prioritization of Physical Over Mental Health:* Most participants described how people in both the Black community and the Black gay community prioritize physical health over mental health.

> *"Physical health is definitely valued more than mental health. Always talking about, you know, people are always talking about what we need to do to take care of our bodies, as far as our body, but we're never advised on what we need to do to take care of our mental state." (P5)*

Physical health is visible and the first external marker of status that is noticed when interacting with other people. Many individuals focus on physical appearance rather than emotional stability. Especially with younger gay Black individuals, there is an emphasis placed on social lives and looking as physically attractive as possible. Participants elaborated about how individuals would more often prioritize the gym over MH care. MH is invisible and not discussed within Black or Black gay communities unless it is a specific space designed to engage in MH topics.

## Discussion:

Though there are few studies that address MH among YB-GBMSM, we will address the lack of literature about non-sexual health concerns in this population. The findings from this study support increased investment in YB-GBMSM mental health. A prominent theme within the data was the idea that MH issues equate to being considered "crazy" by the wider Black community. Several participants were desiring of seeking MH care but acknowledge that many YB-GBMSM in the wider community either are afraid of the stigma associated with HIV and MH and/or lack specific knowledge about accessing MH care. The stigma attached to HIV and MH aligns with previous literature citing stigma as a barrier to seeking MH services.[84] Participants formulated their understanding of MH care views within both the Black and gay communities respectively based on many factors, including fear of speaking out, race and family dynamics, religion, and the prioritization of physical health over MH. While some were grateful for receiving care and accessing resources for MH care, there is still the influence of traditional family values of internalizing MH, and that MH is for white people. Overall, however, many participants revealed that MH care should be prioritized on the same level as physical health.

Participant experiences are consistent with previous literature with regards to the distinct obstacles that YB-GBMSM with HIV face with regard to dealing with MH. These men not only deal with having HIV, but also the added societal stigma of race and sexual identity. There is more stigma attached to being Black and gay, especially when compared to other races and genders. The Black experience in America is often characterized by trauma and violence that impacts MH of both younger and older generations.[85] Further, they deal with the added pressures of honoring family values and finding communities who truly understand their experiences.

Finding support systems proved to be a key part of addressing MH issues and how YB-GBMSM responded to and dealt with MH issues surrounding HIV. This is consistent with literature that shows how informal support is common among Black men and women.[86] Support systems for Black and gay individuals often included individuals who were also part of the same community that could relate to similar mental health struggles. Having a social support system through family, friends, or a positive community positively impacted their MH. Though societal stigma is a very real fear, the prevalent idea was that YB-GBMSM views towards MH care were becoming more common, especially when compared to older generations living with HIV.

Overall within the larger Black community, people are not informed about mental health care. Financial instability greatly influences whether individuals would be able to not only afford care options like therapy or healthcare treatment centers, but physically get to treatment through safe transportation methods. MH symptoms and disorders have the potential to negatively impact HIV-CoC outcomes as YB-GBMSM with HIV face unique barriers to care, leading to lower rates of engagement across the HIV-CoC relative to other PLWH. Working toward accessing those who are financially or physically unable to access MH resources should be a goal moving forward so that anyone who wants care can receive it.

Many participants desired to utilize MH care resources, though only a few elaborated on their specific experiences with using the resources. The findings from this study imply that younger men are overall more accepting of HIV treatment regardless of stigma, whereas older men may focus more on stigma and neglect treatment. Findings from a 2013 study also found that older participants were less likely to seek professional help to manage with a mental health problem compared to young participants.[87] This presents an opportunity for HIV providers to be initiating and facilitating conversations about overcoming stigma. Any individual who desires to seek MH care should be able to access care resources about options and strategies to cope with MH. Eliminating the barriers for YB-GBMSM living with HIV who are wanting to utilize MH resources should be a priority for future research and policy making. This study helped address the underlying social and cultural contexts that influence whether YB-GBMSM living with HIV would seek out mental health care. However, more thorough research is required into how to solve the societal barriers of sub-optimal MH care utilization and HIV-CoC outcomes.

## Limitations

It is possible that further interviews could have helped some of the themes that were not touched upon at depth during this round of interviews. There is potential selection bias as patients recruited from clinics or CBOs may have more favorable attitudes towards HIV and MH care engagement, and those with the most stigmatizing beliefs against MH may not participate in research.

## Conclusions

YB-GBMSM living with HIV in Atlanta are interested in utilizing MH resources but face many barriers to doing so. Interested parties such as researchers, clinicians, and policymakers should advocate for continued research to fully understand the factors that influence YB-GBMSM living with HIV’s access to MH care. This research could serve to mitigate these barriers and assist them in both accessing and utilizing health care resources, like therapy, to deal with MH issues.

## Chapter 4: Recommendations

### 1. Research Regarding Mental Health Care Among YB-GBMSM Living with HIV

A key issue is that there is a dearth of literature regarding the MH care among YB-GBMSM living with HIV specifically. While there is literature looking specifically at Black communities and LGBTQ communities individually living with HIV, there is little research that looks at how individuals who identify with both communities view seeking out MH care. This may stem from the prevalent assumption that the factors working against a young man who is Black, gay, and living with HIV are so mentally challenging, and that these men do not prioritize MH care after receiving their HIV diagnoses. Continuing to examine the status of seeking MH care among YB-GBMSM living with HIV in Atlanta via surveys and other qualitative means would provide further justification for the need to mitigate the barriers this population encounters when trying to navigate their HIV status and lifestyle. Furthermore, there were some participants at the clinic who mentioned only knowing about MH resources due to the location of their treatment (Grady). This is significant because more research would help shine a light on this important topic and lead toward potentially addressing barriers to MH care among this population. Individuals with access to MH care help provide insights that can lead to saturation by inquiring more in-depth about these men’s experiences with MH care and how these resources can be better distributed among other YB-GBMSM.

### 2. Increase Provider-Patient Communication Around Mental Health Resources

Many participants, especially those with access to quality resources, accepted their prospects in life despite their HIV status. Most notably, a few participants expressed gratitude to Grady for providing and explaining resource options during treatment for HIV. I believe it a success for these young men to be able to view a once fatal diagnosis as an altogether manageable disease after receiving appropriate care. The same sort of discourse should exist around the topic of mental health, with providers providing HIV diagnoses discussing the subject with their patients and providing advice on how to access MH resources. It is evident that it would have to be the providers initiating these conversations due to the stigma and socioeconomic surrounding the topic. YB-GBMSM with HIV and their willingness, or lack thereof, to seek out resources on their own. There should be documentation resembling clear guidelines and a thorough review of the mental healthcare possibilities that could be made available to clinicians, who would then be able to have informed conversations with their patients.

### 3. Increase Access to Mental Health Services and Social Support

It is evident that many of the individuals interview for this study needed MH services and social support from family, friends, and community. Many of the participants spoke about seeking support from the gay and Black communities and other PLWH because of shared experiences dealing with HIV and associated MH stigma. Some participants also recounted difficult experiences with their families during their coming out and HIV disclosure processes, if these had occurred at all; moreover, some participants shared stories of friends who had negative experiences coming out and/or disclosing HIV status with others outside of close friends with shared HIV diagnoses. Therefore, I would encourage hospital clinics in Atlanta to consider the formation of social support groups. Hospitals like Grady in particular focus on treatment for young people under 25[88], so the creation of social support groups within the hospital would create support for YB-GBMSM with lack of familial support to find community. YB-GBMSM living with HIV who have had a difficult experience navigating their sexual orientation and HIV status can add to an already difficult time in their lives as they already deal with social stigma by being Black and gay. Though some social support programs do exist in the city of Atlanta, they may not provide the kind of quality care that reputable clinics like Grady provide or may be located in areas that are not easily accessible to those who may not have the appropriate transportation to attend such facilities. Having support groups within the same clinics where YB-GBMSM receive care could cut down on transportation issues since patients would potentially already be in the clinic and could receive care and MH support in the same day. Research does exist on how to successfully implement these types of programs which would be beneficial if reputable clinics were to consider implementing these programs.

### 4. Increase Access to Mental Health Services Through Online Resources

It is evident that that many YB-GBMSM with HIV lack the knowledge of MH care resources. Further, barriers such as socioeconomic status and lack of reliable transportation aid in YB-GBMSM with HIV not being able to access resources, like therapy, on their own. Some participants spoke about how the lack of transportation may discourages PLWH from pursuing MH care. Therefore, I would encourage normalizing the use of teletherapy that could be conducted over phone, text or video chat, depending on the participant's preferences and technological capabilities. This would address the transportation barrier standing in the way of YB-GBMSM with HIV receiving MH care. Not only is teletherapy more accessible to more people, but it is also more convenient. Teletherapy is helpful for people who struggle to access in-person treatment, including disability, lack of quality transportation, live too far away from a treatment location, or are unable to leave their house. Teletherapy is also an importation option to consider because affordability is also a factor determining who can receive care. Some online counseling websites may charge a monthly or weekly subscription fee that helps save money, especially for longer subscription periods. Insurance may help cover the costs, but subscription fees may make therapy more accessible to YB-GBMSM with HIV in Atlanta compared to traditional therapy rates.  One study in 2018[89] found that teletherapy is just as effective as in-person sessions for treating a range of MH disorders, including anxiety and depression.

# References

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[1] HIV in the United States and Dependent Areas. (2019). Retrieved 9 April 2022, from https://www.cdc.gov/hiv/statistics/overview/ataglance.html

[2] HIV in the United States and Dependent Areas. (2019). Retrieved 9 April 2022, from https://www.cdc.gov/hiv/statistics/overview/ataglance.html

[3] New HIV infections down by 18% in the United States of America. (2017). Retrieved 7 April 2022, from https://www.unaids.org/en/resources/presscentre/featurestories/2017/february/20170216_CDCreport

[4] Hussen, S. A., Camp, D. M., Wondmeneh, S. B., Doraivelu, K., Holbrook, N., Moore, S. J., Colasanti, J. A., Ali, M. K., & Farber, E. W. (2021). Mental Health Service Utilization Among Young Black Gay, Bisexual, and Other Men Who Have Sex with Men in HIV Care: A Retrospective Cohort Study. *AIDS patient care and STDs*, *35*(1), 9–14. https://doi.org/10.1089/apc.2020.0202

[5] Gay, Bisexual, and Other MSM | Volume 31 | HIV Surveillance | Reports | Resource Library | HIV/AIDS | CDC. (2021). Retrieved 24 October 2021, from https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-31/content/msm.html

[6] Hightow-Weidman, L., LeGrand, S., Choi, S. K., Egger, J., Hurt, C. B., & Muessig, K. E. (2017). Exploring the HIV continuum of care among young black MSM. *PloS one*, *12*(6), e0179688. https://doi.org/10.1371/journal.pone.0179688

[7] *HIV Care Continuum*. HIV.gov. (2021). Retrieved 16 April 2022, from https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum.

[8] Hussen, S. A., Easley, K. A., Smith, J. C., Shenvi, N., Harper, G. W., Camacho-Gonzalez, A. F., Stephenson, R., & Del Rio, C. (2018). Social Capital, Depressive Symptoms, and HIV Viral Suppression Among Young Black, Gay, Bisexual and Other Men Who Have Sex with Men Living with HIV. *AIDS and behavior*, *22*(9), 3024–3032. https://doi.org/10.1007/s10461-018-2105-6

[9] *HIV Care Continuum*. HIV.gov. (2021). Retrieved 16 April 2022, from https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum.

[10] U.S. Statistics. (2021). Retrieved 24 October 2021, from https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics

[11] Global HIV/AIDS Overview. (2021). Retrieved 24 October 2021, from https://www.hiv.gov/federal-response/pepfar-global-aids/global-hiv-aids-overview

[12] Stephens, C. (2022). 'Got Something To Say:' How ATL Became the Black Gay Mecca. Retrieved 9 April 2022, from https://cassiuslife.com/66017/atlanta-black-gay-mecca/

[13] Stephens, C. (2018). This Ally Helped Turn Atlanta Into a Black Gay Mecca. Retrieved 9 April 2022, from https://www.advocate.com/politicians/2018/1/03/ally-helped-turn-atlanta-black-gay-mecca

[14] Why the South is the epicenter of the AIDS crisis in America. (2021). Retrieved 24 October 2021, from https://www.pbs.org/newshour/show/south-epicenter-aids-crisis-america

[15] Hightow-Weidman, L., LeGrand, S., Choi, S. K., Egger, J., Hurt, C. B., & Muessig, K. E. (2017). Exploring the HIV continuum of care among young black MSM. *PloS one*, *12*(6), e0179688. https://doi.org/10.1371/journal.pone.0179688

[16] McLean, C. P., & Fitzgerald, H. (2016). Treating Posttraumatic Stress Symptoms Among People Living with HIV: a Critical Review of Intervention Trials. Current psychiatry reports, 18(9), 83. https://doi.org/10.1007/s11920-016-0724-z

[17] Saag, L. A., Tamhane, A. R., Batey, D. S., Mugavero, M. J., & Eaton, E. F. (2018). Mental health service utilization is associated with retention in care among persons living with HIV at a university-affiliated HIV clinic. AIDS research and therapy, 15(1), 1. https://doi.org/10.1186/s12981-018-0188-9

[18] Wagner, G. J., Kanouse, D. E., Golinelli, D., Miller, L. G., Daar, E. S., Witt, M. D., Diamond, C., Tilles, J. G., Kemper, C. A., Larsen, R., Goicoechea, M., & Haubrich, R. H. (2006). Cognitive-behavioral intervention to enhance adherence to antiretroviral therapy: a randomized controlled trial (CCTG 578). *AIDS (London, England)*, *20*(9), 1295–1302. https://doi.org/10.1097/01.aids.0000232238.28415.d2

[19] Hussen, S. A., Camp, D. M., Wondmeneh, S. B., Doraivelu, K., Holbrook, N., Moore, S. J., Colasanti, J. A., Ali, M. K., & Farber, E. W. (2021). Mental Health Service Utilization Among Young Black Gay, Bisexual, and Other Men Who Have Sex with Men in HIV Care: A Retrospective Cohort Study. *AIDS patient care and STDs*, *35*(1), 9–14. https://doi.org/10.1089/apc.2020.0202

---

[20] *Global HIV & AIDS statistics — Fact sheet*. Unaids.org. (2022). Retrieved 11 April 2022, from https://www.unaids.org/en/resources/fact-sheet.

[21] U.S. Statistics. (2021). Retrieved 20 April 2022, from https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics

[22] *Atlanta - AIDSVu*. AIDSVu. (2022). Retrieved 11 April 2022, from https://aidsvu.org/local-data/united-states/south/georgia/atlanta/#:~:text=In%202019%2C%20there%20were%2037%2C244,were%20newly%20diagnosed%20with%20HIV.

[23] Atlanta - AIDSVu. AIDSVu. (2022). Retrieved 11 April 2022, from https://aidsvu.org/local-data/united-states/south/georgia/atlanta/#:~:text=In%202019%2C%20there%20were%2037%2C244,were%20newly%20diagnosed%20with%20HIV.

[24] *Global HIV & AIDS statistics — Fact sheet*. Unaids.org. (2022). Retrieved 11 April 2022, from https://www.unaids.org/en/resources/fact-sheet.

[25] U.S. Statistics. (2021). Retrieved 20 April 2022, from https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics

[26] Wade, R. M., & Harper, G. W. (2017). Young Black Gay/Bisexual and Other Men Who Have Sex With Men: A Review and Content Analysis of Health-Focused Research Between 1988 and 2013. American journal of men's health, 11(5), 1388–1405. https://doi.org/10.1177/1557988315606962

[27] Wade, R. M., & Harper, G. W. (2017). Young Black Gay/Bisexual and Other Men Who Have Sex With Men: A Review and Content Analysis of Health-Focused Research Between 1988 and 2013. American journal of men's health, 11(5), 1388–1405. https://doi.org/10.1177/1557988315606962

[28] Gardner EM, McLees MP, Steiner JF, Del Rio C, Burman WJ. The spectrum of engagement in HIV care and its relevance to test-and-treat strategies for prevention of HIV infection. (2011). *Clin Infect Dis.* Mar 15;52(6):793–800. doi: 10.1093/cid/ciq243. http://europepmc.org/abstract/MED/21367734.

[29] Whiteley, Laura & Brown, Larry & Swenson, Rebecca & Kapogiannis, Bill & Harper, Gary. (2013). Mental Health Care among HIV Infected Youth in Medical Care: Disparities and Equalities. Journal of the International Association of Providers of AIDS Care. 13. 10.1177/2325957413488172.

[30] Sullivan, P. S., Taussig, J., Valentine-Graves, M., Luisi, N., Del Rio, C., Guest, J. L., Jones, J., Millett, G., Rosenberg, E. S., Stephenson, R., & Kelley, C. (2021). Disparities in Care Outcomes in Atlanta Between Black and White Men Who Have Sex With Men Living With HIV: Protocol for a Prospective Cohort Study (Engage[men]t). *JMIR research protocols, 10*(2), e21985. https://doi.org/10.2196/21985

[31] Sullivan, P. S., Taussig, J., Valentine-Graves, M., Luisi, N., Del Rio, C., Guest, J. L., Jones, J., Millett, G., Rosenberg, E. S., Stephenson, R., & Kelley, C. (2021). Disparities in Care Outcomes in Atlanta Between Black and White Men Who Have Sex With Men Living With HIV: Protocol for a Prospective Cohort Study (Engage[men]t). *JMIR research protocols*, *10*(2), e21985. https://doi.org/10.2196/21985

[32] Dombrowski, J. C., Simoni, J. M., Katz, D. A., & Golden, M. R. (2015). Barriers to HIV Care and Treatment Among Participants in a Public Health HIV Care Relinkage Program. *AIDS patient care and STDs*, *29*(5), 279–287. https://doi.org/10.1089/apc.2014.0346

[33] Ward, E. C., Wiltshire, J. C., Detry, M. A., & Brown, R. L. (2013). African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. *Nursing research*, *62*(3), 185–194. https://doi.org/10.1097/NNR.0b013e31827bf533

[34] Hankerson, S. H., & Weissman, M. M. (2012). Church-based health programs for mental disorders among African Americans: a review. *Psychiatric services (Washington, D.C.)*, *63*(3), 243–249. https://doi.org/10.1176/appi.ps.201100216

[35] Hankerson, S. H., & Weissman, M. M. (2012). Church-based health programs for mental disorders among African Americans: a review. *Psychiatric services (Washington, D.C.)*, *63*(3), 243–249. https://doi.org/10.1176/appi.ps.201100216

[36] Jones, S., Brooks, J. H., Milam, A. J., Barajas, C. B., LaVeist, T. A., Kane, E., & Furr-Holden, C. (2019). Racial discrimination, John Henryism coping, and behavioral health conditions among predominantly poor, urban African Americans: Implications for community-level opioid problems and mental health services. *Journal of community psychology*, *47*(5), 1032–1042. https://doi.org/10.1002/jcop.22168

[37] Powell, W., Adams, L. B., Cole-Lewis, Y., Agyemang, A., & Upton, R. D. (2016). Masculinity and Race-Related Factors as Barriers to Health Help-Seeking Among African American Men. *Behavioral medicine (Washington, D.C.)*, *42*(3), 150–163. https://doi.org/10.1080/08964289.2016.1165174

[38] Powell, W., Adams, L. B., Cole-Lewis, Y., Agyemang, A., & Upton, R. D. (2016). Masculinity and Race-Related Factors as Barriers to Health Help-Seeking Among African American Men. *Behavioral medicine (Washington, D.C.)*, *42*(3), 150–163. https://doi.org/10.1080/08964289.2016.1165174

---

[39] Addis ME, Mahalik JR. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist*;58(1):5.

[40] Galdas PM, Cheater F, Marshall P. (2005). Men and health help-seeking behaviour: literature review. *Journal of Advanced Nursing*;49(6):616–623.

[41] Courtenay WH. (2000). Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science & Medicine*;50(10):1385–1401.

[42] Reif SS, Whetten K, Wilson ER, et al. (2014). HIV/AIDS in the Southern USA: a disproportionate epidemic. AIDS Care;26(3):351–9.

[43] Adimora A. Drivers of the HIV epidemic in the Southern U.S. 20th Conference on retroviruses and opportunistic infections; 2013 March 5, 2013; Atlanta, GA.

[44] Neighbors HW, Caldwell C, Williams DR, Nesse R, Taylor RJ, Bullard KM, Torres M, Jackson JS. Race, ethnicity, and the use of services for mental disorders: Results from the National Survey of American Life. *Archives of General Psychiatry*. 2007;64:485–494.

[45] Hussen, S. A., Camp, D. M., Wondmeneh, S. B., Doraivelu, K., Holbrook, N., Moore, S. J., Colasanti, J. A., Ali, M. K., & Farber, E. W. (2021). Mental Health Service Utilization Among Young Black Gay, Bisexual, and Other Men Who Have Sex with Men in HIV Care: A Retrospective Cohort Study. *AIDS patient care and STDs*, *35*(1), 9–14. https://doi.org/10.1089/apc.2020.0202

[46] Brown, L. K., Tolou-Shams, M., Lescano, C., Houck, C., Zeidman, J., Pugatch, D., Lourie, K. J., & Project SHIELD Study Group (2006). Depressive symptoms as a predictor of sexual risk among African American adolescents and young adults. The Journal of adolescent health : official publication of the Society for Adolescent Medicine, 39(3), 444.e1–444.e4448. https://doi.org/10.1016/j.jadohealth.2006.01.015

[47] Sen, B. (2004). Adolescent propensity for depressed mood and help seeking: race and gender differences
J Ment Health Policy Econ, 7, pp. 133-145

[48] Gamarel, K. E., Brown, L., Kahler, C. W., Fernandez, M. I., Bruce, D., Nichols, S., & Adolescent Medicine Trials Network for HIV/AIDS Intervention (2016). Prevalence and correlates of substance use among youth living with HIV in clinical settings. Drug and alcohol dependence, 169, 11–18. https://doi.org/10.1016/j.drugalcdep.2016.10.002

[49] Elkington, K. S., Bauermeister, J. A., & Zimmerman, M. A. (2010). Psychological distress, substance use, and HIV/STI risk behaviors among youth. *Journal of youth and adolescence*, *39*(5), 514–527. https://doi.org/10.1007/s10964-010-9524-7

[50] Elkington, K. S., Bauermeister, J. A., & Zimmerman, M. A. (2010). Psychological distress, substance use, and HIV/STI risk behaviors among youth. Journal of youth and adolescence, 39(5), 514–527. https://doi.org/10.1007/s10964-010-9524-7

[51] Gamarel, K. E., Brown, L., Kahler, C. W., Fernandez, M. I., Bruce, D., Nichols, S., & Adolescent Medicine Trials Network for HIV/AIDS Intervention (2016). Prevalence and correlates of substance use among youth living with HIV in clinical settings. Drug and alcohol dependence, 169, 11–18. https://doi.org/10.1016/j.drugalcdep.2016.10.002

[52] Hussen, Sophia & Camp, Daniel & Wondmeneh, Sarah & Doraivelu, Kamini & Holbrook, Nancy & Moore, Shamia & Colasanti, Jonathan & Ali, Mohammed & Farber, Eugene. (2020). Mental Health Service Utilization Among Young Black Gay, Bisexual, and Other Men Who Have Sex with Men in HIV Care: A Retrospective Cohort Study. AIDS Patient Care and STDs. 35. 10.1089/apc.2020.0202.

[53] Sun, C., Nall, J., & Rhodes, S. (2018). Perceptions of Needs, Assets, and Priorities Among Black Men Who Have Sex With Men With HIV: Community-Driven Actions and Impacts of a Participatory Photovoice Process. *American Journal Of Men's Health*, *13*(1), 155798831880490. doi: 10.1177/1557988318804901

[54] National Mental Health Association. *Depression in African Americans is not "Just the Blues"* 1998 Retrieved from https://www.nmha.org/newsroom/system/news.vw.cfm?do=vw&rid=43.

[55] Conner KO, Copeland VC, Grote NK, Koeske G, Rosen D, Reynolds CF, 3rd, Brown C. Mental health treatment seeking among older adults with depression: The impact of stigma and race. *The American Journal of Geriatric*

[56] Johnson ED. (2000). Differences among families coping with serious mental illness: A qualitative analysis. *The American Journal of Orthopsychiatry*;70:126–134.

[57] Ward, E. C., Wiltshire, J. C., Detry, M. A., & Brown, R. L. (2013). African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. Nursing research, 62(3), 185–194. https://doi.org/10.1097/NNR.0b013e31827bf533

[58] Gary FA. (2005). Stigma: Barriers to mental health care among ethnic minorities. *Issues in Mental Health Nursing*;26:979–999.

---

[59] Thompson-Sanders VL, Bazile A, Akbar M. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice*;35:19–26.
[60] Conner KO, Copeland VC, Grote NK, Koeske G, Rosen D, Reynolds CF, 3rd, Brown C. (2010). Mental health treatment seeking among older adults with depression: The impact of stigma and race. *The American Journal of Geriatric Psychiatry*;18:531–543.
[61] Anglin DM, Alberti PM, Link BG, Phelan JC. (2008). Racial differences in beliefs about the effectiveness and necessity of mental health treatment. American Journal of Community Psychology;;42:17–24.
[62] Diala C, Muntaner C, Walrath C, Nickerson KJ, LaVeist TA, Leaf PJ. (2000). Racial differences in attitudes toward professional mental health care and in the use of services. *The American Journal of Orthopsychiatry*;70:455–464.
[63] HIV in the United States and Dependent Areas. (2019). Retrieved 9 April 2022, from https://www.cdc.gov/hiv/statistics/overview/ataglance.html
[64] HIV in the United States and Dependent Areas. (2019). Retrieved 9 April 2022, from https://www.cdc.gov/hiv/statistics/overview/ataglance.html
[65] New HIV infections down by 18% in the United States of America. (2017). Retrieved 7 April 2022, from https://www.unaids.org/en/resources/presscentre/featurestories/2017/february/20170216_CDCreport
[66] Hussen, S. A., Camp, D. M., Wondmeneh, S. B., Doraivelu, K., Holbrook, N., Moore, S. J., Colasanti, J. A., Ali, M. K., & Farber, E. W. (2021). Mental Health Service Utilization Among Young Black Gay, Bisexual, and Other Men Who Have Sex with Men in HIV Care: A Retrospective Cohort Study. *AIDS patient care and STDs*, *35*(1), 9–14. https://doi.org/10.1089/apc.2020.0202
[67] Gay, Bisexual, and Other MSM | Volume 31 | HIV Surveillance | Reports | Resource Library | HIV/AIDS | CDC. (2021). Retrieved 24 October 2021, from https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-31/content/msm.html
[68] Hightow-Weidman, L., LeGrand, S., Choi, S. K., Egger, J., Hurt, C. B., & Muessig, K. E. (2017). Exploring the HIV continuum of care among young black MSM. *PloS one*, *12*(6), e0179688. https://doi.org/10.1371/journal.pone.0179688
[69] *HIV Care Continuum*. HIV.gov. (2021). Retrieved 16 April 2022, from https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum.
[70] Hussen, S. A., Easley, K. A., Smith, J. C., Shenvi, N., Harper, G. W., Camacho-Gonzalez, A. F., Stephenson, R., & Del Rio, C. (2018). Social Capital, Depressive Symptoms, and HIV Viral Suppression Among Young Black, Gay, Bisexual and Other Men Who Have Sex with Men Living with HIV. *AIDS and behavior*, *22*(9), 3024–3032. https://doi.org/10.1007/s10461-018-2105-6
[71] *HIV Care Continuum*. HIV.gov. (2021). Retrieved 16 April 2022, from https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum.
[72] U.S. Statistics. (2021). Retrieved 24 October 2021, from https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics
[73] Global HIV/AIDS Overview. (2021). Retrieved 24 October 2021, from https://www.hiv.gov/federal-response/pepfar-global-aids/global-hiv-aids-overview
[74] Stephens, C. (2022). ‘Got Something To Say:’ How ATL Became the Black Gay Mecca. Retrieved 9 April 2022, from https://cassiuslife.com/66017/atlanta-black-gay-mecca/
[75] Stephens, C. (2018). This Ally Helped Turn Atlanta Into a Black Gay Mecca. Retrieved 9 April 2022, from https://www.advocate.com/politicians/2018/1/03/ally-helped-turn-atlanta-black-gay-mecca
[76] Why the South is the epicenter of the AIDS crisis in America. (2021). Retrieved 24 October 2021, from https://www.pbs.org/newshour/show/south-epicenter-aids-crisis-america
[77] Hightow-Weidman, L., LeGrand, S., Choi, S. K., Egger, J., Hurt, C. B., & Muessig, K. E. (2017). Exploring the HIV continuum of care among young black MSM. *PloS one*, *12*(6), e0179688. https://doi.org/10.1371/journal.pone.0179688
[78] McLean, C. P., & Fitzgerald, H. (2016). Treating Posttraumatic Stress Symptoms Among People Living with HIV: a Critical Review of Intervention Trials. Current psychiatry reports, 18(9), 83. https://doi.org/10.1007/s11920-016-0724-z
[79] Saag, L. A., Tamhane, A. R., Batey, D. S., Mugavero, M. J., & Eaton, E. F. (2018). Mental health service utilization is associated with retention in care among persons living with HIV at a university-affiliated HIV clinic. AIDS research and therapy, 15(1), 1. https://doi.org/10.1186/s12981-018-0188-9
[80] Wagner, G. J., Kanouse, D. E., Golinelli, D., Miller, L. G., Daar, E. S., Witt, M. D., Diamond, C., Tilles, J. G., Kemper, C. A., Larsen, R., Goicoechea, M., & Haubrich, R. H. (2006). Cognitive-behavioral intervention to enhance

---

adherence to antiretroviral therapy: a randomized controlled trial (CCTG 578). *AIDS (London, England)*, *20*(9), 1295–1302. https://doi.org/10.1097/01.aids.0000232238.28415.d2

[81] Hussen, S. A., Camp, D. M., Wondmeneh, S. B., Doraivelu, K., Holbrook, N., Moore, S. J., Colasanti, J. A., Ali, M. K., & Farber, E. W. (2021). Mental Health Service Utilization Among Young Black Gay, Bisexual, and Other Men Who Have Sex with Men in HIV Care: A Retrospective Cohort Study. *AIDS patient care and STDs*, *35*(1), 9–14. https://doi.org/10.1089/apc.2020.0202

[82] Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British journal of pain*, *9*(1), 41–42. https://doi.org/10.1177/2049463714541642

[83] Courtenay WH. (2000). Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science & Medicine*;50(10):1385–1401.

[84] Ward EC, Clark LO, Heidrich S. (2009). African American women's beliefs, coping behaviors, and barriers to seeking mental health services. Qualitative Health Research;19:1589–1601.

[85] Black and African American Communities and Mental Health. (2022). Retrieved 20 April 2022, from https://www.mhanational.org/issues/black-and-african-american-communities-and-mental-health

[86] Ward, E. C., Wiltshire, J. C., Detry, M. A., & Brown, R. L. (2013). African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. *Nursing research*, *62*(3), 185–194. https://doi.org/10.1097/NNR.0b013e31827bf533

[87] Ward, E. C., Wiltshire, J. C., Detry, M. A., & Brown, R. L. (2013). African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. Nursing research, 62(3), 185–194. https://doi.org/10.1097/NNR.0b013e31827bf533

[88] Ponce De Leon Center | Leading the Fight to End HIV/AIDS. Grady Health. (2022). Retrieved 14 April 2022, from https://www.gradyhealth.org/locations/ponce-de-leon-center/.

[89] G. Andrews, A. Basu, P. Cuijpers, M.G. Craske, P. McEvoy, C.L. English, J.M. Newby. (2018). Computer therapy for the anxiety and depression disorders is effective, acceptable and practical health care: An updated meta-analysis,
Journal of Anxiety Disorders. Volume 55, Pages 70-78,ISSN 0887-6185, https://doi.org/10.1016/j.janxdis.2018.01.001.