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Health Implications of Internalized Homonegativity over the Life Course of Young Black Gay, Bisexual and other Men Who Have Sex With Men Living with HIV

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By

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Bachelor of Arts
University of Virginia
2016

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An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health in Global Health
2018

Abstract

Health Implications of Internalized Homonegativity over the Life Course of Young Black Gay, Bisexual and other Men Who Have Sex With Men Living with HIV

By Shamia J. Moore

Background: Minority stress theory posits that homonegativity, whether external to an individual or internalized, has the potential to negatively impact health. We sought to understand the mechanisms through which homonegativity experienced over the life course impacted mental and physical health for young Black gay, bisexual and other men who have sex with men (YB-GBMSM) living with HIV.

Methods: We conducted 30 in-depth interviews with HIV-positive YB-GBMSM ages 18-29 in Atlanta. Interview domains included adolescent experiences with sexuality and coming out, descriptions of social support, trauma history, and medication adherence. We conducted team-based coding and thematic analysis to identify patterns in the data.

Results: Stifling, and sometimes traumatic, environments encountered during adolescence led to internalized homonegativity, which in turn shaped sexual identity formation, risk behaviors, and mental health outcomes. Familial homonegativity led participants to engage with men in secret, and many acknowledged it as a facilitator of contracting HIV. After HIV seroconversion, some participants expressed feelings of self-loathing and depression. The majority of participants distanced themselves from homophobic environments upon reaching adulthood. Although participants described new environments as freeing, distance from support systems sometimes led to homelessness and financial struggles, which often had an adverse impact on HIV medication adherence.

Conclusions: Our analysis suggests that internalized homonegativity plays a significant role in mental and physical health outcomes for YB-GBMSM. In order to mitigate the adverse effects of these experiences, our focus should shift to increasing social support within this population during adolescence and young adulthood. Future interventions aimed at improving health outcomes should be culturally appropriate, identity-affirming, and utilize a trauma-informed approach.

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Acknowledgements

Writing this thesis would not have been possible without the support and encouragement of several people, including my family and friends living in Atlanta and out of town. I would like to thank my friends at Rollins for serving as my sounding board and accountability partners throughout this process. I am eternally grateful for the many roles my thesis advisor, Dr. Sophia Hussen, has played in my graduate career at Rollins, from my first semester as my professor to my last as my thesis advisor. Thank you for guiding, challenging, and pushing me to grow every step of the way. Even during maternity leave, Dr. Hussen was a constant source of support. Her impact on my personal and professional development cannot be overstated. Also, I am thankful for the entire B6 team for their continued dedication and *words of affirmation*. Lastly, I would like to acknowledge the resilient, inspiring participants who shared their impactful stories and reaffirmed my passion for doing this work.

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CHAPTER 1: Introduction

1.1 Introduction and Rationale

Gay, bisexual and other men who have sex with men (GBMSM) are disproportionately affected by HIV/AIDS in the United States. Although GBMSM only make up approximately 2% of the population, over half of all new HIV infections occur within this group [2]. Over one-third of new cases of HIV among GBMSM occur in Black men [41]. Young Black gay bisexual and other men who have sex with men (YB-GBMSM) between the ages of 13 and 24 represent the population most at-risk of contracting the virus [1]. The reasons for elevated HIV risk in this group are incompletely understood. Previous studies have explored several potential causes of disparities in HIV incidence, but examining individual behavioral and biomedical factors alone does not provide the complete answer. In order to fully understand HIV risk and address elevated HIV rates among YB-GBMSM, researchers also need to explore socio-contextual factors, including environment, sexual identity formation, gender role strain, and *homonegativity,* which can be defined as negative societal attitudes about homosexuality and same-sex sexual behavior [52].

Described as "insidious," internalized homonegativity is experienced throughout the life course of lesbian, gay, and bisexual (LGB) individuals and is assumed to persist even after the identity acceptance stage is reached [52]. Minority stress theory posits that homonegativity, whether external to an individual or internalized, has the potential to negatively impact both physical and mental health [52]. The idea that internalized homonegativity and low self-esteem are associated with anxiety and depression is widely accepted [22-25]. Several studies suggest that internalized homonegativity is much higher among sexual minority youth than older individuals [22-25].

There are a limited number of studies focused on internalized homonegativity among Black GBMSM. Previous research suggests that anti-homosexual attitudes and stigma against same-sex sexual behavior may be more widespread in the Black community [22, 24]. Quinn et al. studied the correlates of internalized homonegativity, such as gay community acculturation and self-ascribed masculinity, among a large sample of Black GBMSM in Milwaukee, Cleveland, and Miami [22]. They found that as self-perceived masculinity increased, higher levels of internalized homonegativity were expected [22]. As resilience increased, levels of internalized homonegativity decreased. They also found that Black men may experience more internalized homonegativity than their white counterparts [22]. Also, a recent study of GBMSM found that increased levels of religiosity predicted internalized homonegativity in Black GBMSM [24]. Although the Black church can serve as a source of support in the lives of Black men who have sex with men, it can also serve as a source of stress [24]. Researchers point to anti-homosexual attitudes and internalized homonegativity as a possible predictor for elevated HIV risk among Black GBMSM [22, 24]. Based on this theory, in order to improve the health of the YB-GBMSM population, we should focus on mitigating internalized homonegativity.

Closely related to internalized homonegativity, many researchers have focused on sexual identity formation among sexual minority youth [43, 53, 63]. The sexual identity formation process, described by Cass, can be separated into six stages: (i) Identity Confusion, (ii) Identity Comparison, (iii) Identity Tolerance, (iv) Identity Acceptance, (v) Identity Pride, and (vi) Identity Synthesis [43]. Troiden's Model of Sexual Identity and Development and Coleman's Developmental Stages of the Coming Out Process describe similar processes, characterized by initial feelings of confusion and marginalization and sharing concealed sexual identities with

others [53, 62-63]. All three models end with a stage in which sexual identity becomes seamlessly incorporated into a person's overall sense of identity [62].

The experiences and identity formation of YB-GBMSM are shaped by their status as racial and sexual minorities. Consequently, the identity formation process that this population experiences may be more nuanced than existing sexual identity models allow. According to Jamil, Harper and Hernandez, these models do not consider the adverse lived experiences of those who have both sexual minority and ethnic minority status. [62]. Several studies found that Black men were less likely to experience a positive homosexual identity formation [12-14]. This could be attributed to rigid ideas of masculinity within the Black community, especially among those of lower socioeconomic status [48-51]. Due to the experience of homonegativity and subsequent negative identity formation, YB-GBMSM may face negative mental health outcomes and may attempt to conceal their sexual behavior and same-sex attraction in order to fit into gendered and sexual expectations from society [12-16].

In attempting to examine the health implications of internalized homonegativity over the life course of YB-GBMSM living with HIV, it is also necessary to study the HIV-related illness experience. The HIV care continuum can be described as the stages an individual experiences from HIV diagnosis to the achievement of viral suppression [54]. There are five steps in the HIV Care Continuum: (i) HIV Diagnosis, (ii) Linkage to Care, (iii) Engagement in Care, (iv) Prescribed Anti-retroviral therapy, and (v) Achievement of Viral Suppression [54]. Medication adherence to a regimen of antiretroviral therapy is necessary to achieve viral suppression. There are stark disparities in engagement in HIV care. Oster and collaborators sought to understand

disparities surrounding HIV infection among white and Black GBMSM in the US [35]. They found that among HIV positive men, fewer Black GBMSM reported engaging with healthcare practitioners during the first 3 months after positive HIV diagnosis than white GBMSM [35]. Also, they found Black GBMSM were less likely to be adherent to antiretroviral therapy than white MSM [35]. This is consistent with previous research findings on medication adherence. Young GBMSM and Black GBMSM are least likely to be engaged in care [55]. Addressing internalized homonegativity among YB-GBMSM may be important in eliminating disparities in HIV.

Informed by previous research, we sought to understand the mechanisms through which homonegativity experienced over the life course impacted mental and physical health for YB-GBMSM living with HIV. In this study, we postulated that internalized homonegativity would be found to have a significant impact on self-acceptance and subsequent health outcomes within this population. This study of a sample of YB-GBMSM living with HIV in Atlanta, Georgia, will add to the limited body of knowledge on this population. As a result, public health interventions aimed at improving the health of this population will be better informed.

1.2 Problem Statement

YB-GBMSM between 13 and 24 are the population most at risk of contracting HIV [1]. There is an urgent need to understand the underlying causes of the disparities in HIV in order to control the epidemic. There are several socio-contextual factors related to HIV to consider, such as environment, socioeconomic status, and access to resources. Up to this point, there has been little examination of the relationship between internalized homonegativity, self-acceptance, and

medication adherence. Although there are related studies, few have been conducted specific to YB-GBMSM living with HIV in Atlanta, Georgia. The setting of Atlanta, coined the Black Gay Mecca, is particularly important, as a city that has a large population of Black gay men. Further, over two-thirds of people living with HIV in Atlanta contracted the virus through male-to-male sexual contact [47]. Further research is needed to understand the experiences of YB-GBMSM living with HIV in Atlanta, the epicenter of the HIV epidemic. As a result of addressing this gap in knowledge, public health interventions that are aimed at improving the health of this population will be better informed.

1.3 Statement of Purpose

The health implications of YB-GBMSM living with HIV are nuanced due to the multiple, intersecting identities of YB-GBMSM, which include race, sexual identity, gender expression, and religious affiliation. Qualitative research can provide key insight into the experiences of this population. Through qualitative analysis of in-depth interviews, this paper will examine the health implications of internalized homonegativity experienced over the life course of YB-GBMSM living with HIV in Atlanta, Georgia. This study aims to (i) describe the potential impacts of experienced homonegativity on the health of YB-GBMSM. Based on the hypothesis that internalized homonegativity will be found to have a significant impact on health outcomes of this population, this research will add to the existing scholarship on the prevention and control of HIV in the United States.

1.4 Research Questions

In order to improve understandings of health and barriers to medication adherence in YB-GBMSM, this research study aims to address the research questions:

- What is the role of internalized homonegativity in self-acceptance among YB-GBMSM living with HIV in Atlanta?
- What are the health implications of homonegativity experienced over the life course of YB-GBMSM?

1.5 Significance Statement

The HIV/AIDS epidemic is a global crisis. Approximately 37 million people are living with HIV worldwide [1]. An estimated number of 1.8 million people contracted the virus in 2016, with 2% of new cases occurring in the United States [1]. There is a significant economic burden associated with HIV. The domestic prevention and control of HIV is a challenging issue due to several factors, such as poverty, environment, and individual behavior. HIV continues to spread rapidly in key populations, including GBMSM. YB-GBMSM are the most at risk-population for contracting HIV [41]. Research studies examining the experiences of YB-GBMSM can provide insight into the underlying causes of health disparities related to the spread of HIV.

1.6 Definition of Terms

Self-Acceptance- the *process* of accepting one's sexuality and HIV status over time

Self-Loathing- the state of disliking or disapproving of oneself due to sexual minority status, gender expression, or HIV status

Internalized homonegativity- the internalization of negative societal attitudes about homosexuality generally and about one's own sexual orientation

Familial Homonegativity- negative attitudes about homosexuality and same-sex sexual behavior held by family members

Medication Adherence- the act of strictly following a prescribed HIV treatment regimen

Trauma- any deeply distressing, disturbing or life-threatening occurrences. These occurrences are not limited to physical abuse.

Identity-Affirming Environment- surroundings in which a person's behaviors and ways of life are positively reinforced

Stifling Environment- surroundings in which a person's behaviors and ways of life are suppressed in a negative way

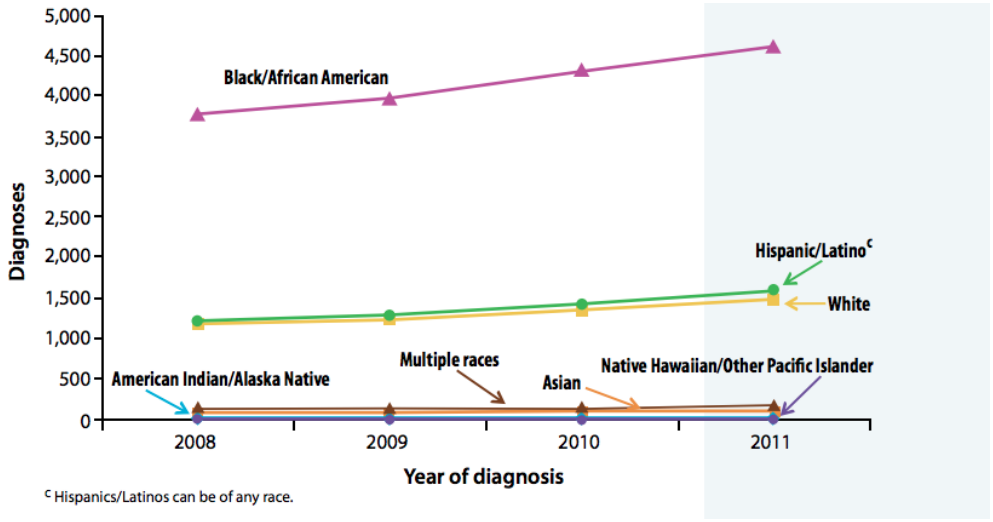
Sexual Identity Formation- the *development process* of youth who experience same-sex attraction and same-sex sexual behavior

Chapter 2: Literature Review

Epidemiology of HIV in the United States among GBMSM

Over 1.1 million people are living with HIV in the United States [1]. Between 2008 and 2014, the overall incidence of new HIV cases in the United States decreased by 18% [41]. GBMSM are disproportionately affected by HIV/AIDS. Although GBMSM only make up approximately 2% of the population, over half of all new HIV infections occur within the GBMSM population [2]. Out of the projected 37,000 new HIV infections that occurred in 2014, 70% were among, 23% were due to heterosexual transmission, and 7% of infections were among injection drug users [1]. All GBMSM are not affected by HIV equally. There are stark disparities across race, age, socioeconomic status, and geographic location [2]. Over one-third of the new cases of HIV among GBMSM occur in Black men [41]. In addition to this, in 2015, there were more new cases of HIV among YB-GBMSM between the ages of 13 and 24 than any other subpopulation [2]. The reasons for these disparities are complex and incompletely understood.

Figure 1: Diagnoses of HIV Infection Among Men Who Have Sex with Men Aged 13-24 Years, by Race/ Ethnicity, 2008-2011- United States and 6 Dependent Areas. Data and graphic from Centers for Disease Control and Prevention (CDC) [42].



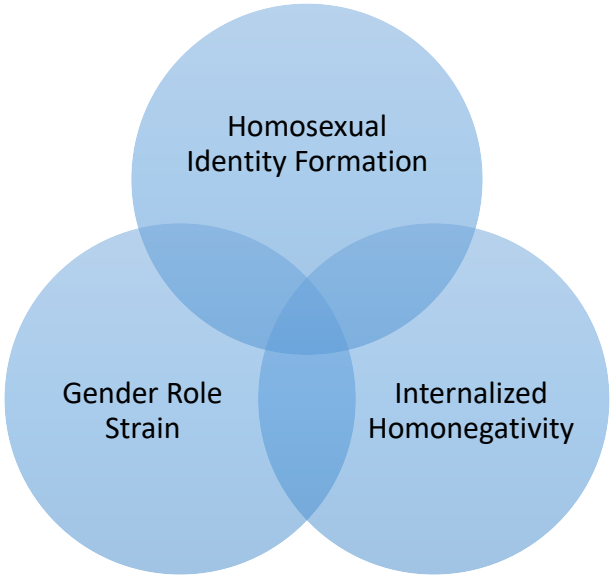
Influences on HIV Risk for Black GBMSM

The research on HIV among Black GBMSM is extensive and can be characterized as an exploration of behavioral, biomedical, and socio-contextual factors that affect the epidemiology of HIV within the population. Studies focused on behavioral factors tend to use quantitative data collection, and include discussion of sexual partner selection, substance abuse, unprotected anal intercourse, and unprotected receptive anal intercourse (URAI). Those focused on biomedical factors highlight the possible role of circumcision and sexually transmitted diseases in increased HIV risk. Studies have explored several potential causes of disparities in HIV incidence, but examining behavioral and biomedical factors alone does not provide the answers. In order to fully understand HIV risk, researchers also need to explore socio-contextual factors, including homosexual identity, gender norms, internalized homonegativity, and experiences within the healthcare system.

Researchers have postulated that tensions between gender norms and homosexual identity are particularly challenging for Black GBMSM [12-15]. These challenges have certain implications for HIV risk and treatment. Vivienne Cass described homosexual identity formation in 1984. Her Homosexual Identity Formation model shows, "the process by which a person comes first to consider and later acquire the identity as 'homosexual' as a relevant aspect of self" [43]. The male gender role strain paradigm was created in the early 1980s by Joseph Pleck [10]. It is characterized by ten propositions, such as, "Violating gender role norms leads to negative psychological consequences" and "Violating gender role norms has more severe consequences for males than females" [11]. Internalized homophobia can be defined as the internalization of negative societal attitudes about homosexuality [28]. Mayfield employed the use of internalized

homonegativity instead of internalized homophobia because the former, he asserted, is an all-encompassing term of all possible forms of anti-homosexuality [21]. The concepts of sexual identity formation, gender role strain, and internalized homonegativity are closely related, and studies focused on these topics have overlapping themes, such as psychological distress, increased HIV risk, coping strategies, and medication adherence.

Figure 2: A visual representation of the relationship between Homosexual Identity Formation, Gender Role Strain, and Internalized Homonegativity in young Black GBMSM.



Sexual Identity

Existing research about sexual identity formation outlines the developmental processes of sexual minority individuals. Several studies describe the process of sexual identity formation [15-16, 36-37]. The majority of studies discuss the difficulty that these individuals have during adolescent development and the possible negative health outcomes associated with sexual identity formation. Sexual identity formation is described by many as complicated, yet critically important in the lives of sexual minority individuals [15-20]. The majority of studies highlighted the psychosocial stress that can arise due to issues related to sexual identity formation. In

accordance with research on gender role strain in Black men who have sex with men, more than one study found that Black men were less likely to experience a positive homosexual identity formation than white men [12-14]. Consequently, Black GBMSM are less likely to share their sexual orientation with others in the form of an "out" sexual identity [15]. One study in particular provided an interesting perspective on gender identity and sexual identity. Malebranche and colleagues discussed the impact of the absence of Black fathers and father-figures in relation to masculine socialization, which includes forming sexual identity [16]. This study also confirmed previous findings about homosexual identity formation in Black men; participants described racial differences in comfort-level with identifying as homosexual [16]. Because of their Blackness, participants discussed not having the freedom to also identify as homosexual [16].

Sexual identity formation begins early within the development process. Several studies specifically focused on the role of age in sexual identity formation [17-20]. First, Brown and Trevethan conducted a study of 166 gay men that linked identity, including internalized shame, internalized homophobia, and attachment style to coming out, familial acceptance of sexuality, and relationship status [17]. A key part of their article is discussion of parents. They assert that the quality of the relationship between a sexual minority youth and his or her parents plays a major role in how the former are able to reach positive identity formation [17]. Similarly, another study found that relationships during childhood are extremely important in the development process. In analyzing data from over 700 gay and bisexual men in Atlanta, White and Stephenson found that many participants asserted that faculty and staff in schools made homophobic remarks [18]. In addition to this, the majority of participants stated that they

experienced persecution due to their homosexuality in the form of verbal harassment, physical harassment, or physical assault [18].

In spite of the challenges of development as a sexual minority youth, it should be noted that the concepts of resilience and coping can be seen throughout the literature on sexual identity formation. Two studies focused on overcoming negative mental health outcomes [19-20]. The first, by Goyer and collaborators, studied homophobic harassment and coping strategies among 262 sexual minority youth [20]. They examined six aspects of sexual identity formation, including coping strategies, age, and sexual attraction. Goyer found more homophobic victimization was related to lower positive homosexual identity formation [20]. In addition to this, they discovered that coping mechanisms, such as those related to problem-solving and avoidance, were used by participants when attempting to avoid the judgment of others, which aligns with the findings of other studies in the field. The second, by Zoeterman and Wright, show that although sexual minority individuals may experience stress due to social pressures, social support and connectedness can mitigate risk of facing negative mental health outcomes [19].

Gender Role Strain

Like studies on sexual identity formation, current research on gender role strain is characterized by anti-homosexual attitudes and internal conflict. Fields et al. studied gender role strain due to conflict between homosexual identity and gender norms among YB-GBMSM, as a potential contributor to HIV risk. They conducted qualitative interviews of 35 men between the ages of 18 and 24 in 2 U.S. cities [12]. The majority of participants were HIV negative, two participants

were HIV positive, and the serostatus of three participants was unknown. Their findings highlight significant gender role strain for Black GBMSM. Similar to studies on homosexual identity formation, many participants experienced psychological distress, attempted to conceal their same-sex sexual behavior and attraction, and worked to prove their manhood. They found that participants discussed negative feedback from family members and peers in the form of anti-homosexuality, which led to social isolation and possible increased HIV risk [12]. They found a relationship between negative coping strategies and increased risk behaviors in the data.

Related to this concept of gender role strain, other scholars have explored the impact of anti-homosexual attitudes on Black GBMSM. These attitudes among family, peers, and community members have negative consequences in the lives of Black GBMSM. Geter and colleagues conducted nine focus groups with YB-GBMSM between the ages of 18 and 29 in Mississippi. Many key themes emerged from their research, such as shame, judgment, stigma, and condom use [13]. They found that anti-homosexual cultural norms can serve as a barrier to safe sex practices and be related to intimate partner violence in the relationships of Black GBMSM [13]. As young men concealed or rejected their sexual orientation altogether due to self-loathing, the likelihood of their condom use decreased while the likelihood of anonymously meeting sexual partners increased [13]. Comparably, Graham and colleagues used an observational cross-sectional design in their study of 54 Black sexual minority men [14]. In addition to the aforementioned barriers, their survey findings show anti-homosexual attitudes in society are associated with mental distress in the form of depressive symptoms and anxiety among Black GBMSM. They discuss a form of *triple consciousness* that this population experiences due to their race, gender identity, and sexuality [14]. Triple consciousness, derived

from W.E.B. du Bois' concept of double consciousness, can be described as the difficult process of reconciling these three identities. Further, these men were suggested to have more symptoms of depression and anxiety than white sexual minority men [14]. The authors posit that for Black GBMSM, the experience of forming positive racial identity cannot be divorced from forming sexual identity, and the constant need to negotiate these identities leads to mental distress [14]. Balaji and collaborating authors also studied the impact of anti-homosexual attitudes on Black GBMSM. They conducted 16 in-depth interviews with young Black men who have sex with men between the ages of 19 and 24 in Jackson, Mississippi, to examine the role of external influences in their lives. They found that anti-homosexual attitudes were pervasive within the young men's social networks, including familial relationships, faith communities, and within the Black community as a whole [24]. They described the process of behavior change in order to assimilate in less affirming situations as "role flexing." Also, the theme of masculinity emerges in many papers written about Black GBMSM [38-40]. Rigid ideas about how men should behave are associated with internalized homonegativity [12,16,24]. In addition to many other negative outcomes associated with internalized homonegativity, Balaji asserts that anti-homosexual attitudes and discrimination can negatively influence a young man's choice to participate in HIV prevention efforts and seek medical care [24].

Internalized Homonegativity

The literature written about the concept of internalized homonegativity focuses on how external factors, such as homophobia and discrimination, work in the lives of sexual minority individuals [22-27]. The topic of internalized homonegativity is closely related to sexual identity formation

and gender role strain, and the information presented within the studies conducted often reflect this. Like studies discussed in the previous sections, youth as a theme emerged throughout the literature. Several studies suggest that internalized homonegativity is much higher among sexual minority youth than older individuals, which is consistent with previous work done on this topic [22-25]. Barnes stated that this internalization can persist even after individuals separate themselves from stifling environments [26]. Comparably, Berg and colleagues conducted a quantitative study of 174,209 GBMSM in 38 European countries. Participants completed a 280-question internet survey. Authors analyzed associations between internalized homonegativity and five variables, including being closeted and younger age [23]. They found that as internalized homonegativity increased, the likelihood that a gay man had been in a homosexual social space decreased. The importance and influence of identity-affirming environments can be seen throughout these studies [22-24].

Research that focused on youth discussed factors related to their well-being and overall mental health. Bauermeister and collaborators conducted a study on the psychological well-being of 350 sexual minority youth between ages 15 and 19 in New York City. Using quantitative analysis of longitudinal data, they found that involvement in same sex relationships was negatively associated with internalized homophobia [25]. This is consistent with previous research that suggests that same-sex peers and social support can decrease the extent to which people internalize homonegativity. The idea that internalized homonegativity and low self-esteem are associated with anxiety and depression is widely accepted [22-25]. Across two studies in particular, authors discussed the idea that the anticipation of experiencing anti-homosexual discrimination, which can be described as *mental internalization*, can result in negative health experiences [18,23]. Consequently, GBMSM have to develop coping strategies

in order to survive. The development of resilience among Black GBMSM is highlighted as a key coping strategy [14,22].

There are few studies focused on internalized homonegativity among Black GBMSM. Researchers point to anti-homosexual attitudes and internalized homonegativity as a possible predictor for elevated HIV risk in the population [22]. Quinn and colleagues studied the correlates of internalized homonegativity, such as gay community acculturation and self-ascribed masculinity, among a large sample of 464 Black GBMSM in Milwaukee, Cleveland, and Miami [22]. Several interesting findings emerged from their research. They found that as self-perceived masculinity increased, higher levels of internalized homonegativity were expected [22]. As resilience increased, levels of internalized homonegativity decreased. These statistically significant results align with aforementioned findings on the importance of resilience. Also, non-gay identity was a predictor of internalized homonegativity in their study [22].

Previous research suggests that anti-homosexual attitudes and stigma against same-sex sexual behavior may be more widespread in the Black community [22, 24]. This aligns with the finding that Black men may experience more internalized homonegativity than their white counterparts. Wilkerson and collaborators studied religiosity and internalized homonegativity in 1165 Christian men who have sex with men [27]. They used a stratification method to separate participants based on their religious associations and found that neither Catholic nor Mainline Protestant faith was a predictor for internalized homonegativity. However, high levels of religiosity among Evangelical Protestants was a predictor of internalized homonegativity among participants [27]. Several studies have linked this phenomenon with the influence of the Black church, which can be placed within the Evangelical Protestant group. Quinn and colleagues also

found that increased levels of religiosity were a predictor of internalized homonegativity in Black men who have sex with men [22]. Although the Black church can serve as a source of stress in the lives of Black men who have sex with men, it can also serve as a source of support [24]. Consequently, men had to learn to fit into this space. The theme of concealing one's homosexual identity also emerged as a coping strategy throughout the literature [20,24-5].

Healthcare Experiences of Black GBMSM Living with HIV

The current research on the healthcare experiences of Black GBMSM living with HIV is defined by discussion of their perceptions of healthcare providers and the healthcare system in general. Medical mistrust has been identified as a key factor in the healthcare seeking process by many researchers [29-31]. Dale et al. conducted a longitudinal study to examine the role of medical mistrust in medication adherence among 140 Black men living with HIV [29]. They found that overall medical mistrust, instead of medical mistrust due to perceived racism, was a predictor of decreased medication adherence [29]. Consequently, medical mistrust can lead to negative health outcomes among this population. *Actual* racial discrimination can also negatively affect health outcomes [30]. Bogart and colleagues found racial discrimination to be the strongest predictor of negative health outcomes, compared to other forms of discrimination [30]. HIV conspiracy beliefs are a type of medical mistrust that exist within the Black community. In another study conducted by Bogart, her team found two specific conspiracy beliefs, the idea that HIV was created by people and that the government is using HIV to experiment on citizens, negatively affected medication adherence [32]. More research about the impact of medical mistrust is needed to advance the field.

Medication adherence among Black GBMSM is also important to consider, as adherence to anti-retroviral medicine is an integral part of achieving and maintaining an undetectable viral load. Studies on this topic explore the differences in levels of medication adherence across races and the underlying causes for those differences [33-35]. Varying levels of medication adherence may contribute to the elevated HIV risk among Black GBMSM. Oster and collaborators sought to understand disparities surrounding HIV infection among white and Black men who have sex with men in the US [35]. They found that among HIV positive men, fewer Black GBMSM reported engaging with healthcare practitioners during the first 3 months after positive HIV diagnosis than white GBMSM [35]. Also, they found Black GBMSM were less likely to be adherent to antiretroviral therapy than white GBMSM [35]. This is consistent with previous research findings on medication adherence. Because of this disparity, Hightow-Weidman and colleagues were motivated to create an evidence-based intervention in order to engage and retain young Black and Latino men who have sex with men in HIV care [33]. Their intervention, STYLE, included an extensive social and medical support network that worked to link Black and Latino youth to care at two possible medical sites. The network was made up of a research team, peer support, and support groups [33]. 63% of the cohort remained engaged in medical care during the two-year follow-up period, which authors deemed successful. Interventions that address engagement in care and medication adherence among Black GBMSM are necessary in order to decrease health disparities related to HIV.

Although there is substantial existing research on young Black GBMSM living with HIV, there are still opportunities to increase knowledge within the field. Many studies focused on internalized homonegativity examine its relation to negative mental health outcomes. The current

study aims to examine the role of internalized homonegativity in self-acceptance and medication adherence among the target population.

Chapter 3: Manuscript

Title: Health Implications of Internalized Homonegativity over the Life Course of Young Black Gay, Bisexual and other Men Who Have Sex With Men Living with HIV

Abstract

Background: Minority stress theory posits that homonegativity, whether external to an individual or internalized, has the potential to negatively impact health. We sought to understand the mechanisms through which homonegativity experienced over the life course impacted mental and physical health for young Black gay, bisexual and other men who have sex with men (YB-GBMSM) living with HIV.

Methods: We conducted 30 in-depth interviews with HIV-positive YB-GBMSM ages 18-29 in Atlanta. Interview domains included adolescent experiences with sexuality and coming out, descriptions of social support, trauma history, and medication adherence. We conducted team-based coding and thematic analysis to identify patterns in the data.

Results: Stifling, and sometimes traumatic, environments encountered during adolescence led to internalized homonegativity, which in turn shaped sexual identity formation, risk behaviors, and mental health outcomes. Familial homonegativity led participants to engage with men in secret, and many acknowledged it as a facilitator of contracting HIV. The majority of participants distanced themselves from homophobic environments upon reaching adulthood. Although participants described new environments as freeing, distance from support systems sometimes led to homelessness and financial struggles, which often had an adverse impact on HIV medication adherence.

Conclusions: Our analysis suggests that internalized homonegativity plays a significant role in mental and physical health outcomes for YB-GBMSM. In order to mitigate the adverse effects of these experiences, our focus should shift to increasing social support within this population during adolescence and young adulthood. Future interventions aimed at improving health outcomes should be culturally appropriate, identity-affirming, and utilize a trauma-informed approach.

Key Words: sexual minority health, HIV/AIDS
Word Count: 250/250

Introduction

Gay, bisexual and other men who have sex with men (GBMSM) are disproportionately affected by HIV/AIDS in the United States. Although GBMSM only make up approximately 2% of the population, over half of all new HIV infections occur within this group [2]. Over one-third of new cases of HIV among GBMSM occur in Black men [41]. Young Black gay bisexual and other men who have sex with men (YB-GBMSM) between the ages of 13 and 24 represent the population most at-risk of contracting the virus [1]. The reasons for elevated HIV risk in this group are incompletely understood. Previous studies have explored several potential causes of disparities in HIV incidence, but examining individual behavioral and biomedical factors alone does not provide the complete answer. In order to fully understand HIV risk and address elevated HIV rates among YB-GBMSM, researchers also need to explore socio-contextual factors, including environment, sexual identity formation, gender role strain, and *homonegativity,* which can be defined as negative societal attitudes about homosexuality and same-sex sexual behavior [52].

Described as "insidious," internalized homonegativity is experienced throughout the life course of lesbian, gay, and bisexual (LGB) individuals and is assumed to persist even after the identity acceptance stage is reached [52]. Minority stress theory posits that homonegativity, whether external to an individual or internalized, has the potential to negatively impact both physical and mental health [52]. The idea that internalized homonegativity and low self-esteem are associated with anxiety and depression is widely accepted [22-25]. Several studies suggest that internalized homonegativity is much higher among sexual minority youth than older individuals [22-25].

There are a limited number of studies focused on internalized homonegativity among Black GBMSM. Previous research suggests that anti-homosexual attitudes and stigma against same-sex sexual behavior may be more widespread in the Black community [22, 24]. Quinn et al. studied the correlates of internalized homonegativity, such as gay community acculturation and self-ascribed masculinity, among a large sample of Black GBMSM in Milwaukee, Cleveland, and Miami [22]. They found that as self-perceived masculinity increased, higher levels of internalized homonegativity were expected [22]. As resilience increased, levels of internalized homonegativity decreased. They also found that Black men may experience more internalized homonegativity than their white counterparts [22]. Also, a recent study of GBMSM found that increased levels of religiosity predicted internalized homonegativity in Black GBMSM [24]. Although the Black church can serve as a source of support in the lives of Black men who have sex with men, it can also serve as a source of stress [24]. Researchers point to anti-homosexual attitudes and internalized homonegativity as a possible predictor for elevated HIV risk among Black GBMSM [22, 24]. Based on this theory, in order to improve the health of the YB-GBMSM population, we should focus on mitigating internalized homonegativity.

Closely related to internalized homonegativity, many researchers have focused on sexual identity formation among sexual minority youth [43, 53, 63]. The sexual identity formation process, described by Cass, can be separated into six stages: (i) Identity Confusion, (ii) Identity Comparison, (iii) Identity Tolerance, (iv) Identity Acceptance, (v) Identity Pride, and (vi) Identity Synthesis [43]. Troiden's Model of Sexual Identity and Development and Coleman's Developmental Stages of the Coming Out Process describe similar processes, characterized by initial feelings of confusion and marginalization and sharing concealed sexual identities with

others [53, 62-63]. All three models end with a stage in which sexual identity becomes seamlessly incorporated into a person's overall sense of identity [62].

The experiences and identity formation of YB-GBMSM are shaped by their racial and sexual minority status. Consequently, the identity formation process that this population experiences may be more nuanced than existing sexual identity models allow. According to Jamil, Harper and Hernandez, these models do not consider the adverse lived experiences of those who have both sexual minority and ethnic minority status. [62]. Several studies found that Black men were less likely to experience a positive homosexual identity formation [12-14]. This could be attributed to rigid ideas of masculinity within the Black community, especially among those of lower socioeconomic status [48-51]. Due to the experience of homonegativity and subsequent negative identity formation, YB-GBMSM may face negative mental health outcomes and may attempt to conceal their sexual behavior and same-sex attraction in order to fit into gendered and sexual expectations from society [12-16].

In attempting to examine the health implications of internalized homonegativity over the life course of YB-GBMSM living with HIV, it is also necessary to study the HIV-related illness experience. The HIV care continuum can be described as the stages an individual experiences from HIV diagnosis to the achievement of viral suppression [54]. There are five steps in the HIV Care Continuum: (i) HIV Diagnosis, (ii) Linkage to Care, (iii) Engagement in Care, (iv) Prescribed Anti-retroviral therapy, and (v) Achievement of Viral Suppression [54]. Medication adherence to a regimen of antiretroviral therapy is necessary to achieve viral suppression. There are stark disparities in engagement in HIV care. Oster and collaborators sought to understand

disparities surrounding HIV infection among white and Black GBMSM in the US [35]. They found that among HIV positive men, fewer Black GBMSM reported engaging with healthcare practitioners during the first 3 months after positive HIV diagnosis than white GBMSM [35]. Also, they found Black GBMSM were less likely to be adherent to antiretroviral therapy than white MSM [35]. This is consistent with previous research findings on medication adherence. Young GBMSM and Black GBMSM are least likely to be engaged in care [55]. Addressing internalized homonegativity among YB-GBMSM may be important in eliminating disparities in HIV.

Informed by previous research, we sought to understand the mechanisms through which homonegativity experienced over the life course impacted mental and physical health for YB-GBMSM living with HIV. In this study, we postulated that internalized homonegativity would be found to have a significant impact on self-acceptance and subsequent health outcomes within this population. This study of a sample of YB-GBMSM living with HIV in Atlanta, Georgia, will add to the limited body of knowledge on this population. As a result, public health interventions aimed at improving the health of this population will be better informed.

Methods

Context

This research was conducted as part of a larger mixed-methods study, "Social Capital and Engagement in Care among Young Black Men who have Sex with Men Living with HIV", in Atlanta, Georgia. Utilizing a community-based participatory approach, the study aimed to increase engagement in care among HIV positive YB-GBMSM through the development and

subsequent implementation of a group-level social capital intervention. In order to inform the intervention development process, in-depth interviews with YB-GBMSM living with HIV in Atlanta were conducted. A key component of this study was the recruitment of a youth advisory board (YAB) comprised of nine YB-GBMSM living with HIV. The YAB provided input in development of the interview guide, recruitment of participants, and conducting of interviews. The study was approved by the Emory University Institutional Review Board and the Grady Research Oversight Committee.

Participants

This qualitative study used data from 30 in-depth interviews that were conducted with YB-GBMSM living with HIV between May and October of 2017.

Participants had to meet the following criteria in order to be eligible for participation: age between 18 and 29 years, self-identified as Black or African-American, male, HIV-positive, and report any history of sex with men. Participants were identified through the Grady Health Center Infectious Disease Program (IDP) clinic, the YAB, local CBOs, and the research team. The team aimed to capture a variety of experiences and backgrounds, and participants were recruited purposively based on their perceived social capital – study staff recruited participants who were perceived to be socially isolated and those who were perceived to be well-connected socially. Before each interview, informed consent was obtained and a self-administered questionnaire was completed by participants. The questionnaire included basic demographic information and items about medication adherence and HIV clinical parameters (Appendix 2).

Design

Informed by social capital theory and resilience theory, research staff developed the semi-structured in-depth interview guide (IDI). The YAB reviewed the IDI guide and provided suggestions for its improvement. The final IDI guide included questions and probes to elicit responses related to adolescent experiences, past trauma, family, relationships, and social support. The guide was grouped into five sections: I. Introduction, II. Network Composition, III. HIV Stigma, Disclosure, and Gay Identity/Homonegativity, IV. Using Social Capital, and V. Reciprocity. Responses from the first three sections were analyzed for this study.

All interviewers were trained in qualitative research methods. The majority of interviews were conducted by members of the research staff. Members of the YAB also conducted interviews accompanied by members of the research staff. All interviews were conducted in a private room within the Grady IDP or a prearranged location that was more accessible to the participant. Participants received written information about the study and a 50 dollar gift card as incentive for participating. Interviews lasted approximately one and a half to two hours and used a semi-structured interview approach. After each interview, members of the research staff convened in order to discuss emerging themes. If interviewers identified recurring themes that were not captured by the interview guide, it was amended iteratively to include related questions.

Interviews were recorded using Sony digital voice recorders and transcribed verbatim by a professional transcriptionist. Transcriptions were then imported into MAXQDA (VERBI software, Berlin, Germany), a qualitative data analysis program, coded, and analyzed thematically.

Thematic Analysis

Thematic analysis was conducted in order to examine patterns across the dataset. The research team began the analytic process by writing memos and coding the de-identified dataset. The codebook was created and amended through an iterative process, which consisted of reading transcripts, identifying recurring themes, discussion about codes, refining definitions, and rereading the interview guide to select structural codes. Both deductive and inductive coding were used in data analysis. After coding the dataset, research staff created an analysis plan organized by the study's research questions. Next, research staff wrote thick descriptions of each theme to explain depth, breadth, context, and nuance. Each topic was compared across the medication adherence and non-adherence subgroups. This informed the qualitative conceptualization process, which included the creation of a conceptual model (Figure 1).

Results

Sample Description

Our sample of 30 participants self-identified as YB-GBMSM between the ages of 18 and 29 (Table 1). The average age of participants was 24.2 years (standard deviation = 2.9 years). All participants in the sample were HIV positive by self-report (Table 1). The majority of participants reported completion of some college. All participants had at least a high school diploma or a trade certification. The highest level of education reached among participants was a bachelor's degree. The majority of participants had an annual income less than 20,000 dollars, and all participants' annual incomes were less than or equal to 60,000 dollars. Of 30 participants in the study, the majority self-reported daily medication adherence and an undetectable viral load. Those who reported non-adherence to medication identified the following barriers:

Haven't found a doctor I like, I don't like taking meds, I can't afford my medicine, and I don't have adequate housing.

Figure 1 visually presents our conceptual framework, which describes the effects of homonegativity experienced over the life course of YB-GBMSM living with HIV. It begins with the racial, gendered, and sexual expectations placed on an individual, which leads to homonegativity experienced at each life stage, the sexual identity formation process, and ends with the *ideal* goal of self-acceptance. This framework represents several common pathways described by our participants. Participants' experiences of homonegativity and responses to it varied, and all participants did not report going through every step represented in the framework.

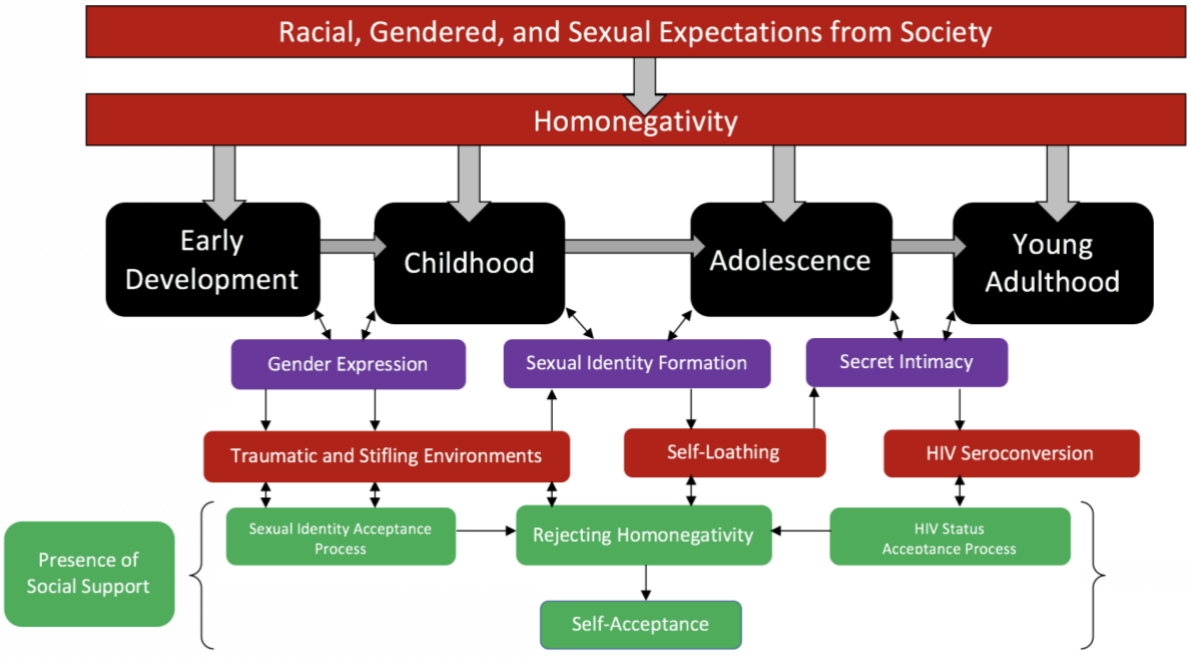


Figure 1. Homonegativity Over the Life Course of YB-GBMSM Living With HIV: Conceptual Framework.

During analysis, the following themes related to our research questions emerged: (i) *gender expression*, (ii) *sexual identity formation*, (iii) *traumatic and stifling environments*, (iv) *secret intimacy*, (v) *self-loathing*, (vi) *self-acceptance*, and (vii) *HIV seroconversion*.

(i) Gender Expression

Familial homonegativity was described by participants as a complex issue. Some were comfortable being out around family members, but at the same time, they were discouraged from being too feminine. Some young men described positive experiences related to gender expression, while the majority shared negative experiences. The themes of masculinity and femininity were discussed throughout the interviews. The majority of participants described themselves as more feminine-presenting. If a participant discussed being described as more feminine, he described both affirming and stigmatizing experiences. Female peers gravitated toward feminine gay men, or the "stereotypical gay." One participant said, *"A lot of females or women come to me. They're like 'Oh, you're so cool'"* (YM 8). In contrast, family did not always respond positively to feminine gender expression. The majority of participants described instances of family members using derogatory terms to refer to them, such as "sissy" and "bitch:"

> *He was saying to my mother a lot, to stop filling his head with childish dreams. That was what made me, he basically blamed her for me being the way that I am today. And he's* [...] *I'm not a man. I am a sissy in his opinion just because of the fact that I am in touch with my emotions.* (YM 21)

(ii) *Sexual Identity Formation*

Participants described the lessons they were taught about sexuality as children at home and at church. Many were taught that being gay was wrong. These teachings played an important role

in shaping sexual identity formation. Some parents did not allow their children to participate in certain activities or behave in ways that were thought to be "gay" during adolescent development. Participants described not being able to pursue their passions because parents disagreed with them:

> *There were a lot of things that I wanted to do that I wasn't allowed to* […] *I wanted to dance, my parents were like, no, because guys don't dance, that's gay.* (YM 6)

> *She was asking me why I had her hand mirror and I told her that I needed it for my hair. And she was like, well, what guy do you know carries a hand mirror? You sure you ain't got no sugar in your tank?* My response? Maybe I do.* (YM 22)

*The phrase "Sugar in your tank" is an informal way to suggest that a man may participate in same-sex sexual behaviors.

In contrast, other participants described supportive experiences with family members, which facilitated positive sexual identity formation.

> *It was never frowned upon, but it was just kind of looked at in the family as okay, he's a little different. It's okay, we still love you, you're a little sweet around the edges. But that's always just been the case with me, I have always been that really, really sweet kid. So eventually I was like you know, I might as well put the two and two together and just realize, I am that gay guy. But it was never frowned upon, it was never looked at as a bad thing, I was never bullied about it, I was never talked badly about.* (YM 13)

> *My mom pretty much went and told everyone. Like, oh my God, [he] gave me a letter and he wrote me, and we had to talk to him, so he's gay. I told her and next thing I know, everyone knows that I'm out.* […] *they all came to me separately and like, hey, I still love you no matter what. Like, I still respect you.* (YM 8)

Many participants spoke about *normality*. They spoke about their home environments not being "normal", or being different from others. When asked what "normal" was, one participant described it as:

> *When I say 'normal,' I kind of like visualize the modern, I guess you could-- the modern TV family [...] I've always understood that I wasn't normal [...] So, it's*

> *like me being, having kind of like moving around all over the place, kind of going through GED instead of high school, getting HIV at a young age, being sexually active, things like that you don't see on the normal modern TV.* (YM8)

Experiencing physical, emotional, or sexual abuse was regarded as abnormal. Homosexuality and being HIV positive were also considered abnormal. Perceptions of normality were shaped by outside influences, such as family and religion. This desire for "normality", in turn, shaped sexual identity formation through feelings of confusion and marginalization. Although one participant described eventually growing comfortable with his sexuality, he said, *"I feel like if I had to redo, I probably would not choose to be gay"* (YM 7).

(iii) *Traumatic And Stifling Environments*

Many participants described stifling religious and home environments during their adolescent development. Although religious environments were described as a source of support by many participants, they were also a source of self-loathing and internalized homonegativity. For example, many participants were told they were "an abomination". Participants discussed negative self-image and internal struggle resulting from their families' religious affiliations and experiences in church.

> *We're very religious. Um, I started dating and talking to guys around 14. I tried to keep it under wraps, but my parents found out when I was 16. We didn't do the whole conversion therapy* […] *but they had their own little version where they took me out of the school activities. I was in church 24/7, as much as possible. Took my cellphone, couldn't talk to anybody. They monitored the music I listened to, the TV shows that I watched. And they also had me talk to an elder, who is an ex-homosexual, who was married with kids. I had to talk to him for about an hour once a week for like, almost a year. And, uh, I mean, I'm still gay, so I'm like, you see how that went over (laughter). I'm not really close to my family like that because of that.* (YM 6).

> *I used to sit in church and be so happy to be there. But any time anything came up regarding sexuality or condemnation, it used to feel like, it used to just feel*

> *like every eye in the building was on me. Uh and that was because I was going through this internal struggle like I'm gay and God hates gay people. God doesn't like gay people. Gay people will go to hell.* (YM 3)

Although researchers expected most anti-homosexual views would be held by fathers, some participants described mothers who were especially negative.

> *And, you know, I told my dad, 'Hey, I think I like guys,' and my father's response was, 'I don't care what you do in your life, I don't care who you sleep with, just as long as you're not a bitch.' Those were his verbatim words and, you know, I just accepted it for what it was.* […] *He didn't want me to be a flaming-ass gay, walking around I guess in high heels and wigs, and all the extra-ness that comes with this lifestyle that you typically will see.* (YM 4)

Similarly, YM7 related a story of what happened when both of his parents caught him using their desktop computer to view pornographic images of men:

> *[My father] just sat there looking at the picture* […] *a dick on the screen and just looking at me. "This the type of shit you're doing?" My mom came in and picked up the chair and swung it at me. And then walked up, picked up the chair and proceeded to knock me over the head with the chair. You know those lawn chairs? Those bitches are heavy mind you.* [YM 7]

Many participants described some form of physical or verbal abuse associated with their sexual behavior. Physical and emotional trauma inflicted by family members caused participants to experience psychological distress.

> *You're told this is an abomination and you're going to go to hell. So, I'm thinking, I'm sitting here praying to God every night, to take it away, crying myself to sleep, doing everything in the book and watching straight porn, doing everything and trying to make myself go straight. And, here I am just like pretty much just tearing myself apart.* (YM 23)

YM 21 recounted experiences of sexual abuse during childhood. His father refused to believe he was raped by his older, stronger brother:

> *My father would call us a liar* [...] *I remember the first time it happened, I was bleeding, and it hurt really bad and I showed my mother and my mother shows my father. And my dad says that's, he probably hurt himself. And my mother told me, "Did you hurt yourself?" I said, "No,* [my brother] *did this to me." And he says to me, "My son isn't a faggot. You're not a faggot. Stop pretending that you are!"* [...] *I grew very angry, very angry to the point where I grew hate in my heart for life.* (YM 21)

Non-parent adults, such as step-parents and parents' romantic partners, were additional sources of homonegativity. Although many participants experienced some form of familial homonegativity, it is important to note that such views were rarely expressed by the entire family. Paradoxically, family members often served as both a source of stigma and support. If participants were kicked out of the house, for example, they were often able to live with another family member.

> *I went to college and my dad was paying for it, but my stepmom said no* […] *She didn't want my brother to turn out gay like me and we had a huge argument. So, I cussed him out and I moved out. I stayed with my uncle. And the funny thing is, I stayed with her brother that they don't like each other, so I am like okay, I know I have some place to go.* (YM 11)

(iv) *Secret Intimacy*

Many young men were raised in identity-stifling environments due to familial homonegativity and religious traditions, which forced participants to explore their sexual attraction for men in secret. Participants described being forced to conceal sexual attraction for other men: *"For a long time I had to live double lives"* (YM 23).

> *I always had a sexual attraction for men and things like that. And, it's like when you live in a structured Christian home you can't really show that or anything like that. It's like you got to bottle it all up.* (YM 20)

Some participants described past experiences of family members catching them associating with other men sexually. This also led to trauma among some participants in the form of constant surveillance, physical abuse, and verbal abuse from family members:

> *The second time they caught me, I was like 18, and I was about to go off to college. I was on BGC* and they found out so they kept me – I was supposed to go to University and instead they made me stay home and go to the community college for two years so they could keep an eye on me and make sure I wasn't doing anything of homosexual nature* [...] *The issue has always been with family. I have found more acceptance for my sexuality outside of my family.*

*Black Gay Chat (BGC) is an online social network for the LGBT community

Secrecy contributed to increased risk behavior among participants and many participants acknowledged it as a facilitator of contracting HIV.

(v) *Self-Loathing*

Cognitive dissonance, social isolation, and depression were described by most participants during their sexual identity formation process. The majority of participants experienced self-loathing early in this process and acknowledged that their sexuality led to "drama" and negative experiences in their lives. However, most negative feelings about sexual orientation subsided over time. Participants that did not eventually experience positive sexual identity formation overall described self-loathing.

> *[When I hear the word gay] I clench. And the reason why I still clench is because I think it's not as hurtful as the word "fag" or I don't even like using the word homosexual; I'm just thinking. I tell my friends all of the time, I'm not gay, I'm not a fag, I'm a try-sexual; I'm going to try anything. What you want me to try?* (YM 12)

Although many participants experienced positive sexual identity formation overall and described self-acceptance, some expressed ongoing internalized homonegativity. These participants

discussed an aversion to being associated with gay stereotypes related to gender expression, much like those condemned by their families: "*Not all of us are swinging pocketbooks and broken wrists*"* (YM 6).

*Swinging pocketbooks (handbags, purses, etc.) and broken wrists refers to mannerisms associated with flamboyance and feminine gender expression.

> *But I kind of do like get annoyed at the fact like the whole stereotype, like the gay friend or the gay best friend, it's like they kind of stereotype like, oh, you're gay so you could help me out with these things or you could do this* […] *you have to be open-minded. Like, that's not what being gay is about* (YM 8)

> *I came out young* […] *I'm like, "Oh you're already gay so you really can't be gay and a fag. Like you can't be gay and too flamboyant, you know. They're dealing with your gayness now* […] *you don't want to put too much on them.* (YM 2)

(vi) *Self-Acceptance*

The self-acceptance process was characterized by change over time. In order to reach self-acceptance, participants had to reject homonegativity perpetuated by families and religious institutions. Age, proximity to negative reinforcement, and a positive HIV diagnosis played an important role in self-acceptance for YB-GBMSM living with HIV. Internalized homonegativity was described as being more prominent for younger men and as a phase to outgrow. Participants implied that hiding their sexuality is something that younger people do. For example, one participant spoke about when he reached a certain age, he had to finally admit to himself that he was gay. Another asserted: "As I am getting older, I am getting more comfortable with my sexuality" (YM 2).

> *At this point I'm grown, so I will tell anybody if they ask. I am not ashamed of who I am. When I was younger I would probably be very cautious about it, but now I'm like if you wanna know, I am going to tell you. That is one thing, I am not going to be ashamed of.* (YM 26)

The process of coming out was not necessarily described as a linear one, and often placed a great amount of stress on the individual. Participants described coming out to other people as easier once they were able to come out to their family members, even if those family members were not accepting of it. One participant expressed that his mom knowing makes him more comfortable with his sexuality:

> *After I told my mom I was gay, I was like, "I don't give a fuck no more. I don't give a fuck about you or you or what the fuck you gotta say and we could fight." At that point I liked to fight. But I mean that was it* […] *after that I think I really, really started appreciating myself and accepting my sexuality internally and I just owned it, and I'm like super gay.* (YM 29)

Adulthood is associated with autonomy. As participants aged, they began to have the agency to leave stifling environments. The majority of participants did not grow up in Atlanta. Many spoke about how moving away from their childhood home was a "freeing" experience. Some participants were able to distance themselves through moving away for college or moving in with friends or relatives.

> *[Disclosing sexuality] was never very easy. But once I got here, you know, I've gotten away from that environment, it's always been pretty easy to me.* (YM 6)

> *Back in Florida, I wasn't confident at all because I couldn't be my true self, so when I moved to Atlanta, I was like okay, I got the gratification, like this is real. I'm comfortable with me, this is my true self. And I couldn't do that in Florida until I started, you know, moved here and see everyone - okay, he's walking around in heels and makeup, that's his true, authentic self. So, this is going to be mine. You know, I'm cool with that, I'm comfortable with it.* (YM 11)

Not all participants experienced successful transitions out of their childhood homes, as moving away from family members often weakened their support networks. Forced displacement led to some participants' homelessness and financial struggles, negatively impacting medication

adherence. Because of the possibility and eventual reality of being disowned, one participant waited until he got a degree, a job, and had a separate place to live before he came out (YM 18).

> *When I got kicked out I had nowhere to go. For a time like I was literally on the street, had nowhere to go […] You know, sitting next to a hotel hoping that the guy would give me a room you know, because I'm just sitting here, I have nowhere to go, walking, I have a garbage bag with things. And that was a very tough time. (YM 7)*

(vii) *HIV Diagnosis/Seroconversion*

Parents' refusal to accept or acknowledge their sons' sexual behaviors was associated with missed opportunities for sexual education:

> *My mom really never talked with me about like sex or like the dangers that can come with having unprotected sex until like she started to realize that I was sexually active. When she realized it, she would like make you know, little slick comments. But it was never like a serious sit down like, "I really want you to know that this can happen if you do this." I think that would have definitely changed things for me. Not saying that I'm blaming her for my situation* [positive HIV status]*, but I do wish I had more knowledge prior to graduating high school.* (YM 12)

> *It had always been frowned upon to be gay, especially where I come from* [...] *That's probably how I ended up in this situation, because I became HIV positive at 15, and I'm now 27* […] *for the longest I used to blame my mom for my status because I'm like why didn't you – you could have been telling me about HIV.* (YM 22)

As trauma can be defined as an extremely distressing and life-altering event, HIV seroconversion can be described as a traumatic experience. Participants experienced a range of reactions to their positive HIV diagnosis, from eventual optimism to devastation. The majority of participants described reaching acceptance of their HIV status and have achieved viral suppression. Receiving a positive HIV diagnosis helped some participants come to terms with their sexuality, although some still expressed ambivalence about it. Some participants discussed that their

diagnosis was the reason why they decided to come out: "*HIV for me, personally, symbolizes that God thought enough about little ole me to give me a chance to love myself"* (YM 5).

> *I just started embracing myself. I'm like, well, it's pretty much nothing else I can do. I got the worst thing that there is. Um, I'm already a walking abomination. So, it's definitely not going away now, so I might as well just live in the truth. And it's just been a three-year process.* (YM 6).

Discovery of identity-affirming spaces, such as support groups for gay men living with HIV and gay clubs, was described as being integral to the self-acceptance process and overall health and well-being. In these spaces, participants asserted they are able to find social support in the form of friends and mentors: "*Being around other gay people who are comfortable with their sexuality. It's like a confidence booster."* (YM 2).

> *To be honest,* [receiving a positive HIV diagnosis] *was a little nerve wracking, but I had already met many individuals before that were positive. And I was able to have conversations with them* […] *being educated is one of the most important things* […] *plus I also had access to the resources necessary to take care of myself. So, once I was coupled with those things, it was easier for me to kind of just keep the ball pushing and not let it affect me so much* (YM 14)

> *Once I found out that I was HIV positive, I started to experience things that I realized a lot of black gay youth experience* […] *I started to see, like, okay, you aren't the only person who went through this or you aren't the only kid that is going to witness things like this.* (YM 8)

Some participants experienced a period of self-loathing and depression after being diagnosed as HIV positive. This represents a second self-acceptance process in the lives of participants. In most participants, the sexual identity acceptance process and HIV status acceptance process were sequential. A few participants asserted that a positive HIV diagnosis helped them accept their sexual identity. Ignorance about HIV and stigma played a role in this self-acceptance process. One participant said, *"When you get information* [about HIV]*, you feel better."* (YM 17).

> *I took the test and they told me my results and I was really pissed off. I was really upset. Um, and I cried for a long time. I got really depressed, I couldn't believe it. After I had found out I had HIV, I wanted to have more sex. I wanted to be more sexually active because I felt like I had gotten the worst of the worst of the diseases. I felt like nothing could be worse than having HIV, you know what I'm saying?* (YM 2)

> *And I sought out to start seeing* [a therapist]*, not necessarily because of my HIV, but because it happened at a time where I was still so young and going through a lot of depression due to other things. It just so happened to be that HIV was now another issue. So, I kind of just decided to talk to her as a stress reliever, kind of get a lot of things off my chest that related to HIV and that did help.* (YM 8)

The narrative that participants contracted HIV because they trusted the wrong person was expressed throughout the interviews. Because participants chose to trust the wrong people, many blamed themselves for contracting HIV. The words "betrayal" and "deceit" were common when speaking about positive HIV status. Although receiving a positive diagnosis was often a devastating experience, some participants expressed that over time their negative feelings about their HIV status waned. One participant expressed that he was glad he became positive because it made him stronger (YM 13). Positive HIV diagnosis was described as an initially traumatic experience, but it often led to resilience among participants.

Discussion

We examined ways in which homonegativity experienced over the life course impacted the health of YB-GBMSM living with HIV in Atlanta. Through analysis we found that stifling, and sometimes traumatic, environments encountered during adolescence led to internalized homonegativity, which in turn shaped sexual identity formation, risk behaviors, and health outcomes.

The sexual identity formation process described by YB-GBMSM was complex, associated with change over time, and was not necessarily linear. Participants demonstrated that stages in the process can be revisited throughout the life course. This is not a novel concept; the sexual identity formation process of sexual minority youth has been widely studied. The process described by participants aligns with Troiden's Model of Sexual Identity and Development, Coleman's Developmental Stages of the Coming Out Process, and the Cass Identity Model [43, 53, 63]. These models explain the experiences of YB-GBMSM to a certain extent, but they are missing an integral component. The sexual identity formation process is experienced based on several factors, including gender, race, and environment. Instead of the "generalized feelings of marginality" based on difference from heterosexual peers described in existing sexual identity models, the feelings of YB-GBMSM stem from not fitting into racial, gendered, and sexual expectations from society [43, 53, 63]. This is consistent with research on gender role strain due to anti-homosexual attitudes among Black GBMSM [12, 14]. These societal views shape homonegativity, which, in turn, negatively impacts the health of this population. The majority of participants expressed psychological distress and attempted to hide their same-sex sexual behavior, which aligns with existing data on internalized homonegativity among GBMSM [22-27].

The association between stifling and traumatic environments during adolescence and HIV risk demonstrated in the data adds to the existing body of knowledge on the relationship between homonegativity, environment, and health outcomes among Black GBMSM [12-16]. Homonegativity is shown to negatively impact the physical and mental health of this population [12-14, 16, 24]. Our interviews suggest that increased distance from traumatic and stifling

environments is a key step to reaching self-acceptance among YB-GBMSM and decreased HIV risk. The narratives reveal a theme of dissociation from stifling religious and home environments as participants gained autonomy. Our findings are logical in comparison to those of Berg and colleagues who found that increased internalized homonegativity was linked to decreased likelihood that a gay man had been in a gay social space, such as a club or sexual minority serving organization [23]. A number of researchers have examined the importance and influence of identity-affirming environments for GBMSM [22-24]. A study by Fields et al. found that familial anti-homosexuality led to social isolation and possible increased HIV risk [12]. Comparably, Geter and colleagues in their study of YB-GBMSM in Mississippi, found that anti-homosexual cultural norms can serve as a barrier to safe sex practices [13].

The self-acceptance process was more nuanced than our initial predictions suggested. Our findings suggest the self-acceptance process of YB-GBMSM living with HIV is two-fold: acceptance of sexual identity and acceptance of HIV status. We found that age plays an important role in rejecting internalized homonegativity and reaching self-acceptance for YB-GBMSM. Participants' assertion that concealing their same-sex attraction was juvenile is consistent with several studies, which suggest that internalized homonegativity is negatively associated with age [22-25]. Similarly, a particularly unsettling and novel finding was the blame that the majority of YB-GBMSM living with HIV placed on their parents for failing to educate them about sex and sexually transmitted infections before seroconversion. These findings represent a need for interventions targeted at YB-GBMSM addressing the importance of sexual health and HIV prevention during early adolescence. As early adolescence is a crucial stage in the sexual identity formation process, young black men who do not identify with a minority

sexual orientation or endorse a history of same-sex behavior should also be educated about their sexual health related to HIV risk. Also, our finding that young men blamed their sexual partners for betrayal due to their seroconversion is significant. The majority of participants described HIV as a condition that was inflicted upon them maliciously. Discussions about sexual agency and the framing of sexual health-promoting practices as a precaution for both partners to consider should be incorporated into education programs.

This study of a sample of YB-GBMSM living with HIV in Atlanta, Georgia, will add to the limited body of knowledge on this population. As a result, public health interventions aimed at improving the health of this population will be better informed.

Limitations

This study had several limitations. Recruitment of YB-GBMSM living with HIV in Atlanta presented certain challenges. Lack of reliable transportation and limited availability during normal business hours contributed to difficulty in recruiting interested individuals. This sample was not necessarily representative of YB-GBMSM living with HIV in Atlanta in terms of their engagement in medical care. The majority of participants were recruited through affiliation with the Grady Health Center Infectious Disease Program (IDP) clinic. Consequently, the majority of participants were engaged in HIV care to some degree. Also, response bias was a limitation of our study. The self-administered demographic questionnaire included questions about medication adherence. Participants may have felt pressured to respond in ways that demonstrate increased medication adherence [61]. The questionnaire included an item about viral load among participants. We recognized that extensive time could have passed between last clinical measure

of viral load and completing the questionnaire. Finally, participants that identified decreased medication adherence did not always complete the last two questions of the questionnaire, which asked participants to identify their barriers to adherence, suggesting that YB-GBMSM living with HIV may have trouble identifying and speaking about their challenges.

Conclusions

Internalized homonegativity experienced over the life course of YB-GBMSM living with HIV has public health implications related to the prevention of HIV and engagement in care among those living with the virus. Our analysis suggests that internalized homonegativity, which arises from stifling environments and is exacerbated by familial homonegativity, plays a significant role in mental and physical health outcomes for YB-GBMSM. In order to mitigate the adverse effects of these experiences, our focus should shift to increasing social support within this population during adolescence and young adulthood. Social support related to developing a positive sexual minority identity could be integral to the prevention and management of HIV among YB-GBMSM. Future interventions aimed at improving health outcomes should be culturally appropriate, identity-affirming, and utilize a trauma-informed approach.

Table 1: Participant Demographics

Demographic Characteristic	Total Sample (n=30)
Age	
Age Range	18-29
Median Age	24.20
Ethnicity: n (%)	
African-American	27 (90.00%)
African-American/Latino	1 (3.33%)
African-American/ American Indian	2 (6.67%)
Annual Income*: n (%)	
x <20,000	17 (56.67%)
20,000< x <40,000	9 (30.00%)
40,000< x <60,000	3 (10.00%)
Not Reported	1 (3.33%)
Education Level: n (%)	
High School Diploma/ GED	9 (30.00%)
Trade Certification	1 (3.33%)
Some College	13 (43.33%)
Associate's Degree	2 (6.67%)
Bachelor's Degree	5 (16.67%)
Daily Medication Adherence	
Yes	21 (70.00%)
No	9 (30.00%)

GED- General Equivalency Diploma; *Measured in US Dollars

Chapter 4: Recommendations

This study aimed to explore the health implications of internalized homonegativity experienced over the life course of YB-GBMSM living with HIV in Atlanta, Georgia. Our findings illustrated several barriers and hardships that this population may face due to homonegativity, both external and internalized, during their lives. This study presented a number of implications for future public health interventions, research, and policy. This chapter describes specific recommendations aimed to promote the health of YB-GBMSM living with HIV. All recommendations given are not necessarily novel initiatives – in some cases, this chapter underscores the necessity of pre-existing programs.

1. Comprehensive Sexual Education

The idea that stifling environments experienced during childhood and adolescence can negatively impact health behaviors was a main finding of our study. Participants not only described the role of these environments as a possible facilitator of HIV seroconversion but also expressed regret about lack of knowledge about sex and sexually transmitted infections. Sexual education is a contentious issue in the United States, and individual school districts can choose what to exclude from the sexual education curriculum [59]. For example, schools can opt-out of teaching students about sexual minorities and sexually transmitted infections, including HIV. This can negatively affect students and the overall health of the population. YB-GBMSM continue to be the most at risk-population for contracting HIV [1]. Failure to provide universal comprehensive sexual education does a disservice to this population. Sexual education programs should affirm the sexual identities of all students, as home and

church environments may be sources of shaming and identity-stifling. Comprehensive sexual education could play a key role in the prevention of HIV in YB-GBMSM [45].

2. **Create Social Support Interventions Specific to YB-GBMSM**

A key theme from our analysis was the importance of social support in the lives of YB-GBMSM. The presence of supportive family members and peers was an integral part of the self-acceptance process. Participants often discussed the idea that relationships with similar individuals (age, sexual orientation, and HIV serostatus) can bolster self- confidence, coping skills, and engagement in HIV care. Creating interventions that foster social support between peers and mentors is integral to improving health outcomes within this population. A necessary part of interventions of this kind are the inclusion of YB-GBMSM living with HIV at the forefront of programs. These young men could serve as peer mentors, coordinators, facilitators and aid in the recruitment of program participants. YB-GBMSM living with HIV may be more receptive to individuals that are similar to them. Social support interventions should be culturally appropriate, identity-affirming, and utilize a trauma-informed approach, as this population may face unique challenges. Also, these social support interventions should lead to the creation of communities, both virtual and in-person, comprised of members of the population. In these communities, moderators should facilitate conversations that promote relationship building and support.

3. **Link YB-GBMSM to Care and Social Support Services Simultaneously**

This is a particularly important recommendation to improve the health of YB-GBMSM living with HIV. Our analysis demonstrates how significant social support can be to the health and well-being of this population. Further, it shows that HIV is not the only issue that members of this population may face. Consequently, we should prioritize streamlining the linkage to

care process to also include *warm transfers* to social support services for YB-GBMSM. Warm transfers begin relationships between CBO staff and potential patients with familiarity. Instead of speaking to front desk staff, or a cold transfer, a staff member would be expecting the potential patient's call. Barriers to service-seeking behavior include inadequate housing, financial constraints, and trouble locating services [45]. Although it will not eliminate all barriers, linking YB-GBMSM to care and additional support services simultaneously increases the likelihood that they will remain in care. For example, the Grady Health Center Infectious Disease Program (IDP) clinic in Atlanta, Georgia, provides mental health services, substance abuse treatment, case management, and housing resources, in addition to primary medical care for those living with HIV. As one of the largest clinics in the United States committed to the treatment of HIV/AIDS, Grady IDP is a unique program. It can be described as comprehensive due to all services being offered within one building. Simultaneous linkage to medical and support services removes an extra step in the process of accessing necessary services.

4. **Address Disparities Related to Socioeconomic Status**

We found that familial homonegativity sometimes led to forced housing displacement and financial hardships among YB-GBMSM living with HIV. The majority of study participants' annual income was below $20,000. Poverty is associated with increased HIV prevalence rates [44]. Also, housing instability, lack of reliable transportation, and lower socioeconomic status are associated with decreased engagement in HIV care [45]. Consequently, our focus should shift to include addressing socioeconomic disparities within this population as a priority in addition to controlling the spread of HIV. If these disparities continue to go unaddressed, the goal of zero new HIV infections will most likely go

unrealized. This is not an easy task, but achieving it is necessary. There is a need for the implementation of structural interventions designed to reduce poverty. To reduce socioeconomic barriers related to HIV in developing nations, microfinance and cash transfer interventions have been explored [45, 46]. As these nations have had success, the United States should test the effectiveness of similar interventions.

5. **Create Partnerships Between Community-Based Organizations Serving YB-GBMSM**

   Partnerships between community based organizations (CBO) can help improve health outcomes of YB-GBMSM living with HIV. Ideally, these partnerships would lead to connections formed between individuals served by these organizations. In Atlanta, several CBOs are effectively serving those living with HIV. Thrive SS, an Atlanta nonprofit organization, works to increase the amount of social support among same gender loving (SGL) men of color [57]. Similarly, Impulse Group Atlanta is an organization that supports and builds community among gay men affected by HIV [58]. Collaboration between CBOs can positively impact the individuals they serve in ways that they might not have been able to accomplish working separately. CBOs should combine resources to host events together. Consequently, participants' social network size would increase as resources would be spread over a larger subset of the population.

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Appendix 1: In-Depth Interview Guide

Social Capital and Engagement in Care Among Young Black MSM Living with HIV
In-Depth Interview—Youth Participants

Thank you so much for agreeing to participate in this interview. We are interested in understanding the lives of young men living with HIV. We want to know more about the people in your life and how you interact with them. Some of these questions could be personal, so we want you to know that no matter what, no names (either yours or the names of anyone you mention) will be included in any documents or publications that result from this research. If it makes you more comfortable, you can also feel free to refer to people using their initials or a nickname –whatever is easiest for you! I also want to reassure you that I will not be judging you for any behaviors, thoughts or feelings you share with me. Finally, just so you know, I will be recording our conversation, so that we can make sure to capture everything you tell us accurately. Do you have any questions before we begin?

Read aloud: Before we get started, what word do you prefer to use to describe your sexual orientation? We want to make sure that we are respectful and describe you in a way that you identify with. *(If answer something other than gay, then substitute participant's preferred term for "gay" throughout the interview.)*

I. Introduction
   a. Tell me about your life right now.
      i. *Probe*: Who do you live with? How's that situation?
      ii. *Probe*: What do you do? Are you in school? Working?
   b. What was your childhood like?
      i. *Probe:* Where did you grow up?
      ii. *Probe:* If not Atlanta, what brought you here? How do you like Atlanta?

II. Network Composition
   a. Tell me about the people in your family.
      i. *Probe:* Who do you feel closest to, and why (*can be more than one person*)?
      ii. *Probe:* Who do you spend the most time with? What do you do together?
      iii. *Probe*: Who do you talk to most frequently? What kinds of things do you talk about?
      iv. *Probe:* Who do you trust the most? Why?
      v. *Probe:* How has your relationship with your family changed since your childhood?
   b. Tell me about your friends.
      i. *Probe:* Tell me about your different groups of friends.
      ii. *Probe*: Of your friends, who do you feel closest to? Why?
      iii. *Probe*: Who do you spend the most time with? What do you do together?
      iv. *Probe*: Who do you talk to most frequently? What kinds of things do you talk about?
      v. *Probe*: Of your friends, who do you trust the most? Why?

c. Tell me about any intimate relationships in your life. (lovers, intimate partner, etc.)
d. Tell me about the Black, gay men who are important in your life.
    i. *Probe*: Of these men, who do you feel closest to, and why?
    ii. *Probe*: Who do you spend the most time with? What do you do together?
    iii. *Probe*: Of these men, who do you trust the most, and why?
    iv. *Probe*: How do you usually meet other Black, gay men for friendship? For dating? For support?
e. Tell me about any gay men who are important in your life, that are not black.
    i. *Probe*: Of these men, who do you feel closest to, and why?
    ii. *Probe*: Who do you spend the most time with? What do you do together?
    iii. *Probe*: Of these men, who do you trust the most, and why?
    iv. *Probe*: How do you usually meet other Black, gay men for friendship? For dating? For support?
f. Tell me about your mentors.
    i. *Probe:* How did you meet them?
    ii. *Probe:* How do they help you?

g. Outside of your friends and family, who are the people who are important to you, or who you spend time with? Tell me about them.

h. Tell me about any organizations you belong to, or any activities you participate in regularly.
    i. *Probe:* Were you in any clubs, organizations, or fraternities when you were in high school or college? (if not in school now) Tell me more about those experiences.
    ii. *Probe*: Are you active in any organizations that are specifically for Black gay men, gay men, or people with HIV? Which ones? What is that like? (If no, why not?)
    iii. What programs specifically for Black gay men have you participated in?
i. How do you use social media to connect with people?
    i. *Probe* – What online groups or organizations do you participate in? What's that like?
    ii. *Probe*- Which apps or websites do you use, and why?
    iii. *Probe* – What type of support do you get from people online?

j. How do you describe your faith? (Non-Believer, spiritual, religious, etc.)
    i. *Probe*: What was your experience with church/religion growing up? How has it changed?

III. HIV Stigma, Disclosure, and Gay identity/Homonegativity

Read Aloud: I am going to ask you some more personal questions. Please remember, feel free to stop me or skip any questions that make you uncomfortable.

a. When we started the interview, you used the word _____ to describe your sexual orientation. What does it mean to you?
    i. *Probe*- How do you feel about your sexual orientation?
    ii. *Probe*- How have your feelings about your sexual orientation changed over time?

b. Can you tell me about some experiences (either good or bad) that you've had disclosing your sexuality to others?
    i. *Probe* - Who are the people in your life that know about your sexuality? How did you tell them? What happened?
    ii. *Probe* - How do you decide who to tell and who not to tell?
    iii. *Probe* - What do you see as the benefits of telling people? What are the risks?

c. Tell me about how you found out that you had HIV.
    i. *Probe* - What made you get tested? What was that experience like?
    ii. *Probe* – How did you deal with it then? How are you dealing with it now?
    iii. *Probe* – How does your support system help you when it comes to HIV?

d. Can you tell me about some experiences (either good or bad) that you've had sharing your HIV status with others?
    i. *Probe* - Who are the people in your life that know about your HIV status? How did you tell them? What happened?
    ii. *Probe* - How do you decide who to tell and who not to tell?
    iii. *Probe* - What do you see as the benefits of telling people? What are the risks?

IV. Using Social Capital

a. Overall, what do you think about the support you have in your life?
    i. *Probe*- What's missing from your support network?
b. What does networking mean to you? How is it important to your life?

Read aloud: For this section, I am going to ask you about some situations where you might need to rely on your support network. If these situations have happened to you before, then please tell us more about them. However, if I ask you about something that's never happened to you, please just imagine that you are in the situation that I am going to describe, and tell me how you might handle things.

c. Has there ever been a time when you were in situation where you didn't have stable housing and needed a place to stay.
    i. How did you handle it? Who did you call? What did they do?
    ii. If not, how would you handle it? Who would you call? Why? What would you expect them to do?

d. Has there ever been a time when you needed a job and wanted to find out about available opportunities.
    i. How did you handle it? Who did you call? What did they do?
    ii. If not, how would you handle it? Who would you call? Why? What would you expect them to do?

e. Has there ever been a time that you felt sad or depressed.
    i. How did you handle it? Who did you call? What did they do?
    ii. If not, how would you handle it? Who would you call? Why? What would you expect them to do?

f. Has there ever been a time that you needed a ride to the doctor's office?
    i. How did you handle it? Who did you call? What did they do?
    ii. If not, how would you handle it? Who would you call? Why? What would you expect them to do?

g. Has there ever been a time that somebody insulted you based on your race, sexuality or HIV status?
    i. How did you handle it? Who did you call? What did they do?
    ii. If not, how would you handle it? Who would you call? Why? What would you expect them to do?

h. Has there ever been a time that you wanted to find an HIV doctor, or switch to a new one.
    i. How did you handle it? Who did you call? What did they do?
    ii. If not, how would you handle it? Who would you call? Why? What would you expect them to do?

i. Has there ever been a time that you needed help remembering to take your HIV meds on a daily basis. Tell me about that.
    i. How did you handle it? Who did you call? What did they do?
    ii. If not, how would you handle it? Who would you call? What would you expect them to do?

V. Helping others (Reciprocity)
    a. How often do you provide help to others? Tell me about those experiences. (Friends, family, intimate partners, community, etc.)
        i. *Probe:* How did this situation come about?
        ii. *Probe:* What made you decide to help in this situation?
        iii. *Probe:* How did it make you feel to provide this assistance?

    b. Negative social capital
        a. Tell me about a time when you did something only because you wanted to fit in with your friends.
        b. Tell me about a time when you felt left out of your friend group.

i. *Probes*- What gave rise to that situation? How did you handle it?

c. Recommendations
    a. How do you think we can help young black gay men living with HIV have more support in their lives?
    b. If you had to create a program catered towards gay Black men living with HIV, what would it look like?
    c. Where do you see yourself in the next 3 years? 5 years?
    d. Is there anything else you'd like us to know?

Thank you so much for your time!

Appendix 2: In-Depth Interview Demographic Questionnaire

Social Capital and Engagement in Care Among Young Black MSM Living with HIV
In-Depth Interview Demographic Questionnaire

Please answer the following questions to the best of your knowledge. Please take your time and read each section thoroughly. Some sections require you to circle the appropriate response while others require you to fill in the blank. There are no right or wrong answers. The questions are designed to confirm your eligibility to participate in this interview as well as assess self-reported HIV-related outcomes. All responses will remain confidential to the extent allowed by law.

Participant ID Code: _____ Today's Date: ____/____/_____

Gender: _____ (Male, Female, Transgender)

Age: _____

Ethnicity:

- **Hispanic/Latino(a)**
- **Not Hispanic/Latino (a)**

Income:

- **Less than 20,000**
- **20,000-40,000**
- **40,000 – 60,000**
- **60,000+**

Education:

- **Some High School**
- **High School Diploma/ GED**
- **Some College**
- **Associates Degree**
- **Bachelor's Degree**
- **Advanced Degree (i.e. Master's, PhD, etc)**
- **Other:_____**

Race: Please select all that apply

- **American Indian/Alaskan Native**
- **Asian**
- **African American/Black**
- **White**
- **Native Hawaiian/Pacific Islander**

1. When were you diagnosed with HIV? ____/_____ (MM/YY)

2. Have you ever visited a doctor about your HIV? **Please circle your answer.**

Yes No (*If no skip to question 8.)*

3. Approximately how many times have you visited a doctor for your HIV care **in the last 12 months**? **Please circle your answer.**

0 times 1 time 2 times 3 or more times

4. When was your last HIV care appointment?

_____/_____/ (MM/YY)

5. Has your doctor prescribed antiretroviral therapy (HIV medications) for you? **Please circle your answer.**

Yes No (*If no, skip to question 6.)*

6. How often do you take these medications? **Please circle your answer.**

Daily Most Days Some Days Never/have not filled prescription

7. When was the last time you had your viral load checked? **Please circle your answer.**

Within the last 3-6 months Between 6-12 months Over 12 months ago

8. Is your viral load undetectable? (*if yes, STOP HERE)*

Yes No (*Skip to question 9.)*

9. Why have you not visited a doctor? **Please circle as many as apply.**

I don't know where to go I don't want people to know my status No insurance
I don't have time Concerned about how I will be treated Don't like doctors
I can't afford to go I'm nervous Other (**please list) _____**

10. What barriers keep you from taking your meds? **Please circle as many as apply.**

Haven't found a doctor I like I don't like taking meds I feel fine
Afraid of side effects I can't afford my medicine I don't need meds
I don't have adequate housing Other (**please list)_____**