RELATIONAL RESILIENCE, SENSE OF COMMUNITY, AND SYNDEMICS AMONG YOUNG BLACK GAY AND BISEXUAL MEN

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ABSTRACT

A CONTEXTUAL ANALYSIS OF SYNDEMIC RESILIENCE AMONG YOUNG BLACK GAY AND BISEXUAL MALES

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Syndemics theory suggests that there are overlapping, synergistic epidemics that contribute to HIV risk in culturally and socioeconomically marginalized communities. As a conceptual framework, syndemics postulates that HIV is only one of many social problems that infringes upon the health of affected communities. The seminal syndemics literature urges researchers and scholars to identify the socio-cultural antecedents of syndemic production and the conditions facilitative of health and well-being; however, much of the syndemics literature has prioritized the identification of syndemics, rather than the causes of syndemics or the factors that preclude syndemic production.

The conceptual syndemics literature is evolving to include attention to protective factors that inhibit or mitigate health problems or risk behavior. In this dissertation, I examined relational factors associated with the avoidance of syndemic production among a group disproportionately likely to be affected by HIV: young Black gay and bisexual men. Using analytic induction, I analyzed the relational lives of 23 young Black gay and bisexual who have avoided syndemic production (i.e., the expression of psychosocial health issues associated with heightened risk for HIV) to examine how relationships and relational factors promote young men's healthy development and sexual health. Using theoretical sampling, I also examined the narratives of 23 young men who evinced syndemic production associated with heighted HIV risk as a means of exploring how they differ in their relational characteristics from men who have avoided syndemics.

The young men who avoided syndemic production had rich, fulfilling, supportive relational lives that included relationships with empathic others who supported them as young Black gay and bisexual men, helped them develop a strong sense of personal identity, and provided them with opportunities to give back to their communities. They also had diverse relational networks of people –particularly family members, male friends, and men in the gay community- who promoted pro-social norms about health behaviors. In contrast, the young men experiencing syndemics described numerous instances of trauma and oppression that infringed upon their desire or ability to form strong, healthy relational connections. In these men, pervasive experiences of oppression were associated with shame, identity incongruence, social isolation, relational disconnect, mistrust in other men, and expectations of further rejection and marginalization. Participants' different relational experiences were examined through community psychology's conceptualization of sense of community.

As an initial glimpse into relational resilience among young Black gay and bisexual men, results of this study provide evidence for a number of strength-based intervention strategies that researchers may utilize not just in HIV prevention programs, but also in addressing antecedent psychosocial health conditions (i.e., syndemics) that increase vulnerability to HIV. As means of attenuating men's socio-structural barriers to health and addressing comorbid psychosocial health issues, interventions must address young men's social isolation, identity-related issues, and sense of community.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

My study describes young Black gay and bisexual males who are thriving and healthy; it also describes young Black gay and bisexual males who are adapting to adversity. Much of the HIV prevention literature addressing the HIV burden among Black gay and bisexual males stems from a deficits-oriented perspective and tends to homogenize and pathologize Black gay and bisexual males. Much of the extant research focuses on poor health outcomes and the conditions under which negative health outcomes arise (Harper, Brodsky, & Bruce, 2012). Research often treats Black gay and bisexual men as if they are a monolithic group, undifferentiated, and prone to pathology (Beatty, Wheeler, & Gaiter, 2004; Mays, Chatters, Cochran, & Mackness, 1998). The deficits-oriented approach assumes that Black gay and bisexual males and their communities are flawed, deficient, and incapable of thriving without outside intervention.

Many Black gay and bisexual males are healthy and thriving despite social marginalization, suggesting a need for a concomitant line of research focused on Black gay and bisexual males who are resilient. From these men, we can learn what skills, resources, and strengths facilitate health and capitalize on this knowledge to improve health promotion efforts. Numerous researchers have recommended that HIV interventions could be enhanced by building on the existing strengths, skills, and resources of gay and bisexual males (Harper & Schneider, 2003; Harper, et al., 2012; Harper & Riplinger, 2012; Herrick, et al., 2011) and Black gay and bisexual males in particular (Bing, Bingham, & Millett, 2008; Harper, Jernawall, & Zea, 2004).

Resiliency-based research corresponds with sexual health promotion approaches to HIV prevention (Wolitski, 2011). A sexual health promotion approach: a) emphasizes

wellness rather than disease prevention, b) acknowledges that single-disease oriented approaches lack effectiveness because they do not address underlying causes of poor sexual health outcomes; and c) recognizes men's strengths, resiliencies, and resources as a basis for HIV intervention design. Consistent with this approach, in this dissertation I use a framework suggesting that there are overlapping, synergistic epidemics (e.g., depression, substance abuse, etc.) that contribute to HIV transmission risk (Mustanski, Garofalo, Herrick, & Donenberg, 2007; Stall, Friedman, & Catania, 2008; Stall, et al., 2003) to identify factors associated with resiliency among young Black gay and bisexual males. Known as syndemics theory, this framework suggests that co-occurring and synergistic psychosocial health problems heighten HIV risk.

I use the syndemics framework to take a resilience-based approach to examining the lives of young Black gay and bisexual males in Michigan. A better understanding of the strengths that exist among young Black gay and bisexual men offers a more comprehensive, contextualized view of the lives of young Black gay and bisexual males. Using a resiliency-based approach, I identify patterns associated with the psychosocial health of young Black gay and bisexual males and the mechanisms through which they may contribute to sexual health. This study was guided by three aims: 1) to describe the protective factors/strengths within young Black gay and bisexual males who lack evidence of psychosocial syndemic production; 2) to explore how young men who have avoided syndemic production differ in their relational experiences from men who evince syndemics; and 3) to explore how relationships and relational factors may promote the development and health of young Black gay and bisexual men.

I organized the dissertation literature review as follows: First, I discuss the epidemiological profile of HIV within the young Black gay and bisexual male population. In this section, I argue that HIV is one of many social issues with a socially unjust impact on Black Americans and sexual minorities and that traditional prevention paradigms may do a disservice to Black gay and bisexual males at risk of HIV. In the second section, I describe syndemics as a conceptual framework through which to view HIV risk among Black gay and bisexual males. I argue that even though the seminal syndemics literature (Singer, 1994) suggests identifying socio-cultural antecedents of syndemic production, much of the syndemics literature has prioritized the identification of syndemics, rather than the causes of syndemics or the factors that preclude syndemic production. Thereafter, I argue that rather than study the socio-cultural antecedents of syndemics, researchers may learn from examining the socio-cultural antecedents (e.g., resiliencies/protective factors) associated with a lack of syndemic production. In the third section, I discuss resiliency-based research as an oft-neglected line of inquiry in regards to Black men and sexual minorities.

To identify whether and how key social settings and relationships promote the health of Michigan's young Black gay and bisexual males, I used data from a statewide needs assessment conducted with 180 Black men who have sex with men (MSM). Using sub-samples of these men (e.g., those who have avoided syndemic production and those who evince syndemics), I used analytic induction to identify patterns associated with syndemic production, and the lack thereof, in these data.

CHAPTER 1: LITERATURE REVIEW

Epidemiology of HIV

HIV is one of many social issues with a socially unjust impact on Black Americans and sexual minorities. In the United States, HIV infections and AIDS-related deaths have had a disproportionate toll on Black Americans. While the percentage of HIV diagnoses among whites has decreased since the beginning of the HIV epidemic, the percentages among racial minorities has increased. In 2009, Black Americans represented approximately 14% of the United States population, but accounted for nearly half of persons living with HIV and all new HIV diagnoses (CDC, 2012). In 2009, Black Americans had eight times the odds of receiving an HIV diagnosis as did white Americans (Prejean et al., 2011). Additionally, HIV-infected Black Americans die earlier from disease progression than do HIV-infected white Americans (Losina et al., 2009; Millett et al., 2012).

Domestically, male-to-male sexual contact is the predominant means of HIV exposure. According to HIV incidence estimates, men who have sex with men (MSM) account for more than half of all new HIV infections despite accounting for approximately 2% of the U.S. population (Hall et al., 2008). Recently, Beyrer and colleagues (2012) conducted a review of HIV surveillance studies published from the beginning of 2007 to the end of June 2011: regional aggregated surveillance data collected with MSM populations in North America indicated the prevalence of HIV was approximately 15%. Among MSM, the HIV epidemic is also heavily concentrated within the Black population and has been since the early days of the epidemic. In one of the earliest sero-prevalence studies conducted in San Francisco, 66% of Black MSM (compared to 49% of White and 50% of Hispanic MSM) tested positive for HIV infection (Samuel & Winklestein, 1987). This racial distribution of

HIV cases remains, despite 25 years of researchers and surveillance specialists having acknowledged its existence.

According to population-based estimates, racial minority MSM have higher HIV incidence, prevalence, and mortality rates than do white MSM (Hall, Byers, Ling, Espinoza, 2007; Lieb, White, Grigg, Thompson, Liberti, & Fallon, 2010; Millett et al., 2012; Prejean et al., 2011). In a five-city, venue-based survey in which sero-status data were collected, Black MSM had an HIV prevalence of 46%, compared with 21% and 17% for White and Latino MSM, respectively (CDC, 2005). In 2008, a study conducted across 21 cities observed that 28% of Black MSM (compared to 18% among Latino and 16% among White MSM) were HIV-infected. Further, half of the HIV-infected Black MSM were unaware of their infection (CDC, 2010). Recently, Millett and colleagues (2012) conducted a meta-analysis of 174 studies conducted between 1981 and the end of 2011: Black MSM had three times the odds of contracting HIV when compared to other MSM.

Epidemiological data paint an alarming picture of increasing numbers of young Black MSM diagnosed with and living with HIV. Nationally, racial differences in HIV infection rates are particularly acute among young MSM (13-29 years). From 2006-2009, there was a 48% increase in HIV diagnoses among young Black MSM (aged 13-29) (Prejean et al., 2011). Young Black MSM were also the only demographic group to experience a significant increase in infections during this time (Prejean et al., 2011). A study carried out in seven urban centers reported an HIV-prevalence of 16% among young Black MSM (ages 15-22), 7% in Latino MSM, and 3% in white MSM (Harawa et al., 2004). Multi-site studies suggest that young Black MSM have seven to 12 times greater odds of having HIV as compared with young white MSM (Harawa et al., 2004; MacKellar et al., 2005). In the meta-analysis performed by Millett and colleagues (2012), the results of 33 studies among young MSM (aged 13-29) demonstrated young Black MSM had five times the odds of being HIV positive

as compared to other young MSM. Among young MSM (18-24), young Black MSM are particularly unaware of their HIV status (CDC, 2005; Millett et al., 2012).

A recent review of the literature addressed reasons for such a pronounced racial difference in HIV rates among adult MSM (Millett, Flores, Peterson, & Bakeman, 2007). Millet et al (2007) analyzed 12 hypotheses thought to influence HIV burden among Black MSM. Behavioral risk factors did not contribute to elevated HIV prevalence in Black MSM; rather, unrecognized infection, late diagnoses in the course of the infection, and a higher prevalence of sexually transmitted infections (STIs; which increase biological susceptibility to HIV) contributed to the higher rates of HIV among Black MSM (Millett et al., 2007). High-risk sexual behavior among Black MSM may be more likely to lead to new infections because of men's higher probability of exposure to an HIV-infected partner and their increased biological susceptibility due to higher incidence rates of STIs. Similar evidence emerged in Millett and colleagues' (2012) recent meta-analysis. Though Black MSM had much higher odds of being HIV-infected, they engaged in fewer sexual risk behaviors, less sex-related drug and alcohol use, and more preventive behavior (e.g., more frequent HIV testing, fewer sexual partners) than white MSM.

Millett and colleagues' (2007) study showed that the disproportionate burden of HIV among Black MSM cannot be explained by their engagement in high rates of sexual risk behavior. The authors noted that these data are "paradoxical" in that Black MSM's greater likelihood of HIV infection is consistently associated with less sexual risk behavior compared to other MSM. Others have argued that the paradoxical racial dimensions of the HIV epidemic are best explained by structural inequalities (e.g., isolation, racism, marginalization, poverty) that make Black communities more likely to come into contact with HIV and less likely to test for and treat it (Maulsby et al., 2014; Robinson et al., 2012). For example, in a meta-analysis of racial comparative studies with outcomes associated with HIV risk and

infection, Millett and colleagues (2012) found that Black MSM have a two-fold greater odds of having experienced structural barriers to health such as unemployment, low income, incarceration, low education, and lack of health insurance. Structural barriers to health such as these lower the availability and accessibility of health sustaining resources and limit the availability and choice of sex partners.

Prompted by Millett's work, Feldman (2010) conducted a review of the literature focused on young Black MSM because Millett and colleagues' (2007) earlier study had overlooked this population. Feldman's (2010) findings also revealed scant evidence to suggest that the disproportionately high rates of HIV among young Black MSM were attributable to higher frequency of engaging in sexual risk behavior. Rather, Feldman's (2010) review supported the notion that increased risk for HIV among young Black MSM may be attributable to their sexual networks and tendency to engage in sex with higher risk partners (e.g., older partners, within-race partners, known HIV-infected partners). These findings corroborate analyses conducted with racially diverse heterosexual youth in that they suggest that reported sexual behaviors do not account for disparate rates of HIV infection among Black youth (Halfors, Iritani, Miller, & Bauer, 2007). Taken together, these studies provide strong evidence that sexual risk behavior is an insufficient explanation for the over-representation of Black MSM among men infected with HIV.

Epidemiology of HIV in Michigan

As is the case nationally, Michigan's (where the current research takes place) HIV epidemic disproportionately affects the Black population. According to the Michigan Census (2010), approximately 14% of Michigan's population is Black. Statewide, Black adolescents accounted for 84% of teenagers diagnosed with HIV in the last 5 years; among people over age 20 diagnosed with HIV during this period, 60% were Black (Michigan Department of

Community Health, 2012a). The impact of the epidemic on this demographic group is evident among males (Black males: 7,750 HIV cases; white males: 5,850 HIV cases) and females (Black females: 3,070 HIV cases; white females: 860 HIV cases) (Michigan Department of Community Health, 2010).

MSM constitute the most affected behavioral risk group, accounting for 53% of reported HIV cases statewide (Michigan Department of Community Health, 2010). Whereas new HIV diagnoses remained stable from 2004 to 2008 across all MSM, the percent of cases among Black MSM has increased by an average of 4% per year during this same time (Michigan Department of Community Health, 2010). From 2006-2010, young Black MSM accounted for 58% of new HIV diagnoses in persons aged 13 to 19 (Michigan Department of Community Health, 2012a). In this same period, Black MSM accounted for approximately one-quarter of new diagnoses in persons over age 20. These data stress the importance of HIV prevention tailored to young Black MSM in Michigan.

HIV cases in Michigan are geographically dispersed; however, the epidemic concentrates in Southeast Michigan. Nearly two-thirds of Michigan's HIV-infected MSM reside in Detroit, though less than 10% of the state's residents live in the Detroit Metropolitan area (Michigan Department of Community Health, 2010). Further, new cases of HIV among adolescents and young adults (ages 13 to 24) occur primarily in Southeast Michigan (almost three-quarters of the state's cases in this age group); of the new HIV-infected young adults in Southeast Michigan, nearly two-thirds (62%) were residents of the city of Detroit at the time of diagnosis (Michigan Department of Community Health, 2010). As is the case statewide, the majority of persons living with HIV in Detroit are Black males who have contracted the virus through sex with another male (Michigan Department of Community Health, 2012b). Further, nearly half of these men in Metro Detroit are co-infected with other sexually transmitted infections such as syphilis (Michigan Department of Community Health, 2013).

HIV prevention and young Black MSM

Cohen (1999), in an exploration of the history and politics of the HIV epidemic within Black communities, describes how Black gay men were relatively invisible during the early years of the epidemic. She chastises the political and epidemiological response as being slow to recognize that the epidemic was wreaking disproportionate havoc and death in the Black community. She details ways in which political and systemic biases resulted in a failure to respond adequately to the HIV epidemic in this population. Historically, the HIV prevention response among Black MSM is rife with social injustices (Cohen, 1999; Hill Collins, 2004). Currently, Black MSM occupy a marginal position in the HIV prevention literature and are infrequently the targets of intervention.

In 2010, the White House released the National HIV Strategy (NHAS), the United States' first coordinated HIV implementation plan. Its goals include: reducing the number of new HIV infections, improving access to and outcomes of HIV-related care, and reducing HIV-related health disparities by 2015. In an effort to focus on the populations most affected by HIV, the NHAS suggests prioritizing young Black MSM in prevention, testing, treatment, and linkage-to-care efforts. This clarion call is necessary, as few interventions specifically target racial minority MSM. Despite the disproportionate impact of the domestic HIV epidemic on Black MSM, prevention efforts have had limited focus on this population. Prevention experts and practitioners argue that there is an urgent need for interventions tailored to young Black MSM (Bing et al., 2008; Harper & Riplinger, 2012; Peterson & Jones, 2009; Mays, Cochran, & Zamudio, 2004; Purcell & Hubbard McCree, 2009: Wilson & Moore, 2009).

Harper & Riplinger (2012) reviewed 92 research studies describing primary HIV prevention interventions for adolescents and young adults over a 20-year span. Of these

studies, only five detailed interventions focused on gay and bisexual adolescents, two of which described the same intervention. Notably, these interventions for gay and bisexual males included fewer Black participants when compared to interventions focused on heterosexual adolescents. The authors argue that the lack of concentrated focus on young gay and bisexual male populations, and the disparate rates of HIV infection within this population, signifies an urgent need for the development, implementation, and evaluation of primary HIV prevention interventions for young gay and bisexual males.

There are few evidence-based interventions for Black MSM. Collins (2011) described how most evidence-based HIV interventions targeting Black communities do not target to MSM. Further, evidence-based HIV interventions targeting MSM rarely specifically target Black MSM. Among other demographic groups, interventions frequently target racial groups with the highest HIV prevalence rates (Collins, 2011). Currently, only two evidence-based interventions (Many men, Many Voices and D-UP!) currently available in the Centers of Disease Control and Prevention's (CDC) Compendium of Effective Behavioral Interventions are specifically tailored to the cultural values and needs of Black MSM (Jones et al., 2009; Wilton et al., 2009).

The lack of accessible HIV prevention interventions to a disproportionately high-risk population indicates a socially unjust prevention approach. According to Prilleltensky (2001), social justice requires the fair and equitable distribution of power, resources, and obligations to groups of people in consideration of their needs, societal position, and abilities. Socially just HIV prevention approaches would therefore start by targeting groups disproportionately affected by the epidemic and for whom the prevention response has not been commensurate.

The lack of interventions tailored to Black MSM is one structural barrier to health and evidence of inequality. Prevention approaches prefaced on social justice would also recognize

that while behavioral/individual level interventions have been effective, they will not mitigate the harsh racial inequalities that precipitate HIV transmission within marginalized communities. Prevention approaches myopically attuned to sexual behavior and norms fail to recognize the crosscutting issues that plague these communities or acknowledge the role that structural, relational, and systemic factors play in perpetuating the alarming rates of HIV among young Black MSM (see "Syndemics overview" section).

Syndemics overview

Syndemics theory (Singer, 1994; Stall et al., 2008) frames this dissertation. Syndemics theory has flourished in the study of HIV prevention and received attention from public health professionals and the Centers for Disease Control as a way of conceptualizing and identifying the antecedents of HIV among culturally and socioeconomically marginalized populations. Conceptually, syndemics has broadened the scope of sexual health research beyond the myopic attention to HIV.

According to the Centers for Disease Control and Prevention (2009), a syndemic is "two or more afflictions, interacting synergistically, contributing to excess burden of disease in a population." Syndemics operate synergistically and additively such that one epidemic amplifies or magnifies the likelihood or the effects of another (Singer, 1994; Singer et al., 2006). Merrill Singer (1994), a critical medical anthropologist, introduced syndemics into the epidemiological and public health lexicon. Singer coined the term to explain the poor health profiles of substance-abusing ethnic minority women in the North-eastern U.S. who were concomitantly experiencing high rates of STIs and HIV. According to Singer, syndemics are culturally produced within a context of poverty and cultural marginalization.

Singer (1996) introduced the concept of syndemic to define what he saw as the intertwined and mutually reinforcing links between substance abuse, violence, and AIDS

among the urban poor (the "SAVA" epidemic). To qualify as a syndemic, multiple psychosocial and health related issues must be epidemic in a community, they need to cluster together, and they need to result in additional health consequences. Since Singer coined this term, numerous syndemics have been identified (Singer & Clair, 2003), not all of which pertain to HIV. Stall et al. (2003; 2008) extended this work by reporting on a syndemic of psychosocial health problems (e.g., substance abuse, mental health, and violence) that increased risk for sexual risk-taking and HIV among MSM. A notable difference between Singer's and Stall's conceptualization of what constitutes a syndemic is in regards to their treatment of HIV. Singer considered HIV as part of syndemics, whereas Stall considered HIV as a consequence of syndemics. HIV may be conceptualized as part of a syndemic or as an outcome of syndemics depending on the population and research purpose. Singer's emphasis was on how diseases interact with one another (e.g., synergism and disease interplay) and to elucidating the social conditions that give rise to, and maintain, the SAVA epidemic. These two lines of scholarship (e.g., biological disease synergism and examination of social context) have largely split along disciplinary lines as syndemics theory has evolved. Biomedical scholars have largely relied on syndemic's concept of synergism to examine biological disease interactions (e.g., how one disease may make one more biologically susceptible to another, such as how STDs make one more biologically susceptible to HIV); these scholars often conceptualize HIV as part of syndemics (Singer & Clair, 2003). This line of inquiry and conceptualization of HIV as part of syndemics makes sense given a disciplinary orientation toward understanding disease states and interactions. Social science and public health scholars such as Stall have instead appropriated a syndemic framework focused on identifying syndemics in various communities that are associated with heightened HIV risk and to identifying the social processes by which these syndemics emerge. This line of inquiry and conceptualization of HIV as a consequence of syndemics makes sense given a

disciplinary orientation toward a) primary prevention of HIV and b) understanding diseases in social context. Though both lines of inquiry are necessary in order to understand (and prevent) a disease such as HIV from a biopsychosocial perspective (Singer & Clair, 2003), it is this latter conceptualization that pertains to the current study.

Characteristics of a syndemic framework applied to sexual health

Numerous characteristics undergird a syndemic framework as applied to sexual health. The syndemic nomological net begins with the definition of syndemics as described above; yet syndemics must also be distinguished from similar concepts such as epidemics and co-morbidity (Singer, 1994: CDC, 2009). A syndemic refers to the concentration (within a certain population, place, and time) of multiple co-occurring epidemics that interact and reinforce one another and ultimately giving rise to other health problems. Though each health problem may independently have a negative impact on overall health and well-being (e.g., an epidemic), an increasing body of evidence suggests that when these problems co-occur (e.g., are co-morbid), they interact in a way that amplifies the effects of each other. Simply, syndemics a) are epidemics that cluster within marginalized populations, b) interact synergistically, and c) additively contribute to poor health outcomes.

Importantly, syndemics theory dissociates HIV from the concept of an epidemic, and instead conceptualizes HIV as one of many social problems that infringes upon the health of affected populations (Halkitis, 2010). Traditionally, the biomedical approach to public health has treated diseases such as HIV as distinct social problems, separate from one another, and separate from the contexts within which they are produced and maintained. In contrast, a syndemics framework assumes social problems do not develop in isolation from one another. The public health research perspective has been to research and respond to diseases as discrete phenomena with discrete solutions. Only within the last decade have theories such as

syndemics suggested that this conceptualization is a distortion and that HIV, in reality, is never separate from other diseases and social problems (Halkitis, 2010).

Implications of using a syndemics framework applied to sexual health

A syndemics orientation has important implications for research agendas and public health practices because recognition of syndemics calls into question the feasibility of standard HIV prevention interventions. The recognition that multiple diseases and social problems concentrate within specific populations and environments necessitates a more holistic, contextualized approach to the study of sexual health (Halkitis, 2010). A syndemic framework reminds researchers that despite the devastating toll that HIV has had on particular communities, it may not be the preeminent concern afflicting marginalized populations. Accordingly, syndemic theory implies it is necessary to identify and understand the other epidemics that work in tandem to predispose MSM to HIV. Ideally, a syndemics research agenda emphasizes the identification of the deleterious social conditions that perpetuate disease and the conditions facilitative of well-being and sexual health.

Rather than solely focusing on disease clustering and identifying co-terminus epidemics, the syndemics literature has segued into an emphasis on the social conditions under which syndemics arise. From its earliest incarnation, syndemics were assumed to be caused by social marginalization and deleterious social conditions (Singer, 1994). This causal assumption is consistent with the assumptions similar theories such as problem-behavior theory have made in regards to the antecedents and determinants of adolescent risk behavior. Problem-behavior theory, a conceptual framework for understanding the confluence of problem behaviors, is one of the most renowned frameworks explaining adolescent developmental difficulties (Jessor, 1991). A key precept of problem-behavior theory is that problem behaviors (e.g., those which run counter to conventional legal or social norms for

adolescents) and their associated health conditions exist in a constellation whereby involvement in one risk behavior increases the likelihood of engagement in others. The foremost premise of this theory, as with syndemics theory, is that social problems or behavioral concerns result from person-environment interactions. In both theories, enmeshed, mutually enhancing health or behavioral problems develop in a context of social inequalities and are predisposed by noxious social conditions.

Much progress has been made identifying the social and structural conditions driving syndemic processes and the HIV epidemic. Identifying these conditions is important to the development of interventions that address the underlying socio-environmental root causes that develop, link, and, exacerbate syndemics processes among MSM. Researchers recognize that mental health and other psychosocial determinants greatly impact sexual behavior and risk among YMSM (Halikitas, 2010; Rosario, Schrimshaw, & Hunter, 2006). Yet, HIV prevention has operated with limited regard to concomitant health and social problems, an oversight which advocates of a syndemic orientation have argued may compromise intervention effectiveness (Halkitas, 2010; Safren, Reisner, Herrick, Mimiaga, & Stall, 2010; Safren, Blashill, & O'cleirigh, 2011; Stall et al., 2003; Stall et al., 2008.) Without recognition of the numerous other concerns woven into the fabric of MSM's lives and without addressing antecedent concerns, the outcomes of HIV prevention efforts will not reach full fruition.

Recently, Safren and colleagues argued that syndemic production may be the driving force behind the HIV epidemic (Safren et al., 2010). These authors argue that psychosocial factors influence sexual behavior (primary prevention), HIV/STI testing behavior (secondary prevention), adherence to care (tertiary prevention), and intervention effectiveness. They claim that interventions focused exclusively on sexual behavior and cognition may have yielded small effect sizes that last a short period of time because they have not concurrently addressed these other co-occurring psychosocial health problems. Accordingly, to the extent

that sexual risk co-occurs with other psychosocial health problems, interventions must address these co-occurring health issues.

Despite recognition of concomitant health concerns in MSM communities, current interventions do not address syndemic concerns. Review of the CDC's evidence-based interventions tailored to MSM indicates that only few address the interplay between substance use and HIV infection (Tilley, 2009). More complex intervention designs attuned to syndemic production and concerns are warranted.

Syndemics as a theoretical framework among MSM

Consistent with the focus on culture marginalization underlying the syndemic approach (Singer, 1994, 1996), Stall et al. (2008) laid out a model for syndemic development in MSM. Stall's (2008) conceptualization of syndemics among MSM is fundamentally developmental in nature. Stall notes that these syndemic health issues tend to be present in adolescence and young adulthood; as a result, Stall et al.'s model (2008) identifies phenomena that occur during childhood and adolescence that may shape health problems into adulthood. This model posits that three primary dynamics are the cause of syndemic production among gay men: a) early adolescent male gender socialization, including gender policing, violence and victimization for not meeting gender ideals, and abusive sexual initiation; b) homophobic attacks that occur early and often within men's lives; and c) migration to gay communities amidst high background prevalence rates of substance abuse, mental health problems, violence, STIs, and HIV. Like other prominent health-related frameworks for sexual minorities such as Ilan Meyer's social minority stress model (Meyer, 1995: 2003), Stall emphasizes heterosexism and homophobia as primary structural causes of poor development and ill health among MSM. Stall's theoretical model suggests that cultural marginalization and adversity play a key role in syndemic development and that the presence

of co-occurring psychosocial health conditions (e.g, substance abuse, depression, violence exposure) mediates the effect of adversity on HIV risk behavior.

The empirical syndemics literature among MSM

The empirical syndemics literature among MSM is still in its infancy; investigators have yet to examine whether syndemic production mediates the relationship between adversity and HIV risk behavior; additionally, potential moderators of the relationship between adversity and syndemics or syndemics and risk behavior have yet to be empirically examined. Instead, the syndemics empirical literature among MSM has focused on identifying syndemics in various communities that are associated with heightened HIV risk and to identifying the social processes under which syndemics emerge.

Specifically, Stall et al. (2003) adapted syndemic theory to illustrate the co-occurring epidemics facing MSM that that make them more susceptible to HIV. The researchers postulated that sexual assault, depression, substance abuse, and intimate partner violence have an additive effect on the likelihood of engaging in sexual risk behavior and of contracting HIV. In their probability sample of 2881 MSM from four major US cities, the odds of a participant having engaged in unprotected anal intercourse increased based on the number of psychosocial problems he experienced; the odds of a participant being HIV infected also increased with the addition of each psychosocial problem. Specifically, greater number of psychosocial health problems was associated with ascending odds ratios for having high-risk sex and ascending prevalence rates for HIV infection compared with the group of men with no self-reported psychosocial health problems (Stall et al., 2003).

Stall's (2003) approach to measuring the impact of syndemics on sexual health risk has become the most popular way to assess whether multiple psychosocial factors have an additive influence on sexual risk behavior and HIV status. Simplistic analytically, Stall's

approach involves: a) identifying the psychosocial conditions thought to be prevalent in particular populations, b) assessing the bivariate relationships among indicators of sexual behavioral risk or health, c) and computing a count of psychosocial health problems (e.g., referred to as the 'syndemic variable') that is used to test the additive relationship between psychosocial problems and sexual risk behaviors or HIV/STI history. Since Stall's (2003) original application of syndemic theory to test the additive effect of psychosocial health problems on the sexual health of MSM, empirical research using a similar methodological approach has been used to locate syndemics among YMSM (Mustanski et al., 2007) and Black MSM (Dyer et al., 2012).

Dyer et al. (2012) used a similar analytic approach in their analysis of 301 Black MSM. Dyer and colleagues (2012) examined the association between depression, substance use, intimate partner violence, stress, sexual compulsion, and unprotected anal intercourse. These researchers analyzed whether there was an additive effect of the number of health conditions on unprotected anal intercourse. Findings suggested that Black MSM who reported three or more co-occurring health conditions engaged in more unprotected anal intercourse with their partners compared to those who reported fewer health conditions.

Though much of the syndemics literature has emphasized adult syndemic production over the experiences of youth, researchers have validated Stall's additive syndemic model in populations of YMSM. Mustanski et al. (2007) found a significant additive relationship between substance use, psychological distress, partner violence, sexual assault, and risk of HIV infection in a sample of 310 ethnically diverse YMSM (aged 16 to 24). The additive effects of these four psychosocial problems increased the odds of having multiple sex partners, engaging in unprotected intercourse, and of being HIV infected (Mustanski, et al., 2007). Additionally, participants with four or more psychosocial health problems had three times the prevalence of HIV relative to those with fewer problems.

Investigators have used the aforementioned analytic approach to identify proximal psychosocial antecedents of sexual risk behavior and HIV among MSM. The syndemics literature has evolved away from a sole focus on the elucidation of overlapping epidemics, towards one focused on the identification of socio-cultural, economic, and environmental antecedents of syndemic production. This line of research seeks to examine factors influencing vulnerability and to identify the conditions under which HIV becomes embroiled within particular populations. Herrick et al (2012) assessed lifetime predictors of syndemic production, defined as having experienced two or more of the following psychosocial problems: drug use, depression, stress, sexual compulsion, and intimate partner violence. Using a life course perspective consistent with the syndemic framework, Herrick and colleagues (2012) divided predictors into 4 life stages: early life events (e.g., childhood satisfaction, parental substance abuse, parental domestic violence, physical abuse, childhood sexual assault, childhood victimization, gay-related victimization, aggressive environment, masculinity attainment), coming out events (e.g., internalized homophobia), adulthood events (sexual assault, event discrimination), and occurrences in the past year (e.g., current marginalization, internalized homophobia, and life satisfaction). In bivariate modeling, each of the 16 life course events was significantly associated with the syndemic variable. Using a subsample of Black MSM from the same larger study, Dyer and colleagues (2012) conducted a similar analysis, using the same predictors to examine the differences between Black MSM with and without a syndemic condition (i.e., two or more psychosocial health problems). In this study, Black MSM exhibiting syndemic production were significantly more likely to have been the target of gay and non-gay related victimization, lack social connectedness during childhood, have struggled with masculinity attainment, have experienced more internalized homophobia when coming out, and report more discrimination and internalized homophobia in adulthood compared to men who did not exhibit syndemic production. These

studies extended syndemic theory among MSM by empirically examining the development of syndemic production.

Syndemics as a theoretical framework befitting community psychology

As a conceptual framework, Stall's model resonates with me as a community psychologist. The framework is consistent with the principles of the field because of its focus on marginalized groups and attentiveness to structural and macrosystemic etiological causes of disease and social problems. Singer (1994) originally theorized that cultural marginalization, inequitable distribution of resources, and other macrosystemic causes were the etiological roots of syndemics. Subsequent research using a syndemics framework has shown that divergent marginalized groups evince syndemic production, suggesting that oppressive social conditions create the conditions under which synergistic epidemics develop and interact with one another (Dyer et al., 2012; Egan et al., 2011; Herrick et al., 2012). In the HIV prevention and treatment literature, syndemics theory is one of the only frameworks to insinuate that adverse social conditions put marginal groups at heightened risk of social problems and disease (Easton, 2004). Indeed, syndemics is one of the few frameworks to hypothesize environmental and social causes for the adverse health outcomes experienced by groups such as MSM. Unlike many other HIV-related theories, syndemics theory recognizes that HIV burden falls most heavily on the disenfranchised, oppressed, and socially marginalized. These key theoretical precepts force researchers to confront the reality that HIV takes its toll on already vulnerable communities and recognize that HIV is only one of a diverse array of problems confronted by communities prone to poor sexual health outcomes.

Conceptually, Stall's model also holds appeal because it implies that a psychological sense of community may moderate the pathway from adversity to syndemics. Rather, the model posits that participation in gay communities may moderate the pathway from adversity

to syndemics. Stall's model proposes that as gay men access gay community networks, they must balance the stressors and resources that come with participation in a new setting. Gay community involvement can allow men to access strengths. At the same time, men's participation in gay community networks and settings may require breaking linkages to other (e.g., family) forms of support, confer added risk, and create difficulties in creating new social networks. Stall's conceptualization of the strengths and stressors that come along with participation in gay community networks can be interpreted through the lens of community psychology's concept of the psychological sense of community. Community involvement may confer upon men a feeling of belonging, shared emotional connection with other men, and a fulfillment of their needs – a positive psychological sense of community that we would expect to be associated with positive outcomes (McMillan & Chavis, 1986). On the other hand, participation in the gay community can also be seen to have liabilities such that men may experience a negative psychological sense of community, or a negative relationship with the gay community to the extent that the perceived risks of participation outweigh the rewards (Brodsky, 1996). Stall's conceptualization of the gay community is thus appealing from a community psychological perspective because he proposes it as a protective factor, but also because he articulates it in a way that is sensitive to the fact that not all men may experience it in the same way. Stall's model thus suggests that in the understanding of syndemics among MSM, there is a fundamental need to examine not only if men participate in the gay community, but to explore how they experience their involvement.

Empirical and conceptual mismatch

In proposing that positive community affiliation with the gay community may provide young gay men with sources of support that are protective against syndemic health threats, Stall suggests that it is important to examine the relational contexts of young men's lives.

However, the syndemic literature has not yet segued into a focus on young men's lives in relational context. Rather, empirical work (as described above), has measured variables at the individual (e.g., internalized homophobia) or the macrosystemic (e.g., discrimination, victimization, poverty) level. The syndemics literature has yet to examine more proximally (e.g., microsystemic) related influences on young men's health and development. A lack of empirical consideration of relational or microsystemic constructs in the study of syndemics among MSM is curious given: a) Stall's conceptual model specifies their importance; b) the developmental nature of the model and the fact that developmental theory calls explicit attention to the influence or microsystems on youth health and development (Bronfrennbrenner, 1979); c) the fact that a number of correlates of HIV-related risk behavior related to YMSM's microsystems have been identified (Mustanski et al., 2011); and d) the plethora of research on psychosocial syndemic conditions indicating the important protective effects of microsystemic factors (see section on resiliency factors). This dearth of empirical focus suggests that in order to further investigate the processes involved in syndemic production, more data are needed on young men's relational experiences.

The syndemic framework is also inherently resilience-based (see next section) in that it outlines potential sources of gay men's strength and healthy development. However, the bulk of the syndemics literature has focused on the identification of risk factors that make young men vulnerable to syndemics. There has not been a concomitant line of inquiry examining sources of young men's resilience. Like much formative research with sexual minority populations (see next section), the syndemics literature has not yet evolved from focusing on the negative experiences of marginalized youth to examining their strengths and coping strategies. As such, there is also a need for an analytic focus on conditions associated with young men's healthy development and well-being.

Resilience

Researchers operationalize resiliency in numerous ways. Resilience generally refers to a state of positive development or health within a context of adversity. Masten (2001) proposed a popular definition of resiliency (2001): resiliency is about obtaining good outcomes in spite of serious threats to adaptation or development (p. 221). Resiliency-based research often focuses on groups who have experienced significant life-course hardships across various domains of their lives and seeks to identify why and how some people have the capacity to overcome adversity and achieve good health in marginal circumstances.

Many researchers conceive of resilience as an interpersonal trait or individual-level phenomenon (e.g, self-esteem) (Kaplan, 1999; Masten, 1994; Stevenson & Zimmerman, 2005). Theoretical models from this individual-level approach conceptualize resilience as personality traits (e.g., self-esteem) or intrapersonal variables (e.g., intelligence) that protect individuals from the adverse effects of adversity and/or help them to cope with personal challenges. At the individual level, resilience research focuses on identifying assets that distinguish youth who obtain healthy outcomes or development within a context of adversity from those who do not.

Researchers have criticized this conceptualization of resilience for its over-emphasis on individual level phenomena; they have argued that resilience research might also look at socio-ecological factors that contribute to the same outcomes. These conceptualizations of resilience are more dynamic and attuned to proximal and distal contextual mechanisms that affect individual expressions of resiliency. For example, the construct of relational resilience focuses on relationships as the main mechanism for fostering interpersonal resilience. This conceptualization of resilience posits that relationships enhance (or impede) adaptive growth and health. From a relational resilience perspective, resilience is not merely an internal trait,

but a relational process formed through "growth-fostering relationship" (Connelly, 2005; Jordan, 2005). This model of resilience assumes that some of the main motives in life are to "grow through and toward connection" and to "participate in growth-fostering relationships" (Jordan, 2005, p. 82). Relational resilience thus underscores the centrality of relationships on youth development and health and embeds our understanding of resilience within relationships (with the self and others) and relational environments such as community settings.

I emphasize this conceptualization of resilience in this dissertation research for four primary reasons. First, on a theoretical basis (as specified above), the syndemics conceptual model implicates that relational factors that support young men's developing sexual identities (e.g., gay community involvement) may be important sources of resilience in young gay men's lives. Second, from a disciplinary orientation, this emphasis on factors beyond the individual-level is in keeping with the principles and values of community psychology. Third, from a conceptual perspective, a relational model of resilience offers a promising analytic framework for work with marginalized populations. Placing emphasis on the underlying processes of relationships that encourage health and development brings to the fore the often misunderstood and neglected relational aspects of marginalized group's lives. A relational focus is imperative when examining health-promoting factors among historically marginalized groups. Many marginalized groups, Black Americans and sexual minority groups alike, have strong community ties and often value interdependence; therefore, research attentive to learning what promotes their health may be best served by considering how marginalized communities engage in mutually supportive and responsive relationships (Jordan, 2005). Indeed, much of the extant literature on resilience within gay communities (see next section) focuses on constructs (e.g., mentoring, social support) underscoring that the presence of supportive and nurturing relationships is critical to attenuating the negative

impact of adversity in the lives of gay and bisexual youth. Fourth, oppression (e.g., heterosexism, sexism, racism) often promulgates relational disconnection in the lives of young gay and bisexual men. As men, they are reared in a socio-cultural framework that emphasizes independence, autonomy, and self-reliance. As individuals who are sexually, romantically, and relationally attracted to members of their same-sex, they sometimes must conceal important aspects of themselves (e.g., passing as heterosexual) or engage in "survival strategies" that may cause relational disconnect and isolation. Western masculinity norms and heterosexist oppression thus operate in ways that complicate young gay and bisexual men's ability and desire to seek out and form intimate, authentic relationships. Developing and sustaining growth fostering relationships is therefore indicative of men's resilience to overcome oppressive socio-cultural edicts and conditions. Attention to relationships and relational elements (including the relationship with the self) that are growth fostering among young Black MSM was the focus of this dissertation.

Resilience as a tool for intervention

Numerous researchers have suggested resiliencies and protective factors can be harnessed to facilitate sexual health interventions (Bing et al., 2008; Herrick et al., 2011; Millett & Peterson, 2007; Mustanski, Newcomb, DuBois, Garcia, & Grov, 2011). Few studies, however, identify resiliency factors that might inhibit or mitigate health problems or risk behavior (Millett & Peterson, 2007). In general, researchers and practitioners prioritize the study of people who exhibit risk behavior or developmental problems, rather than people who are healthy and well adjusted. Put another way, people who exhibit psychosocial problems are generally the foci of research. However, men who do not exhibit such problems may also be valuable as sources of intervention insights. This former perspective often

undergirds a deficit orientation toward the study of social problems and has permeated the literature on sexual minorities and Black populations alike.

Black families and communities have historically been studied from a deficits perspective that paints a pathological portrait of racial minorities (Briscoe, 2000). Other scholars have noted that studies related to Black sexuality and sexual behaviors have particularly been framed in a social problems framework (Cohen, 1999; Hill Collins, 2000). Such is also the case with sexual minorities, whereby pathology and problem behavior have taken center stage, often with an assumption that sexual minorities are in some way deficient or deviant (Harper et al., 2012; Harper & Schneider, 2003; Savin-Williams, 2001: 2008). Speaking to this issue with research on same-sex attracted youth, Savin-Williams (2008) describes the current conundrum of this deficits paradigm as "… the irresistible and overpowering attention to the problematic nature of same-sex oriented populations rather than a focus on their capacities to adjust, thrive, and lead exceptionally ordinary lives. It is as if same-sex oriented populations are only interesting to the extent that they differ in the negative (p. 137)." Research by Stevenson & Zimmerman (2005) makes a particularly poignant statement in this regard; their review of the public health literature among adolescents showed that there is a paucity of research with sexual minority youth stemming from a strengths-based perspective.

Black gay and bisexual men have been particularly absent from the research and scholarly literature (Harper et al., 2004). As Harper and colleagues (2004) argue, the voices of healthy and thriving Black sexual minorities are almost entirely absent in academic literature. Such researchers have argued for a concomitant focus on the positive attributes of sexual minority populations that is attentive to protective factors, resiliencies, and strengths (Harper et al., 2012; Harper & Schneider, 2003; Russell, 2005; Saewyc, 2011; Savin-Williams, 2008). As voiced by Harper et al. (2012):

> *While continuing research is needed on the developmental challenges faced by LGB adolescents, especially those who are also members of other oppressed groups such as youth of color, a parallel line of scientific inquiry is also needed to explore the strengths and resiliencies demonstrated by LGB youth….a strengths-based focus on sexual orientation identity acceptance for LGB youth is warranted* (Harper et al., 2012, p. 26).

Resiliency based research is desperately needed to provide a more comprehensive portrayal of Black sexual minority youth and to dispel myths and misconceptions about these communities (Anderson, 1998).

Herrick and colleagues (2011) issued the clarion call for a resilience-based approach to HIV prevention among MSM. These authors argued that harnessing the strengths of MSM may increase the effectiveness and acceptability of interventions to treat, manage, and prevent HIV. They further urged scholars to acknowledge that the majority of MSM do not, in fact, become HIV positive or even participate in high risk sexual behavior. The largely unwritten story is that even though MSM contend with a multitude of social stressors, a sizable number of MSM must have noteworthy reservoirs of resilience to mitigate and withstand negative sexual and psychosocial health outcomes (Herrick et al., 2011; Herrick et al., 2012; Moeller et al., 2011; Parsons et al., 2011). Resiliencies that they proposed studying further included shamelessness (e.g., regarding their identities), sexual creativity (e.g., risk reduction strategies), social creativity, social activism, self-monitoring, and social support. Notably, a number of these constructs are explicitly (e.g., social support and social activism) or implicitly (e.g, social creativity) relational in nature.

Why focus on resiliency as a basis for informing HIV prevention or sexual health interventions? The alternative model fosters interventions that seek to address risk factors for poor health outcomes; understandably, it makes intuitive sense that understanding what is

going wrong may lead to the identification of solutions. According to Herrick et al., (2011) potential fallacies exist with this perspective. In general, deficits-based approaches identify that which produces risk, rather than that which is associated with safety or well-being; based on analysis with the highest risk people, these interventions are reactive rather than proactive. Deficits-based approaches also identify what not to do (e.g., do not have unsafe sex with sero-discordant partners), rather than identify what to do (e.g., be sexually creative by using these risk reduction strategies). Such messages, particularly those that decry particular behavior, may often sound uninviting and therefore preclude intervention uptake. Being person-focused, they also leave people in environments that may well not be conducive to sustained behavior change or health. Given these limitations, the authors concluded that focusing on the naturally occurring strengths, resources, and skills that already exist within MSM and their communities may increase intervention effectiveness.

Building upon that which is already occurring and helping MSM access their existing strengths and resources has explicit benefits. Strengths-based intervention strategies are culturally and contextually relevant (Wyatt, 2009); for example, the elucidation of naturally occurring strengths and resources implies a valuation of the protective strategies already utilized in these communities. At the individual or community level, this value consonance may decrease resistance to participation (Miller & Shinn, 2005). Strength-based interventions that build pre-existing resources or organic community strengths are akin to indigenous prevention approaches as described by Barrera and colleagues (2011). Indigenous prevention approaches are "prevention interventions that have been developed in the community, have demonstrated feasibility of implementation and acceptability in that community, but lack experimental evidence of effectiveness (O'Connell, Boat, & Warner, 2009, p. 7). These interventions develop organically in the community, making them intrinsically high in external validity, and thus highly consonant with the values of community psychology

(Miller & Shinn, 2005). Resiliency-based approaches to sexual health promotion may similarly aim to bolster existing resources, individual strengths, and community assets. However, implementing these intervention strategies is contingent upon garnering sufficient, contextually relevant information about the strengths and resources that exist among young Black MSM and how these strengths and resources contribute to healthy development. The following sections describe key socializing settings and relational factors that may promote healthy development of young Black MSM in spite of risk exposure.

Family

Family is one of the most the most fundamental social systems influencing human development and families play critical roles in healthy development. Particularly, family is a key socializing influence on youths' gender roles, sexual values, sexual attitudes, and sexual behaviors (Perrino et al. 2000). Family influence is particularly important for Black youth who come from a cultural background that emphasize the primacy of the family (Murry & Brody, 2004).

Parental relationships influence the health and well-being of sexual minority youth. In general, research with sexual minority youth has focused on the poor relationships youth have with their families. In one study, sexual minority youth who reported higher levels of family rejection were 8.4 times more likely to report suicide attempts, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse compared with peers who reported no or low levels of family rejection (Ryan, Huebner, Diaz, & Sanchez, 2009). While many sexual minority youth experience strained relationships, parental rejection, and disenfranchisement, not all sexual minority people share these experiences (Garofalo et al. 2008). Bouris et al (2010) conducted a systematic literature review to assess whether parents

of sexual minority youth (aged 10-24) can promote health and well-being. Their review suggested that supportive and caring parent-child relationships provide protection from sexual risk behavior, substance use, violence and victimization, mental health disorders, and suicide.

Family support protects against HIV infection among young MSM and Black youth. In a study of 302 ethnically diverse YMSM (aged 16-24), Garofalo et al (2008) found that family connectedness significantly lowered the odds a youth was HIV positive by 30%. LaSala (2007) conducted a study on parental influences on the safer sex practices of gay male youth (ages 16-25). In his sample of 35 parents and 30 youth, 83% of parents regularly discussed safer sex practices with their sons and 57% of the youth reported that their relationship with their parents influenced their safer sex practices. Among Black heterosexual youth, supportive, communicative family environments reduce the risk of engaging in sexual risk behavior (Murry & Brody 2002). Indeed, in one longitudinal study, Black youth who regularly discussed sex and sexuality with their parents were less influenced by their peers and less likely to engage in sexual risk behavior (Brody, Ge, Katz, & Arias, 2000).

Mothers, in particular, may be resources for Black MSM. Data consistently show that mothers are most frequently the family member who knows of their son's sexual orientation identity (Dube, & Savin-Williams, 1999; D'Augelli, Hershberger, & Pilkington, 1998; Garofalo et al., 2008; Mays, Chatters, Cochran, & Mackness, 1998). For example, Garofalo et al's (2008) data suggested that over 80% of youth (ages 16-24) had disclosed their sexual orientation identity to their mothers. Mothers are the family member most likely to be supportive and accepting of their son's sexual identity (D'Augelli et al., 1998; Garofalo et al., 2008) and are frequently cited as sources of sexuality specific social support by sexual minority youth (Doty, Willoughby, Lindhl, & Malik, 2010). To examine youths' perceptions of support for coping with sexuality stress, Doty et al. (2010) examined the sources of

sexuality-specific forms of social support among lesbian, gay, and bisexual individuals (ages 14-21). Mothers were cited as a source of sexuality-specific social support by 85% of participants. In regards to sexual health, mothers may try to influence the sexual behavior of their gay son's through sex education, provision of condoms, and discussions of sexuality (Kubicek, Beyer, Weiss, Iverson, & Kipke, 2010).

Other female relatives such as sisters may also offer positive sources of support for young Black MSM. In addition to mothers, Black sexual minority youth (Mays et al., 1998) and gay youth (D'Augelli et al., 1998; Mustanski et al., 2011) frequently cite sisters as being accepting of their sexual orientation identity. In research with sexual minority youth, sisters were the family member participants cited as the most likely to be accepting of their sexual orientation identity (Mustanski et al., 2011). For gay male youth, sisters are also the family members least likely to verbally abuse and physically threaten their siblings upon disclosure of their sexual orientation (D'Augelli et al., 1998).

These data suggest that family acceptance or rejection shapes youths' views of their selves and supportive family members can play a role in the healthy development of Black YMSM. It is unclear how family members, particularly mothers, shape resiliency among Black YMSM. They may influence sexual health directly through the propagation of sexual values and provision of sexual health resources or provide a buffer against various forms of distress through the provision of social support and sexuality-specific social support in particular.

Gay community

As indicated earlier, Stall's conceptual model suggests it is likely that felling connected to the gay community is an important relational factor to consider in the study of syndemics among MSM. Though the term gay community is operationalized in a variety of

ways, it generally refers to the collective identity constructed around relational ties between people who are sexual and/or gender minorities (Ferris, 2006). From a developmental perspective, connecting with the gay community tends to coincide with and be invaluable to young gay men's coming out processes and the abatement of internalized homophobia (e.g., Corrigan & Matthews, 2003; Galatzer-Levy & Cohler, 2002; Rosario, Hunter, Maguen, & Gwarz, 2001).

Numerous studies across a variety of different health-related issues suggest that gay community connections may serve health protective functions. Protective effects of gay community connectedness have been demonstrated in studies regarding mental health and psychological well-being (Kertzner et al., 2009; Ramirez-Valles, Fegus, Reisen, Poppen, & Zea, 2005), sexual risk (Flowers, Duncan, & Frankis; 2000; Ramirez-Valles, 2002), and safer sex practices (Herek & Glunt, 1995; Ramirez-Valles & Brown, 2003).

Theoretical literature suggests that connectedness to the gay community may play an ameliorative role in the relationship between structural adversity and health because involvement with other sexual minorities helps young MSM build buffers against sexual minority stress, establish comfort or pride in one's sexual identity, and develop connections with individuals facing similar developmental and socio-structural struggles (Meyer, 2003; Ramirez-Valles, 2002). For example, Meyer's social minority stress model indicates that connectedness to the gay community is important in that it allows sexual minority youth to make positive social comparisons to people like them, instead of internalizing negative beliefs based on heterosexist beliefs and sexual prejudice (Meyer, 2003).

Community connectedness has also been associated with protection against sexual risk and protection against HIV infection. For young MSM who often lack culturally appropriate sexual health education, being connected to the gay community may be the only

avenue through which to be exposed to relevant HIV prevention, education, and testing (Grov, Parsons, & Bimbi, 2007; Mullens, Staunton, Debattista, Hamernik, & Gill, 2009). Young MSM who are connected to the gay community may also take advantage of other services and resources specifically designed for gay and bisexual youth such as medical care and testing services, support and empowerment groups, and gay-straight alliances. Ramirez-Valles (2002) articulated a conceptual framework for considering the protective effects of community involvement for gay and bisexual men's sexual health. Ramirez-Valles' (2002) model suggests that involvement in the gay community and HIV-related groups and organizations promotes men's health by providing social support, enhancing feelings of self-efficacy and positive sexual-identity, and reinforcing norms supportive of safer sex practices (Ramirez-Valles, 2002). Stall postulates and these studies suggest that connectedness to a community of similar others is important for young men's identity development and health.

Alternative families

Historically, Black communities often form extended families, fictive kin, and alternative families due to a history of economic and social exclusions (Brisco, 2000; Hill Collins, 2000). Alternative families are a normative cultural phenomenon in Black communities. As such, they lay the foundation for the formation of alternative families for racial minority gay and bisexual men. When biological families are unwilling to nurture sexual minority youth, gay and lesbian youth may create families of choice (Dahlheimer & Feigal, 1994). In the gay community, the House/Ball scene is an exemplar of this Black cultural tradition to respond to marginalization through communal modes of social support (Rivera Colon, 2009).

Existing prior to the Harlem Renaissance, house/ball culture is a clandestine community consisting of mostly Black and Latino/a sexual minorities (Arnold & Bailey,

2009). Houses provide a familial structure for YMSM of color and transgender people; often structured like fraternities, houses often consist of people who are a part of "house families" comprised of a "house mother and father" and their "house children" (Arnold & Bailey, 2009); Murrill, et al., 2009). House members engage in balls (i.e., fashion and dance competitions) at which young MSM congregate for social support and entertainment. Houses thus often function as alternative families whose purpose is to organize balls and provide support (e.g., a network of friends, settings allowing sexual and gender expression) for socially marginalized youth of color (Arnold & Bailey, 2009).

Evidence suggests that house-ball communities have embraced the need for HIV prevention and may promote health and positive development. Wilson & Moore (2009) interviewed 71 HIV service staff personnel across nine states and asked about their perceptions of barriers and facilitators of the HIV epidemic among Black MSM. Participants thought that the house and ball community was an important, though undervalued, context for HIV prevention activities. Further, these experts suggested that promoting community-building efforts that connect Black MSM to one another, such as the house-ball community provides, is an important part of promoting health in this community (Wilson & Moore, 2009). House communities also have a history of assuming salient leadership roles in HIV prevention within MSM communities (Wilton, 2009). Wilton (2009) further describes house-ball communities that sponsor balls with prevention themes and details how HIV prevention services are commonly provided at ball competitions. These examples show that participation in houses/balls may directly affect sexual health by increasing access to and the acceptability of using prevention services. Membership in these communities may also affect sexual or psychosocial health less directly.

For socially disenfranchised youth, house/ball communities are often critical to the provision of familial, cultural, and kinship networks (Phillips, Peterson, Binson, Hidalgo, &

Magnus, 2011; Wilton, 2009). Core values associated with the house/ball scene often include stressing the importance of sexual and gender expression (Arnold & Bailey, 2009; Wilton, 2009). Balls provide a celebratory context for identity expression, validation, and expansion and houses provide a means through which to construct these identities in relation to others (Arnold & Bailey, 2009). For groups that have experienced multiple forms of marginalization based on the intersections of their racial, sexual, and gender identities, these types of organic support networks may provide a buffer against life stressors (Sanchez, Finlayson, Murrill, Guilin, & Dean, 2010). Arnold & Bailey (2009) also imply that participation in houses may facilitate health because of the emphasis placed on personal development by house parents. In their ethnographic study, "house mothers" often provided their "house children" with advice (including about sexual health) and emotional support, whereas "house fathers" helped members overcome structural barriers to health (e.g., obtaining employment, returning to school, staying out of prison). As these examples show, houses/balls may promote resiliency due to the emphasis placed on positive youth development, the provision of various forms of sexuality-specific social support, advocacy of self-protecting behaviors, and creation of avenues for identity expression.

Mentorship

Natural mentors, role models, or non-parental adults are people such as extended family members, teachers, counselors, or neighbors sought out informally by youth for support and guidance who often play an integral role in youths' healthy development. Mentors may provide advice, serve as models of adult behavior, teach youth to regulate their emotions and behaviors, provide opportunities or social support, and help shape youth' conceptions of their emerging identities (Rhodes, 2005). This type of mentoring relationship is common among both sexual minority youth and Black youth.

Sexual minority youth may find formal mentoring programs and opportunities hostile to who they are (Gastric & Johnson, 2009; Harper et al., 2012). As such, sexual minority youth often lack social support from adults who do not require that they compartmentalize their identities. Lacking access to supportive adults, sexual minority youth may find mentoring relationships appealing. Research suggests that sexual minority youth are more likely than heterosexual youth to seek informal, non-parental adult mentors (Gastric & Johnson, 2009).

Natural mentors and non-parental adults often play a primary role in the development of Black youth. In Harper and colleagues' (2012) study of 63 multi-ethnic gay youth, Black participants most commonly reported seeking out non-parental adults as mentors and role models. Given the importance placed upon alternative family structures and mentors in the Black community, incorporating natural mentors into HIV prevention efforts may be one means of enhancing the cultural relevance of interventions for this population (Wyatt, 2009).

Research suggests there are numerous benefits to having natural mentors in the lives of Black youth. For example, natural mentors have a longitudinal positive impact on mental health and sexual risk behaviors on Black youth (Hurd & Zimmerman, 2010). More specifically, female mentors are associated with positive mental health outcomes among Black youth (Bryant & Zimmerman, 2003). Among Black MSM, mentors are an important means of social support (Harper et al., 2012). Further, in qualitative research on the strategies racial minority MSM (aged 18-49) use to manage racism and homophobia, Black MSM described learning identity-management strategies, including how to cope with racism, from their role models (Choi, Han, Paul, & Ayyala, 2011). These results suggest that natural mentors may promote resiliency in the lives of young Black MSM.

Resilience summary

In the previous sections, I detailed ways in which various types of relationships may be fundamental to the health and well-being of young Black gay and bisexual males. I described the literature on how family, the gay community, mentoring relationships, and constructed families promote the health and well-being of young Black gay and bisexual males; there are undoubtedly other relationships (e.g., romantic, online friendships) that promote healthy growth and development in the lives of young Black gay and bisexual males. Additionally, there are numerous other potential protective factors and mechanisms at the individual and systemic (e.g., policy) level that have health and development implications for young Black gay and bisexual males. I bounded the review of the literature based on my study's analytic emphasis on relational resilience (see section on "resilience").

The current study

My study offers an initial glimpse into relational resilience in the lives of young Black MSM. Its focus on young men's relational experiences and emphasis on resilience in the face of adversity is consistent with Stall's conceptual model. Specifically, in this study, I examined the relational lives of young Black MSM who have avoided syndemic production (i.e., the expression of psychosocial health issues associated with heightened risk for HIV) to understand how they differ in their socio-cultural relational characteristics from men who manifest syndemic production. The first aim of this study was to describe the protective factors/strengths that exist within young Black gay and bisexual males who lack evidence of psychosocial syndemic production. This approach to examining these young men recognizes and celebrates young Black MSM's resiliencies and resources Given the lack of empirical data upon which to base this analysis, I undertook an emergent and largely descriptive

approach to examining the data associated with the participants who have avoided syndemic production.

The second aim of this study was to explore how young men who have avoided syndemics differ in their relational experiences from men who evince syndemics. Though young men who have avoided syndemic production were the analytic foci, I also examined those participants who evince syndemic production. I conducted two separate qualitative analyses, one with a sample of young men who have avoided syndemics and one with a sample of young men who evince syndemics. This approach allowed me to identify necessary conditions that distinguish these two samples of men. Comparing the relational themes generated from analysis of these two samples allowed me to identity relational patterns uniquely associated with young men's well-being.

The third aim of this study was to explore how relationships and relational factors may promote the healthy development and the health of young Black MSM. I answered this research question with a more fine-grained qualitative analysis of the data from the men who have avoided syndemic production. For example, the comparative analysis suggested that men who have remained healthy have supportive relationships with females in their immediate family. A more in-depth analysis of these men's data described how these females provide growth-fostering relationships for these young men and what these young men are taking away from these relationships.

CHAPTER 2: METHOD

I present cross-sectional data from a study of young Black MSM between the ages of 14 and 24. Analyses compare a sample of young men who show no evidence of syndemic production to a sample of young men who show extensive syndemic production. The data I used were derived from a larger study conducted on behalf of the Michigan Department of Community Health. The Young Men's Health Study (YMHS), which took place from winter-fall 2009, was designed to document the HIV prevention needs of adolescent and young adult Black MSM for the purpose of informing the statewide community planning process for HIV prevention (PI: Robin Miller; Co-PI: Miles McNall).

YMHS participants

My dissertation was focused on examination of young Black gay and bisexual men who have avoided syndemic production and young men who have experienced syndemics. As such, using the sampling strategies described below (see case selection section), young men who met these criteria were considered in this effort. In all, the YMHS study recruited 180 participants across the state. Eligibility criteria included the following: 13 to 24 years of age, identified as Black or African American, born a biological male, had sex with a male in the prior 2 years, resided in Michigan, and had not been interviewed before.

For the purposes of this analysis, I theoretically sampled a group of 46 participants from among the YMHS sample: 23 Detroit participants who engaged in safer sex practices and exhibited a lack of syndemic production and 23 participants who exhibited a history of sexual abuse, depression, and substance abuse (i.e., syndemic production). These samples form the basis for two separate analyses (described in the analysis section).

Throughout this dissertation, I refer to this first sample of participants as men who lack syndemic production or men who do not evince syndemics. I refer to the second sample of participants as men who evince syndemic production or young men who are experiencing syndemics. I recognize that these terms are linguistically cumbersome. However, I want to be conscientious of the language used to describe these young men's health profiles. I do not wish to imply that men who do not personally express syndemics are not affected by syndemics; they are part of a small, insular group about which stereotypes and misconceptions abound regarding the health of their community. Further, as a part of that community, they are affected by others who do experience syndemics. Though different terms (e.g., healthy, resilient, or non-syndemic) may be more linguistically pragmatic, I disagree with the semantic meanings that these terms imply.

Procedures (YMHS)

We used three recruitment strategies to identify eligible participants. First, we used elements of respondent driven sampling (RDS), a sampling method developed to recruit samples of hard -to-reach and hidden populations in a way that ideally possess the characteristics of a probability sample (Heckathorn, 1997). When effective as a recruitment strategy, RDS provides social network data and provides a way to evaluate sexual and drug-using networks in high-risk populations.

In RDS, seeds participate in a study; after study participation, these seeds recruit people in their social networks who meet study criteria. We gave each participant three coupons, each marked with a unique serial identification number and date of expiration. Participants who gave coupons to people in their networks who met study criteria received additional $5.00 remuneration if we heard from their network members. Through our advisory panel (see section on instrument), we recruited six young men who met study

eligibility criteria as our initial seeds. We identified two seeds in Wayne County, and one seed in each of Washtenaw, Kent, Berrien, and Ingham counties; these counties have the highest HIV prevalence rates in the state. We recruited two seeds in Wayne County given its population size relative to other counties.

We intended to use RDS as the sole recruitment strategy until we obtained a sample size of 180; however, after a few weeks of data collection, it became apparent that the rate of return was too slow to meet the reporting deadline set by the funder. Due to difficulties with RDS, we supplemented our data collection using alternate recruitment procedures. Alternate recruitment procedures entailed venue-based methods. We posted fliers and announcements about the study in bars, community-based organizations, and other venues where members of the target population were likely to spend time (again, within the aforementioned high prevalence counties, as well as in Genesee and Saginaw counties). These fliers provided prospective participants with a phone number and an email address they could use to contact study personnel to assess eligibility. Additionally, we sent interviewers to locations and events where members of our target population congregated (e.g., bars, community-based organizations, balls). Recruitment locations were identified by our advisory council, internet searches, local newspapers, and through the information we obtained during key informant interviews. Participants recruited via these convenience sampling procedures were also offered the opportunity to recruit three network members and receive up to $15.00 additional remuneration. Roughly 20% of the participants were referred by other participants.

Recruiters and project staff assessed eligibility and scheduled interview times for those persons who were eligible and interested in participating. We assessed study eligibility for the YMHS using a brief screening interview. Participants also provided us with their name and contact information so that at the end of the study period, they could be reimbursed for any coupons that they distributed to their network members. In all, we screened 352

people, of whom 280 were eligible. The primary reasons for ineligibility included: failure to meet the age requirement (53%), no sex within the required time frame (14%), no sex with males (13%), or having already been interviewed (8%). During spring and fall of 2009, we interviewed 197 young Black MSM from throughout the state of Michigan. Of these, 180 men completed the interview and provided usable data. Geographically, 59% resided in the Detroit Metropolitan area and 41% lived elsewhere, approximately reflecting the distribution of the HIV epidemic in the state.

We scheduled eligible participants for interviews at times and locations they found convenient; due to having a large cadre of interviewers diverse in gender, race, and sexual orientation, we asked participants if they had any demographic preferences regarding their interviewer. When possible (e.g., due to interviewer availability), participant preferences were taken into account when scheduling interviewers. If participants did not have a preference, we scheduled interviewers according to their availability and geographic proximity to the desired location. Interview locations included public and university libraries, community-based organizations, public parks, interviewees' homes, and interviewers' cars.

Prior to interviews, participants signed informed consent (age $\geq$18 years) or assent forms (age <17 years), depending on age. The Michigan State University institutional review board granted a waiver of parental consent. The consent process informed participants about the nature of the study, the risks associated with participation, their right to decline participation or withdraw from the study, and the procedures in place meant to ensure their confidentiality. Interviews were recorded with the permission of participants; one participant declined to have his interview recorded. Interviews lasted an average of 70 minutes (range = 36 to 138 minutes). At the end of the interview, participants were compensated $25.00 for their time and provided with a list of local referrals for HIV services and LGBT resources.

We trained and monitored 13 interviewers who performed data collection. Most interviewers were doctoral and Master's level graduate students from diverse disciplinary backgrounds (e.g., clinical and community psychology, public health, and human development). Due to the geographic distribution of potential interviewees, we recruited interviewers who studied at universities in close proximity to the aforementioned geographic target areas. Additionally, a few community members with experience in social work, HIV prevention, and/or working with the target population also performed interviews. All interviewers were trained on the project background and purpose, HIV and HIV prevention, cultural competency with Black MSM, and the use of the protocol. Training entailed conducting mock interviews performed with the project investigators or research assistants. Throughout data collection, a project staff member checked interviews to ascertain their quality and provide feedback to interviewers.

To ensure confidentiality, all data were securely kept in the principal investigator's project space. The study also obtained a special designation from the Michigan Department of Community Health that provided special confidentiality protection for these data. Research assistants transcribed, de-identified, and cleaned (i.e., checked for accuracy) the interviews. Following transcription, we destroyed audio recordings to protect participants' confidentiality. The YMHS was approved by Michigan State University's Social Science, Behavioral, Education Institutional Review Board (ID#i031939).

Instrument

HIV prevention and care leaders around the state were involved in project design. We interviewed 21 key informants from local community-based organizations, health departments, and representatives of the Michigan HIV Council (the CDC-mandated prevention planning body for Michigan) to ascertain their informational needs. We developed

the interview protocol around these information needs in collaboration with six young men from the target population who served as an advisory panel on the project. The advisory council also helped process the key informant data, established interview topic priorities, determined what questions should be asked qualitatively instead of through quantitative measures, and reviewed drafts of the interview protocol. The final protocol contained a combination of standardized survey measures, open-ended questions, and demographic information. The protocol inquired about participants' sexual and ethnic identity, peers, family, Black communities, involvement in the gay community, experiences with religion, role models, sources of social support, health care use, knowledge of HIV and sexually transmitted infections, HIV and sexually transmitted infection testing experiences, sexual and substance use behavior, mental health, and exposure to various forms of violence and abuse. Only the items used in the current study are described.

Demographics

Age: To measure age, participants were asked to report their current age in years.

Sexual Identity: We asked participants to describe their sexual identity. Response options included gay, bisexual, heterosexual/straight, and other. We included a heterosexual/other response option because youth may engage in same-sex behavior yet identify as heterosexual.

Gender Identity: We asked participants to describe their gender identity. Response options included male, female, transgender, and other. We included a response option of female because some gender non-conforming youth may identify as female rather than transgender.

Educational Attainment: Participants were asked three questions about their educational experiences. Given the age range of participants, we asked them a closed-response question about whether they were currently in school. Additionally, we asked them the highest grade they had completed in school (e.g., 8th grade or less, some high school, high school graduate, some college, college graduate, more than 4 year degree) and, among those currently in school, their current grade level.

Employment: Participants were asked about their employment. In a closed response question they were asked if they were currently employed either full or part time.

Income: Among those who were employed, we asked for their monthly salary.

Syndemic variables

I used the following measures to theoretically sample (see section on case selection) young men based on their degree of syndemic production. Notably, these measures are akin to those that researchers have consistently applied across studies of syndemic development in MSM populations (Dyer et al., 2012; Herrick et al., 2012; Mustanski et al., 2007; Stall et al., 2003).

Sexual abuse: We assessed various forms of traumatic experiences (e.g., physical, sexual, emotional, and financial abuse) using a modified version of a lifetime traumatic experiences index (Widom, Dutton, Czaja, and Dumont (2005).A single item (yes/no), having experienced coerced sex, was used to measure sexual trauma. In the full sample, 32% of participants reported a history of sexual abuse. For these analyses, data were coded so that 0 = no history of sexual abuse and 1 = history of sexual abuse.

Depression: We assessed depression with the Center for Epidemiological Studies Depression (CES-D) scale (Radloff, 1977). This 20-item scale is summed and scores may

range from 0 to 60; a score of 16 or higher indicates a clinically significant level of depression. In the full sample, 33% scored in the clinically significant range (M = 14.7; SD = 10.7). Internal consistency (Cronbach's Alpha) for this sample was .89. For these analyses, data were recoded as 0 = mentally healthy; 1 = clinically significant level of depression.

Substance abuse: To measure substance use, we used a brief screening instrument for detecting substance abuse in adolescents (Knight et al., 1999). Scores may range from 0 to 9; scores of 2 or higher indicate problem substance use. In the full sample, 54% scored in the problem substance abuse range (M = 3.1; SD = 2.3). Cronbach's alpha for this sample was 75. For these analyses, data were recoded so that 0 = non-substance abusing and 1 = substance abusing.

Sexual behavior: We asked participants detailed information about their sexual histories and recent sexual relationships (Fishbein & Coutinho, 1997). For participants who reported having had sex in the last 90 days, they were asked to provide detailed demographic (e.g., age, race, type of partnership) and behavioral (e.g., type of sex act, frequency of sex acts, frequency of condom use) information on up to three sexual partnerships over the previous 90 days. In addition, many participants elaborated on aspects of current sexual relationships in the open-ended sections on HIV and STI testing, knowledge of HIV and STIs, and safer sex influences.

Relational data

I conducted the primary analyses (see analysis section) using the qualitative portions of the interview protocol that assessed young men's relationships and interactions with other people and organizations. Participants discussed facets of various relationships throughout the protocol; men described their relationships with family, peers, mentors/role models, the gay community, the black community, and in religious settings. Young men also commonly

discussed their relationships with family, peers, sexual partners, or others when discussing who influenced their safer sex practices and/or describing previous HIV and STI testing experiences. As a needs assessment, the interview protocol covered a breadth of topics, many of which pertained to the relational nature of these men's lives.

Feelings about racial and sexual identity: We asked young men five identity related questions that pertained to their race and five similar questions that pertained to their sexuality. We asked them how their race and sexuality affected how people treat them in general; we also asked participants how their race and sexuality affected how sex partners threated them. Four open-ended questions ascertained their feelings about their race and sexuality (e.g., "How does being Black/gay affect how you feel about yourself?" And "how does being Black/gay affect how you feel having sex with men?"). We also asked participants how their race and their sexuality affected their exposure to HIV.

Family: Five questions assessed the composition and quality of young men's family relationships. To assess the make-up of participants' families, we asked them to describe their families ("Who do you think of when you things about your family?") and to specify whether they were referencing biological families or families of choice. To assess the quality of family relationships, we asked participants about their relationship with their families (e.g. "describe your relationship with your family") and whether they felt supported by their families. We also asked participants what they had learned from their families about homosexuality to gauge familial response to and support for participants' sexuality.

Gay Community: Young men were asked five open-ended questions and one closed-response question about their involvement in the gay community. The closed-response question inquired as to whether participants considered themselves a part of the LGBTQ community. Participants who did considered themselves a part of this community were then

asked whether they felt supported by this community. Young men were also asked to describe their involvement in groups for young Black gay and bisexual men and how they became involved in these groups. Due to the nature of the needs assessment, we also asked men health-related questions about these groups (e.g., "What health issues are members of these groups talking about?" And "How do members of these groups learn to care for their health?").

Mentors and role models: We asked about the presence, function, and quality of mentoring relationships through four open-ended questions: "Who are the role models or mentors in your life?"; "What makes them your role models or mentors?"; "How do your role models or mentors influence the choices you make or the things you do?"; and "How do the role models or mentors in your life affect your decisions about practicing safer sex?"

Religion: To assess involvement in religious settings, we asked participants two closed-response questions: whether they were formally a member or a church and whether they were a current member. We also asked participants one open-ended question about church teachings regarding HIV and one open-ended question about church teachings about homosexuality. To gauge perceptions of religious support, participants were asked whether they felt supported at church.

Safety: We asked participants to compare how they felt across various social settings and to explain and elaborate on where (e.g., at church, among peers, in the Black community, among family, or in the gay community) they felt the most and least safe, protected and respected ("where do you feel the most/least safe, protected, and respected" and "Why").

Dissertation case selection

This dissertation examines young Black gay and bisexual men who have avoided syndemic production and young men who have experienced syndemics. I derived analytic samples from the larger YMHS dataset. For the purposes of this study, I theoretically sampled a group of 46 participants from among the YMHS sample: 23 Detroit participants who engaged in safer sex practices and exhibited a lack of syndemic production and 23 participants who exhibited a history of each sexual abuse, depression, and substance abuse (i.e., syndemic production).

To identify the men in each sample, I used theoretically informed cluster analysis. As a data reduction strategy, researchers often intentionally select cases based on theory (Marshall, 1996; Namey, Guest, Thairu, & Johnson, 2008). I used theory-driven cluster-sampling to select groups of young Black MSM based on the degree to which they express syndemic production associated with HIV risk within this population.

Stage 1: experience of syndemics

I used three psychosocial variables (e.g., depression, substance abuse, and sexual abuse) to identify cases of theoretical relevance for this study (Dyer et al., 2012; Mustanski et al., 2007; Stall et al., 2003; Stall et al., 2008). To identify typologies of men, I used the list cases function in SPSS version 20 (IBM, 2011) to identify men who did not exhibit syndemic production (i.e., no history of sexual abuse, substance abuse, or depression) and men who exhibited syndemic production (i.e., history of sexual abuse, substance abuse, and depression). This initial sampling strategy identified 23 men who evinced syndemics and 29 participants who have avoided psychosocial health issues associated with heightened odds for HIV.

Stage 2: geographic considerations

Based on previous analyses (Miller et al., 2013), I anticipated that participants from the Detroit area would exhibit different health profiles than participants from elsewhere. I anticipated that a primary demographic difference between the two groups would concern their county of residence. In the interest of creating a homogenous analytic sample, I analysed the county of residence of the 23 men who evinced syndemics and the 29 participants who have avoided syndemic production. Men experiencing syndemic production represented a geographic cross section of participants in the YMHS data set. In contrast, 28 of the 29 (97%) young men who did not exhibit syndemic production were Detroit residents (the remaining man who lacked evidence of syndemic production was from Flint).

As there was only one case from out-State in the analytic sample of men who lacked syndemic production, I excluded this case from analysis. Excluding this case was justified because it is likely that Detroit participants possess a different set of resources available to them that serve as protection from syndemic production. Additionally, as there was only one participant from Out-State Detroit, I lacked sufficient data with which to conduct case analysis. This case exclusion left me with an analytic sample of 28 men from Detroit who exhibited a lack of syndemic production.

Stage 3: sexual behavior considerations

As a second strategy to create a homogenous sample, I delimited the cases of young men who avoided syndemic production to those who also engaged in safer sex practices. Syndemic theory would predict that the men in this sub-sample engage in little sexual risk behavior associated with HIV risk. They are likely to have few sexual partners and engage in sexual risk reduction practices such as condom use or HIV testing prior to discontinuing condom use in relationships. As expected, the majority of participants (23/28; 82%) engaged

in low risk or safer sex practices. The majority (14) of participants had sex with 1 or 2 partners in the last 90 days while using condoms 100% of the time. Four men had not had sex in the last year, 2 men had not had sex in the last 90 days, and 1 man only participated in oral sex within the last 90 days. Two men did not use condoms with their long-term sexual partners, but in their qualitative data they described being tested for HIV with their boyfriends prior to sex. The remaining 5 participants were not included in analysis, leaving an analytic sample of 23 young men who have avoided syndemic production and who engage in safer sex practices. There are a few reasons why sexual behavior was used to delimit the cases only from the sample of young men who did not experience syndemics. Because these young men do not exhibit psychosocial conditions associated with heightened HIV risk or behavioral risk associated with HIV, it is from these men that I could best hope to identify protective factors that may assist young Black MSM in avoiding syndemic production as well as sexual behavioral risk. I refrained from delimiting the cases of men experiencing syndemics by their sexual risk behavior due to this study's focus on protective resilience (Stevensen & Zimmerman, 2005) rather than compensatory resilience (i.e., protective factors that may counteract syndemic exposure and provide protection against behavioral risk). An implication of this decision is that the comparative component of this study compares the relational experiences of young men who differentially expressed syndemic production (regardless of sexual risk behavior). This decision was also informed by Safren and colleagues' (2010) work suggesting that it is not only sexual behavioral risk that makes MSM experiencing syndemics more vulnerable to HIV; they may be more susceptible to negative outcomes along the continuum of care. Therefore, delimiting these men by their behavioral risk would neglect the fact that they may face added health burden in multiple ways.

Analytic participants

Table 1 displays demographic information for the two analytic samples. As can be seen, the vast majority of men in each group had a male gender identity. Men experiencing syndemics were more likely to identify as bisexual when compared to men who avoided syndemics; however, this difference was not statistically significant. Similar proportions of each group were in school (57% vs 55%) and employed (65% each). The two analytic samples also did not significantly differ in their level of education (most having at least graduated high school), monthly income (predominantly low income), or housing status (most having stable living situations on their own or with family). I conducted difference tests (e.g., chi-square test for categorical variables and independent sample t-tests for continuous variables) to assess whether there were significant demographic differences between the two analytic samples. The two analytic samples did not significantly differ on any characteristic but age. An independent samples t-test indicated that men experiencing syndemics were significantly older (M=20.91, SD = 1.91) than men who were not experiencing syndemics (M = 19.35, SD = 1.95), t (44) = 2.76, p, .01.). The men experiencing syndemics reflected a geographic cross section of the YMHS sample. Among these participants, 9 lived in Detroit, 4 in Lansing, 4 in Flint, 3 in Benton Harbor, 2 in Ann Arbor, and 1 in Saginaw.

As sexual assault history distinguishes these two samples, I also examined the limited data that men experiencing syndemics supplied about their sexual assaults. Men reported experiencing sexual assault between the ages of 5 and 19 (M= 9.96; SD = 4.51). A few reported multiple sexual assault experiences. Among these participants, their relationships with their assailants were most frequently family members (n=12), strangers (n=9) and peers (n=4).

Table 1: Demographics

	Men experiencing syndemics (23)	Men who do not evince syndemics (23)
Mean Age (SD)	20.91(1.91)	19.35(1.95)**
Sexual orientation		
Gay	59%	83%
Bisexual	41%	17%
Gender Identity		
Male	91%	96%
Transgender	9%	4%
Currently in School	57%	55%
Level of education		
Less than high school	22%	17%
High school/GED	44%	63%
Some college	35%	21%
College graduate		
Employed (part or full time)	65%	65%
Mean Monthly Income (SD)	1249 (1179)	1633(1118)
Housing		
Lives with family	52%	61%
Lives on own	35%	30%
Unstable	13%	9%

Note. Mean differences between samples were assessed using independent sample t-tests. Differences in proportions between samples were assessed using chi-square tests of independence. **Statistically significant at $P < .01$

Analysis

The analysis approach I employed primarily followed the principles of analytic induction (Robinson, 1951; Erickson, 1986). Researchers use analytic induction to develop, modify, and test assertions- comparable to quantitative hypotheses- inductively derived from empirical data. In this case, I performed two separate analyses, one using the subsample of 23 men who evinced syndemics and one using the subsample of 23 men from Detroit who did

not evince syndemics and who engaged in safer sex practices. I analyzed each subsample separately to identify assertions that distinguish conditions between cases.

Classical analytic induction (Znaniecki, 1934; Robinson, 1951) was conceived of as a qualitative method through which to identity universal, causal processes. More modern and modified forms of analytic induction (Turner, 1953; Robinson, 1951) now de-emphasize the search for causal explanations and mechanistic processes. In addition, modern forms of analytic induction may instead identify, as is the case in this study, more descriptive assertions that delineate participant behaviors, perceptions, and relationships (Baillien, Neyens, DeWitte, & DeCuyper, 2009; Bhattacharyya, Volk, & Lumpe, 2009; Gilgun, 1995; Graham, Walsh, & Shier, 2009; Swan, 2009). Modified analytic induction thus has the goal of constructing descriptive propositional statements of relationships among concepts.

Descriptive analytic induction was deemed an appropriate analytic method for a couple of reasons. First, as a qualitative method, analytic induction is especially ideal for identifying and examining contradicting outcomes in data (Katz, 2001). Analytic induction entails the identification of a set of assertions that pertain to groups of people reporting particular experiences. In the instance where reference groups can be identified that do not report those experiences, analytic induction may be used as a way to distinguish categories of cases. Though not typically conceived of as a qualitative comparison technique, analytic induction's emphasis on identifying necessary conditions (Robinson, 1951) that define categories of cases implies that it can be used to examine contrasting outcomes in data, or in this case, to contrasting the histories of men experiencing syndemics from men who have avoided syndemic production.

Second, analytic induction is an appropriate form of analysis due to the topical emphasis on resilience in the lives of a marginalized group. Many of the formative studies in

which analytic induction was employed involved analysis of groups that were socially marginalized and often considered deviant such as opiate addicts (Lindesmith 1968), abortion seekers (Manning, 1971), marijuana users (Becker, 1953), and youth thieves (West, 1978). As a method, analytic induction helps shed light on the surrounding circumstances and antecedent conditions associated with a group of people. In this way, the method helps reconceptualize marginalized groups, such as Black MSM, which was an important epistemic goal of this study.

Last, even in its descriptive application, analytic induction supports retrodiction: the development of assertions that if a given condition (e.g., syndemics) is evident, it will be associated with one or more things (Katz, 2001). Retrodiction is distinct from mechanistic prediction in which emphasis is placed on the identification of antecedent conditions that result in particular behaviors or circumstances. Instead, the use of analytic induction results in the identification of one or more necessary conditions under which a phenomena, such as syndemics or the lack thereof, is liable to occur. This analytic process, therefore, can help identify relational conditions associated with the presence or absence of syndemics among young Black MSM. Because analytic induction supports retrodiction, it is a qualitative method well suited for studies, such as this one, where a primary intent is the identification of interventions.

Figure 1 depicts the analytic induction process as used in these analyses. Notably, this process was akin to the steps in analytic induction as specified by Robinson (1951):

1. Develop an initial definition of the phenomenon of interest.

2. Develop assertions that explain the phenomenon.

3. Examine one participant's interview data (i.e., case) to determine if the assertion describes their experience.

4. Reframe or re-define the assertion if the data provide disconfirming evidence.

5. Examine the second case with the new assertion.

6. Continue the process of assertion modification and case examination until all cases are explained by the final assertion.

Figure 1 depicts how this process was conducted in practice. The first step entailed developing a rough definition of the phenomena to be explained. This process involved garnering a thorough understanding of syndemics, relevant constructs associated with health among young Black MSM, and the interview data. I familiarized myself with key relational constructs associated with young Black MSM's health by conducting a literature review. Additionally, this process involved acclimating myself to the data by engaging in initial reads of the interview transcripts.

I then initially structurally coded the interviews. Prior to assertion development, I structurally coded each interview as a way to familiarize myself with the data and prepare the data for more fine-grained analysis (MacQueen, McLellan-Lemal, Bartholow, & Milstein, 2008). Structural coding is a form of high level coding whereby researchers divide the text into large chunks of data that pertain to key topics of interest (e.g., gay identity, Black identity, family support, etc.). This coding procedure allows for the quick identification of key excerpts in the interviews to focus on during later analytic stages. This initial structural coding helps researchers begin to immerse themselves in the data; as a precursor to a study using analytic induction, structural coding also necessitates a broad inspection of all the cases, a process that facilitates the development of initial analytic assertions. The following

table demonstrates how I structurally coded a segment of interview text. Non-italicized codes were initial topical codes that emerged during a first reading of the interviews. Italicized codes are more descriptive, fine-grained thematic codes that I applied at later stages of analysis (see below).

Table 2: Structural coding example

Interview text	Structural code
I: And how else does being gay affect how you, feel about yourself? *R: I guess I have a high sense of , pride, I guess, in myself and I guess whatever I do, it's not always you know, gay related but gay is a big part of who I am and I'm happy with, myself today.* *I: What is it that gives you, uh, high sense of pride?* *R: The work that I do. Would be the main thing as far as helping the community, and, helping out being a part in, serving the community that I'm a part of….I'm a part of the miracle program which is a, national program, and I just relate it to HIV, AIDS work and prevention so we um pretty much work around the state just doin', um, you know, teachin' people about HIV and prevention and STD's and things where people get tested, and for everything, has to do with the healthcare field and HIV related. So we test people, counsel people, you know.*	Identity *Pride in sexual identity* *Sexual identity salience* Community involvement *Relationship between identity and community involvement* HIV prevention involvement

After engaging in this high level structural coding, I then drafted initial assertions. Analytic induction allows researchers to develop assertions based on extant theory and literature, our assumptions, or initial reads of the data; assertion generation may therefore be a priori or emergent. For the current study, I developed assertions based on the interview data. I also identified which structural codes I could query to test these assertions (e.g., text coded as 'identity' could be queried for assertions related to identity). I then tested each of

these initial assertions, case by case. As I re-read each participant's interview transcripts, I determined whether the information confirmed, disconfirmed, or was not applicable for each assertion. When originally testing assertions, I also engaged in more fine-grained structural coding as described above. This coding delineated various themes in the data that provided evidence for the assertions. For example, one of my assertions was that 'young men not experiencing syndemics exhibit pride in their sexual identities and recognize that there are benefits associated with being gay and bisexual.' Various structural codes (e.g., sexual identity pride, sexual identity salience, positive conceptualizations of being gay) within and across cases identify text which provides support for that assertion. Within individual cases, there may thus be numerous instances of validation for key assertions.

Data analyses then proceeded across cases, meaning that I examined each case for confirming and disconfirming evidence for each assertion. One of the strengths of analytic induction is that final assertions should pertain to all cases under investigation. In analytic induction, assertions are developed and refined in an iterative process until they are maximally generalizable to all cases under investigation Put another way, analytic induction entails the progressive redefinition of assertions; as analysis proceeds across cases, those cases that do not conform to the initial assertions result in a modification of the assertions. For example, one of my initial assertions was that young men experiencing syndemics exhibit characteristic attitudes and behaviors associated with internalized homophobia; for a majority of cases, this assertion fit the data quite well. However, further case examination suggested this initial assertion was too simplistic. Whereas many participants exhibited internal homophobia, others struggled with other facets of their identities such as their race, class, religious identity, or gender. I changed this assertion (e.g., "these young men believe two or more of their identities to be mutually incompatible") to accommodate these cases and to create an assertion that was maximally generalizable across all cases.

Cases may also provide disconfirming evidence for assertions. In these instances, there are three options that may be appropriate: noting contingencies in the case that may allow you to explain and keep the assertion, removing assertions if they are not adequately explained in the data, and creating new assertions. Not all of these options may be relevant for each analysis. Analytic decisions as to how to handle disconfirming evidence within and across cases largely depends on whether analysts can identify key contingencies in the disconfirming cases and whether an evidentiary warrant can be established for newly generated assertions (see below on explanation of evidentiary warrant). In my analytic process, I used two of these analytic techniques (as depicted in figure 2) to address cases that exhibited disconfirming evidence.

In one instance, I was able to identify key contingencies in disconfirming cases that allowed me to maintain my initial assertion. Contingencies define the conditions under which assertions do not pertain to particular cases. One of my assertions for the group of young men experiencing syndemics contains such a contingency: "Young men experiencing syndemics experienced extreme family conflict and alienation; however, having another 'out' gay relative was an important contingency, as these young men did receive sexuality-related social support from their families of origin." This assertion therefore did not pertain to the cases of the two participants who grew up with other sexual minority persons in their families of origin. Assertions then apply to those cases that remain.

I also excluded assertions for which I could not establish an adequate evidentiary warrant. One of the assertions that I discarded was not explained sufficiently across cases, by which I mean that this assertion was not supported by the data after I engaged in a more thorough analysis of the interview transcripts. After my first read of the interview transcripts, I proposed that 'young men not experiencing syndemics participate in alternate family networks.' Subsequent reads of the data suggested that the majority of participants did not

participate in alternate or gay family networks; discrepant cases outnumbered those cases that fit this assertion. I therefore determined that this proposition did not adequately fit the data and eliminated it. Upon looking more closely at the young men's experiences in gay or alternate families, I noted (via structural codes) that many of these participants develop gay families; as such, this finding provided evidence that young men engage in forms of social action (i.e., the creation of alternate family structures for gay youth being one example) that support the gay community. Thus, though I discarded the proposition related to involvement in alternative families, looking at these data through an alternate lens provided evidence that validated an alternate proposition that I had generated.

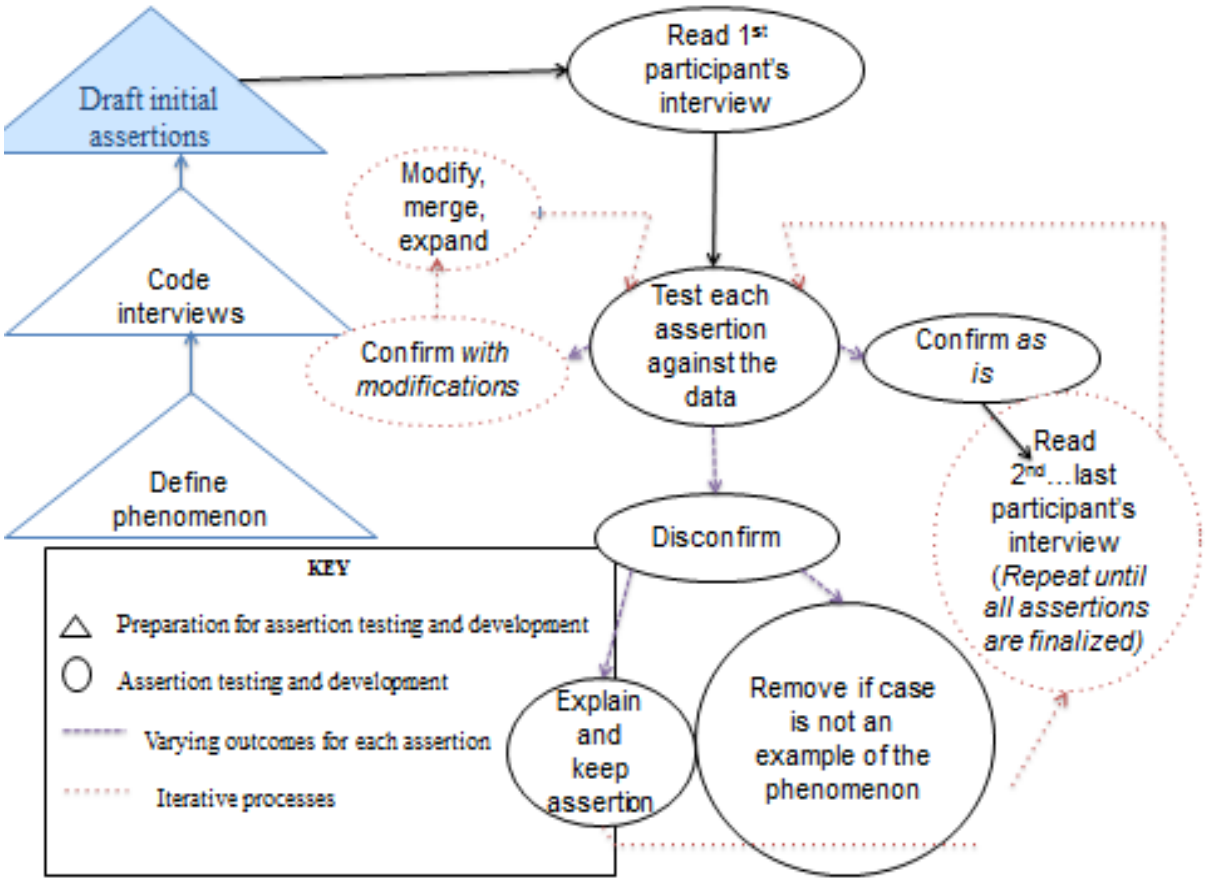

Figure 1: Example of assertion generation and testing

Throughout this analytic process, researchers aim to establish the evidentiary warrant for each assertion. That is, they seek conforming and disconfirming evidence by repeatedly reviewing the data to test the validity of and examine the strength of the support for each assertion. Assertions with a strong evidentiary warrant have been tested and re-tested, exhibit confirming evidence frequently within individual cases, are validated by all cases under examination, and contain what Erickson (1986) refers to as key linkages. Key linkages indicate that there are relationships or patterns between or among assertions; key linkages indicate that there are cross-cutting themes within the data. Throughout the results I briefly indicate key linkages between assertions and then describe these linkages more fully in the discussion.

Credibility

There are manifold ways to increase the data's credibility, or the believability of the results (Miles & Huberman, 1994). In this proposed research, I used the following strategies to increase the credibility and confirmability of this analysis: 1) prolonged engagement with the data, 2) interrater reliability, and 3) analytic and reflexive memoing.

Prolonged engagement with the data

A technique for increasing analytic credibility is for the analyst to experience prolonged engagement with the data. Some of this engagement came prior to analysis, as I was involved in the development of the research protocol, data collection process, and data management. I listened to many of the interviews to evaluate the quality of the interviewers and for the purpose of transcription. I developed a familiarity with the transcripts due to my involvement with other analyses using these data. For this analysis, prolonged engagement with the data entailed multiple reads of the transcripts and iterative code development and application over a period of nine months.

Interrater reliability

According to Miles and Huberman (1994), code stability is achieved once the definitions of each code are cogent and clear enough that another person can reliably fit the codes to the text; coding checks are therefore a way to assess the quality of the process by which qualitative data yield conclusions. To this end, I employed a research assistant with previous training in qualitative coding and the use of qualitative software to assess inter-rater reliability. Though this secondary coder was not involved in data collection or the YMHS, she had previous experience working on projects related to HIV among young MSM.

The secondary coder helped assess reliability at the level of the codes. This check entailed assessing the degree to which she could reliably apply the more fine-grained codes to the text (i.e., child nodes). To facilitate this process, I utilized a number of guidelines for facilitating the efficiency of coding as specified by Hruschka and colleagues (2004). They recommend that coders utilize data and codes that are clearly organized. The use of software aided in the organization of texts and codes. They also recommend that when employing multiple coders, analysts place limits on the number of codes that are assessed during each coding round. Analysts may limit code comparison to only a few interview questions or limit the number of codes used overall. In this case, I placed restrictions around topic themes coded during each coding round. For example, during a given coding round, we placed emphasis on key content areas as delineated by high-level structural codes. As an example, querying 'family' allowed for the identification of key text to which family-related sub-codes (e.g., family sexuality-related support, family sex-related support) applied. Third, we engaged in an iterative code development and analysis process whereby we engaged in intermittent assessment of the coding schema and instructions (Hruschka et al., 2004). This process entailed first piloting all the sub-codes on a small sample of the interviews. We each coded the same sample of interviews from each group of cases (e.g., men experiencing syndemics

and men who lack syndemic production). Thereafter, we used NVIVO's code comparison function to compute reliability statistics (e.g., kappa) to assess to the degree to which codes could reliably be applied. We then met to discuss the use of our codes and the corresponding reliability statistics. Notably, it is common that there will initially be low agreement on coding (Hruska et al., 2004). Discussion about the instances in which there was a low degree of reliability resulted in the refinement to particular codes or alterations to coding instructions. For instance, on this first pass we noted that much of the disagreement was not due to the conceptual application of the codes or definitional ambiguity, but rather due to the lack of rules regarding coding boundaries (e.g., inclusion/exclusion of interview questions, inclusion/exclusion of blank space). As a result, we made rules concerning how much text around each node to code so that a coding comparison query would more accurately assess the conceptual application of the codes (kappa is computed by character, not by word). Additionally, we discussed instances where there was a conceptual difference in the way that we were applying particular codes. For instance, at an early stage of this process, my definition for 'internalized homophobia' did not accurately convey the way in which I had coded textual instances indicative of internalized homophobia. As a result, these conversations resulted in refinement and additions to code definitions. After these initial pilot tests and subsequent alterations, we coded a randomly selected subsample of each group of cases (e.g, men experiencing syndemics and men who lack syndemic production) using these new procedural rules and code definitions. At this stage, I purposefully chose cases that were different from those in the pilot test, as including those cases that we had already discussed would have artificially deflated our reliability statistics (due to having coded them prior to procedural changes and addressing definitional ambiguity). Thereafter, again using NVIVO's code comparison function, I computed reliability statistics (e.g., kappa) to assess inter-coder-agreement. Inter-rater agreement for all codes was above .82, indicating that the codes, which

provided evidence for the assertions, could reliably be applied. Despite attempts to limit the coding of extraneous characters, much of the disagreement between coders was not due to conceptual use of the codes, but to the coding of irrelevant space surrounding the text.

Analytic memoing

I used memoing to refine and keep track of ideas and evolutions to assertions. Memoing is a way to develop ideas, organize concepts and relationships between codes, and investigate the merits of particular analytic categories (Charmaz, 2006). Throughout analysis, I wrote two different types of memos. Analytic memos focused on code development, application, assertion refinement, and relationships among assertions. These memos also constitute an audit trail as they describe the development and modification of assertions, detail why assertions were altered, and contain key verbatim text and codes that provide evidence for assertions. In qualitative research, these memos often form the backbone of analysis because, when integrated together, form the basis of a results section that is intimately grounded in the data.

I also kept reflexive memos to gauge how my beliefs and preconceptions were directing my examination and interpretation of the data. Consistent with feminist, constructivist epistemological beliefs, I believe that my interpretation of participants' experiences is reliant on my own standpoint (Charmaz, 2006). My knowledge of HIV risk among Black MSM, educational rearing in psychology and public health, or personal beliefs and influence my attunement to and interpretation of the data (Charmaz, 2006). Reflexive memoing was a way to examine the view I brought to the data. These personal memos helped me examine hidden assumptions in my own, as well as in the participants' inferences.

CHAPTER 3: RESULTS

In this study, I examined the relational lives of young Black MSM who have avoided syndemic production to understand how they differ in their socio-cultural relational characteristics from men who manifest syndemic production. In the sections that follow, I describe the assertions that emerged within the sample of young men who did not evince syndemics. Then, I describe assertions that emerged when analyzing the interviews of young men experiencing syndemics associated with heightened HIV risk. Though I primarily report the findings related to these samples separately, I do occasionally reference key differences that emerged between the samples. The next five assertions pertain to participants from Detroit who did not show evidence of syndemics.

Men who lack evidence of syndemics

Pride

Assertion 1: Black gay and bisexual males who do not evince syndemics, exhibit pride in their sexual identities and recognize that there are benefits associated with being gay and bisexual. Additionally, these men experience identity integration such that being Black or being a man is not mutually incompatible with being gay or bisexual. They are proud Black gay and bisexual men. Herrick et al. (2011) suggest that a sense of shamelessness or pride "may be one of the greatest strengths that sexual minority communities have developed and it may be very important in disrupting syndemic progression and its impact on HIV risk and infections" (p. S28). Pride is antithetical to prototypical internalized heterosexism (e.g., a sense if being different, less than, defective, or alone).

Participants staved off prototypical forms of internalized oppression. Young men were asked how being gay or bisexual affects how they feel about themselves. They all conveyed self-acceptance and described positive facets of being Black gay and bisexual men.

For example, responses to this question included: *"it's cool, all I can say is, mmmm great*," "*it makes me feel good about myself*," "*I feel positive about myself*," "*I really love myself*," and "*I love bein' a boy that likes boys*."

Participants live within a heterocentric culture, meaning that they are surrounded by negative attitudes, biases, and discrimination in favor of opposite-sex sexuality and relationships (Herek, 1990). Though there was considerable variability, participants' lives were filled with negative messages (e.g., from school peers, churches, family and strangers) which largely denied or denigrated same-sex relationships and behavior. These young men exhibited self-acceptance despite acknowledging pervasive negative societal views of gay and bisexual men. They developed a healthy sense of being gay or bisexual even with histories of homophobic attacks, structural heterosexism, and masculine socialization stress (i.e., the shaming or punishment of boys and men for failing to achieve masculine ideals). Despite experiences of oppression and marginalization, these young men constructed positive sexual identities.

Several young men also had a strong sense of a personal sexual identity. They were critical of and rejected stereotypes associated with gay and bisexual men and stressed the importance of developing a personal identity that was not restricted by societal messages regarding what gay and bisexual men "should" do, think, and feel. Several participants articulated a belief that the majority of societal messages connected with the gay community or with Black gay men are negative and harmful (e.g., promiscuity, addicts, HIV). These men described the rejection of these harmful stereotypes.

Participants also indicated self-acceptance by indicating that there were benefits associated with their sexual orientation identities; they articulated numerous positive

conceptualizations regarding their sexual orientation identities. Chief among these positive personal conceptualizations of being gay or bisexual was a strong sense of pride:

> *I guess I have a high sense of pride, I guess, in myself… whatever I do, it's not always, you know, gay related, but gay is a big part of who I am. And I'm happy with myself, today.*

These young men communicated that pride was related to a sense of authenticity ("*I can do whatever I want to do… that's why I feel good about myself- I can do it on my own and not do something that I don't want to do).* Pride also arose from a feeling of being unique, or special, as was the case with a young man who believed being gay "*makes me better than everybody else. It gives me an advantage in life, 'cause I'm not like everybody else*." As the quotes by these participants suggest, exploring and accepting their sexuality allowed for the opportunity to be who they are and to feel special, resulting in an enhanced sense of self-worth.

Participants also elaborated on aspects of their sexuality that they particularly enjoyed. They emphasized that their sexuality gave them new means of self-expression, suggesting that social creativity is valued: "*I love myself, it gives me a chance to express myself through other things*." Others found a sense of life purpose by participating in social causes through their involvement in AIDS service organizations and LGBT centers, indicating a proclivity for engagement in social action and community involvement. Specifically, participants described a desire to be knowledgeable on, and inform others about, issues that affect the gay community. These young men also described how being gay or bisexual afforded them new means of friendships and relationships through initiation into gay culture, highlighting the importance of sexuality-related social support:

I just feel like a whole 'nother new person…The reason why it make me feel like a whole 'nother person is because…. now it seem like when I'm gay, that's when I have more friends than I had before when I was straight.

Black gay and bisexual males who avoided syndemic production acknowledged numerous benefits of being gay, including increased and valued avenues of self-expression, social action, and social support.

Noticeably absent from these participants' interviews are statements indicating experiences of identity incongruence. None described feeling doubly oppressed as members of two marginalized groups. None described a sense that their race was incompatible with their sexual orientation identity, nor that their sense of masculinity was compromised by virtue of their sexual orientation identity. As a sense of identity incongruence was a core theme among the participants who are experiencing syndemics, it is noteworthy that these young men did not describe a similar struggle.

Maintaining pride using stigma management techniques

Assertion 2: Black gay and bisexual males who do not evince syndemics used three primary stigma management strategies to counter others' attempts to shame them: cognitive reframing, being dismissive of stigma, and the strategic avoidance of people and places that perpetuate heterosexism/homophobia. Young men used the aforementioned stigma management strategies to help them integrate facets of their sexual and religious identities.

Many young Black gay and bisexual men value attending church; yet, religious institutions are often among the most oppressive, non-gay friendly contexts (Ward, 2005). Religious teachings and activities that perpetuate various forms of institutional heterosexism, sexual prejudice, and masculinity stress may promote shame in young gay and bisexual men.

Young men who did not evince syndemics developed strategies deigned to ameliorate distress caused by religious and other forms of oppression. These participants reported three primary stigma management strategies: cognitive reframing, being dismissive of stigma, and the strategic avoidance of people and places that perpetuate heterosexism/homophobia. Used in religious settings, these strategies allowed young men to avoid or dismiss sexual shaming and to integrate facets of their sexual orientation and religious identities. In religious settings, they made use of the aforementioned cognitive change strategies: in particular, they attended gay affirming churches or did not attend church and may be atheistic (e.g., strategic avoidance) or reinterpreted or dismissed heterosexist or sexist church teachings as a reflection of structural oppression (e.g., cognitive reframing).

Young men used cognitive framing strategies that helped them resist heterosexist and homophobic messages. Cognitive reframing involves the identification and dispute of harmful, maladaptive, or irrational thoughts (Goffman, 1974); in this case, young men exhibited cognitive reframing strategies that provide a form of resistance to other's attempts to shame them. In particular, they were adept at restructuring heterosexist messages. These young men valued their own opinions ("*It's their opinion, I have mine. So, it's all good with me*") regarding their sexual orientation over those of others, a strategy used to assuage the internalization of heterosexism.

Cognitive reframing strategies were used to counter stereotypes of gay and bisexual men (e.g., all have HIV, are promiscuous, can't hold down or are not desiring of relationships), the causes of homosexuality, and heterosexist beliefs, particularly those based on Biblical interpretation or religious grounds. For example, this young man described his reinterpretation of church teachings about homosexuality:

> *[I've been taught] It's a sin, it's against the God, that you will go to hell if you do that. But in the end I think that's wrong because it says also that if you get tattoos or piercings, if you have sex before you get married, you still not be able to go [to Heaven]. But that's just being a hypocrite I think. 'Cuz everybody gets their ears pierced, everybody has sex before they get married. It's just a select few that don't, that abide by those rules*.

Young men reassessed religious teachings to be more consistent with their identities as gay men. In the quote above, the young man conceptualized people whose heterosexist beliefs were based on religious understandings as "*hypocrites*" who likely did not abide by other Biblical "*rules.*" From this perspective, heterosexist beliefs and comments become a criticism on others and on the structural factors that perpetuate and maintain heterosexism and homophobia. These young men recognize heterosexism as oppression, and acknowledge that some people are "*homophobes*," "*ignorant*," have "*a fear of what they don't understand*," or are just trying to protect their own images.

Another strategy that helped these young men preserve a positive self-image was that of being dismissive of stigma. The most direct form of being dismissive consisted of participants overlooking or ignoring attempts to ridicule, shame, or threaten them. Young men said that they "*don't pay no attention*" to people who tease them or stare at them, "*keep on with my day*" when they perceive others as judgmental, and don't let others' ignorance affect them ("*I don't let it affect me though*").They cultivated a thick skin of indifference. A second dismissive strategy involved the belief that they were fortunate relative to other gay and bisexual men. These young men recognized the unfortunate reality that as young gay men, they could be victims of violent crime, disowned by their families, or institutionally discriminated against due to their sexuality. By contrast, they considered their experiences as gay and bisexual men as "*nothin' too bad.*"

Young men were selective in where they went and with whom they interacted, choosing to go places where they felt safe and respected. Young men's strategy to avoid places where they felt unsafe or disrespected was principally evident in their descriptions of their involvement in church settings. They sought out supportive, gay affirming churches or ceased attending churches where they did not feel safe, supported, and accepted.

Participants attended gay affirming or gay friendly churches where they learned that being gay is compatible with religious teachings and doctrines. Their pastors preached, "*everyone's equal, no matter what they do," "it doesn't matter if you're gay or not…every person has their own relationship with God," "it doesn't matter what their sexual orientation is, everyone is a child of God*." These young men heard that everyone was equal in God's eyes. Churches services and teachings contained affirming messages. Further, congregants treated gay people tolerantly and "*the same as they treat everybody else*."

At these churches, young men also received safer sex advice ("*whatever you are is whatever you is, just be safe*.") and HIV testing advice:

> *…he's [the pastor] always saying if you are having sex to always be safe with it. Don't have sex without a condom. Always get tested. He even came up with a point that I always stuck with: when, before you even have sex with a partner for both of you to get tested to know your HIV status*.

One young man even described his church as "a *big ol' happy family*" where he and his boyfriend are very "*happy*" and participate in a "*couple's minist*ry" with heterosexual and same-sex couples. Young men attending gay-affirming churches could align their religious beliefs and identities with their sexual orientation and were able not only to avoid shame, but also to find supportive, affirming environments and relationships. For these young men, their churches and fellow congregants provided sources of sexuality-related social support. At

these churches, there were avenues to engage in social action on topics (e.g., gay rights or HIV prevention) of interest and relevance to these young men's' lives.

Others ceased attending churches where they did not feel safe, supported, and accepted. These participants chose not to attend places that taught them being gay was "*evil*," "*a sin*," "*bad*," "*the way of the Devil*," or "*against God.*" Church, to these young men, was a place they did not feel "*one hundred percent comfortable*" or felt liable to be "*shunned*." Non-attendance was described as due to the unwillingness of the church to be accepting of their sexual orientation: "*No 'cuz I've always been gay and I always felt like the church was against it and they are against it and I don't care what people say. ...so I don't go to church*." These young men identified as agnostic/atheist ("*I don't believe in church or the Bible*") or were actively seeking out gay-affirming churches where they would be supported.

In general, these stigma management strategies indicate that young men have developed a cadre of approaches that allow them to cope with experiences of heterosexism and homophobia; additionally, these strategies are particularly useful in helping young men respond to religious teachings and practices in a way that allows them to develop and maintain positive sexual orientation identities, and for some, to maintain valued religious identities.

Social support from families of origin

Assertion 3: Black gay and bisexual men who do not evince syndemics received sexuality-related social support from their families or origin. Biological family members provided sexuality-related support in numerous forms, not the least of which was family members' acceptance of participants' sexual orientation. Family conveyed to young men: "*no matter who you are, we acceptin' of you. Whoever you is, it doesn't matter*." Some young men were fortunate to have their entire biological family supportive of their sexual

orientation. The following excerpt comes from a participant whose family surprised him with how supportive they have been of his sexual orientation:

> *Nothin' negative… they don't have like a negative vibe against gay people. Period. They don't have like a negative vibe about it. Because I thought that they were going to have a negative vibe when I told 'em, but it was like, no. My family they're like open hearted. So it's like they don't really get into the negativity part… they're very open with gays…*

As this young man indicated, though he originally feared his family's response to his sexual identity, he has since learned that they are accepting and "*open-hearted."* Indeed, many participants acknowledged how frequently young gay men do not receive support from their families and thus recognized that they were fortunate to have understanding and supportive family members.

Often, when specific people were described as being supportive, they were female family members such as sisters, mothers, grandmothers, and female cousins. A handful of participants had other family members who were also sexual minorities: "*well my mother is a lesbian. Her sister is a lesbian, which is my aunt. Their brother is gay, which is my uncle….I'm a say about 95% of my entire family is gay… So you don't hear anything too bad… Just hear be safe."* Gay family members provided emotional support, advice on coming out to friends and family, and helped young men accept their sexual orientation: "*my sister…she's bisexual, so she really helped me along. To being, you know, comfortable with myself*."

Participants described members of their families who were not supportive of their identities as respectfully tolerant and largely silent on the matter. Young men described how people in their families "*don't like it, but they accept it because that's what I am."* Other

young men said that their sexual orientation is "*not really talked about*," family members do not "*speak too much on it*," or that disapproving family members just "*ignore it*." This finding resonates with research showing that while there is often condemnation and ostracism of same-sex relationships in Black families, there is paradoxically an unspoken acceptance of sexual minorities who remain silent (Collins, 2004; Gomez et al., 1999). Rust (1996) also maintained that in Black culture, parents are accepting of same-sex behavior if it is not explicitly mentioned. As such, young Black men may equate acceptance of their sexual identities, in some instances, with reticence on the part of family members.

For these young men, family members who spoke with them openly about sexual orientation related issues were chiefly concerned that young men *"be safe"* and *"be careful*." Family conveyed concern about participants' physical and sexual safety: "*My mom though she didn't really mind it. You know, just long as you was okay and you was happy, my mom was happy."* A number of participants had family members who gave them safer sex advice ("*they told me to be careful, sex wise. Period. Guys and girls"*), which young men took to heart:

> *I mean I wasn't using condoms at first…I mean I just started using condoms because my mom was telling me that if you are out here having sex with other men and stuff, you should be out here using condoms because you don't want to catch the HIV from one of these people…So, I mean, I listen to my mom.*

As the previous excerpt suggests, this young man only incorporated condoms consistently into his sexual life after his mother expressed a desire for him to protect himself. Family members (particularly mothers and sisters) also provided young men with condoms. Their mothers *"introduced [them] to a condom,"* gave HIV and STD prevention workshops at churches, and were aware of and supportive of the work they did for the gay community or in the HIV prevention field:

Like, when I started doing Mpowerment …when I started doing this and I was telling them [his family] about 'oh yeah we do this and we go out to clubs and give out safer kits and condoms and lube' and tell 'em what all we do. And they're very very supportive about that.

These young men had parents and family members in the role of HIV educators. Again, specific family members who promoted sexual health tended to be females such as sisters and mothers and grandmothers.

Family members also advised participants about the dangers of heterosexism and homophobia and suggested that they be vigilant of potential attacks. Family members communicated their concerns to participants, as was the case with this young man's grandmother:

When I go to clubs and stuff it be like, she always tell me be careful. But, like being gay, she just says be careful because there's a lot of people in the world who doesn't like it. So she just says be careful and stuff like that. Said look out for it."

Family also gave young men advice on how to stave off discrimination. For example, one young man's mother suggested he compartmentalize his work and personal life:

I learned things from my momma. And she tells me things and I listen to her. …Like how you present yourself in life. Like whatever you do sexually it should be between you and your partner at home. Like you go to work, you can understand you being gay at work, but you just keep that between you and your partner. Don't bring it to work, you know. That's your personal life.

Supportive family members also defended participants against less accepting family members, as was the case when this young man's mother defended him against his religiously intolerant aunt:

…when I'm over my auntie's house or my auntie's or my uncle's and then they say something about me, then my mom always…says stuff like to protect me and stuff like that. Gives her opinion…Most of time I tell her, I tell her 'it's okay.' I say 'you don't have to do that.' I say, 'Mom, I'm old enough to protect myself and stuff.'

These young men had family members who made it apparent to others that they best be tolerant. Other young men received practical forms of assistance, such as transportation to gay-identified social events: *"They're supportive. 100%. Uh, they take me to like gay events. Supporting me. Out of town, and things."* This type of support made it possible for participants to connect with other gay and bisexual men in social venues they may not have otherwise been able to access. As these examples show, young men received a variety of different forms of sexuality-related social support from their families of origin. They had family members who were affirmative of their identities as young gay and bisexual men.

Community affiliation and support

Assertion 4: Black gay and bisexual males who did not experience syndemics were initiated into gay culture through friendship networks and involvement in gay-community settings such as LGBT service centers and AIDS service organizations; through these social service organizations, they further developed friendship networks, become a part of a gay culture that promotes health, and developed a healthy sense of group solidarity and connection.

There is often a natural proclivity among marginalized people to seek out or create settings that are affirming. Yet amidst a pervasively negative sociocultural context of heterosexism and homophobia, it is often difficult for young gay and bisexual men to form strong ties with other gay and bisexual men in healthy ways. Thus, many gay and bisexual young adults lack social connections with other gay people. This social disconnect from gay

culture may be especially true among young Black gay and bisexual men who describe the "gay community" often as one that is racist, unwelcoming, or not meeting of their needs (Battle, Cohen, Warren, Ferguson, & Audum, 2000).

All participants frequented Detroit's LGBT and AIDS service organizations and reported friendship networks of other gay and bisexual men who accepting of their sexual orientation. Unlike participants experiencing syndemics, none of these young men avoided LGBT spaces or events, nor did they report dissatisfaction with or experiences of marginalization within the gay community. Rather, they reported intimate gay friendship networks and community affiliations.

There are different avenues through which men achieve contact with gay culture (e.g, at gay bars, sex venues, social organizations, friendship networks), and the means of initiation may yield different social networks, understandings of gay social norms, and different experiences of forming bonds with other men. Men who lack evidence of syndemic health problems initiated contact with gay culture via social organizations or through their peers. Young men reported that their friendship networks revolved around social service organizations. Their friends introduced them to social service organizations such as the Ruth Ellis Center or Affirmations or AIDS service organizations such as Mpowerment Detroit or Rec Boyz (see social action section). Or, they became aware of these organizations while at various venues (e.g., bars) where they encountered outreach activities and subsequently became interested in attending the centers or the events supported by the centers. Participants who created gay families often discovered their "kids of choice" through these organizations (see social action section). These organizations thus serve as hubs for the creation of relationships that are not predicated on substance abuse (e.g, gay bars) or sex (e.g., sex venues and online communities).

Participants detailed numerous benefits of their participation within gay male community settings and connections to the gay community. They described a variety of ways in which involvement in gay communities or gay friendly spaces was identity affirming. These young men's identities are often debased or devalued within larger society. An important function of gay-friendly settings and communities is therefore to help marginalized persons create, bolster, maintain, and celebrate facets of their identities. These young men identified and cultivated relationships with people who affirmed their identities as young Black gay and bisexual men. Participants alluded to a number of ways in which these relationships and spaces were identity affirming. The following excerpts describe how young men experienced participation in local service organizations as affirming of their identities:

> *Sometimes people have their way of life and a lot of them may closet themselves in their own home or confine themselves to just their area they're familiar with because they don't believe that the world is accepting of them. So it gives you an opportunity to branch out into the community….this Ruth Ellis Center is a place for you to hang out with people like you, of the same or similar preference for lifestyle…You may feel alone or you may feel different, but coming to these centers you feel more subjective to accepting who you are and appreciating it. Because it's really a gift because it's hard to be this way.*

To these young men, places where they could openly connect with others like them were "*a gift*." Participants described how this type of environment was especially important for them when they were younger and just coming to terms with their sexual orientation identities:

> *So it was actually a place where I could go to be gay. Because at the time I was like kind of closeted and I wasn't really, you know, as out as I am today. And I think*

maybe the center helps you find out, find who you are as a person also. Because you see that it's not so bad to be that way. So it helps people, especially young people.

As these excerpts indicate, these settings afforded young men opportunities to act in ways that were consonant with their identities as young Black gay and bisexual men. They helped young men feel less alienated and alone. Further, they promoted the idea of authenticity and helped young men find aspects of their identities that they might value and appreciate.

Gay communities and gay-friendly spaces were also described as spaces where young men felt safe and respected; they were an oasis in an otherwise difficult social environment, or places they might "*feel, I guess, free for just that short period of time."* In these locations, they felt safe and welcome to "*just be myself*" without fear of ostracism. Young men also described how gay friendly spaces provided opportunities for them to enact cultural practices that are a part of who they are, but that are devalued within the larger society. Dancing or vogueing, singing, and artistic practices were promoted and celebrated. Young men could be admired or respected for their skills and interests.

In these settings, men often engaged in conversations about community violence, poverty, men's health, and the HIV/ epidemic within their community. These were venues where men could talk about: "*issues in relation to your lifestyle and problems you may be having at home*" or "*stress, 'cause everybody goes through stress*" or "*just livin' as a Black, young, gay man, as a whole.*" Some of these discussions gave rise to social criticism and therefore afforded participants opportunities to critique, as well as obtain advice on how to cope with, the oppressive conditions under which they lived. These discussions entailed deconstructing pejorative cultural stereotypes and representations relative to Black gay and bisexual men. Other discussions revolved around various forms of oppression and ways in which young men might mitigate or circumvent their experiences with racism, heterosexism,

and/or homophobia. These venues promoted frank dialogues that may help young men lessen experiences of, or ameliorate the psychological distress associated with, oppression. Indirectly, these types of discussions may also articulate to young men that they are capable of overcoming oppression.

Young men felt connected to other individuals who had gone through similar experiences. They believed that only other Black gay and bisexual males could understand the realities that they faced. As one young man described, "*they can understand more where I am coming from.*" They valued having a community of others who could empathize with their experiences and being around people who are "*just like you."* Young men also indicated a penchant for being more accepting of advice from people they felt were similar to them. They detailed how important it was that they had people in their lives who shared with them their experiences and knowledge to model or otherwise instruct them in how to be young gay and bisexual Black men. They also connected with others who served as healthy guides into gay culture. These young men cited older or well-respected Black gay and bisexual members of the community who took them "*under their wings*." Participants discussed how these formative relationships with other gay and bisexual men contributed to less of a sense of alienation and exclusion.

Young men looked up to older Black gay and bisexual whom they met through community organizations as role models and mentors. They respected these older Black gay and bisexual men for their work in the community and ability to give sage advice and guidance of relevance to young gay men:

> *...the role models I do have, I really look up to them as far as education wise. They doin' things, you know, doin' a lot of things for the community...not only that they*

talk to me about prevention. They also, also help me out when it comes to , you know, like risky behavior.

As the quote indicates, this participant valued a relationship in which he felt his health was being encouraged. Role models were people from whom participants felt comfortable seeking advice; moreover, they were "*leadin' by example*." Role models were also individuals whom participants felt provided a mechanism for them to become involved in their community; as leaders in the HIV prevention field, Detroit's house community, or LGBT service centers, they were people who paved a way for and urged participants to become more socially involved (see social action section).

These settings and the relationships developed within them also fostered pro-social norms about safer sex, HIV and STI counseling, and relationships among men. The settings promoted sexual health through their interventions, provision of safer sex kits, and delivery of accessible testing opportunities. They provided resources for young men. Gay affirmative settings were also ones where young men learned a lot about HIV in their communities and became knowledgeable about safer sex practices. Participants spoke of their attendance at local HIV prevention and safer sex programs, saying that they valued the gay community because "*that's how I learned a lot about HIV or STDs*" and that it was often their participation in non-incentivized groups - "*Rec Boyz, YBU, basically HIV prevention groups*"- that taught them how to care for their health, influenced their safer sex practices, and taught them "*how to not get sick*." For example, one young man explained that he and his friends learn to take care of their health in the following way: "*We go to a lot of seminars. To learn things we'll go to health meetings whenever we can and get a lot of information. You know we try to be as healthy as possible*."

All of these young men indicated a commitment to pursuing HIV education. In addition to attending prevention groups and safer sex seminars at local HIV service organizations or LGBT community based organizations, young men showed that they valued HIV education by reaching out to local HIV experts when they needed advice or wanted to stay up-to-date on new developments in HIV research. Others relied on their friends who worked as HIV testers and counselors to provide them with updates, as did this young man who explained how his friend influences his sexual health practices:

> *…in our circle we got a friend that works for like this health clinic, and like, when he get information on different stuff, he'll talk to us about it. Or if we need some information, we can call him… me personally, I call him because he works in the health field I asked him personally, like, 'as you hear different information, hear different things, would you call me and let me know and talk to me about it so I could keep updates with different things*.'

Men described the relationships within these settings as facilitative of supportive peer norms for condom use, HIV testing, and healthy relationships. All participants described ways in which their friends (and sex partners) positively influenced their sexual health.

Social action

Assertion 5: Black gay and bisexual males who do not evince syndemics supported their community through advocating for LGBT rights, working with HIV prevention and care efforts, or constructing supportive communities where gay and bisexual youth can find support and acceptance. They are actively working to affect change in their communities. In particular, they engaged in various forms of social action and volunteerism that were intimately connected to their identities as gay and bisexual men. Through work in formal organizations, serving as mentors and role models in their friend groups, and developing

alternate family structures for gay and bisexual youth, these young men display a desire to provide alternate support mechanisms for, promote the health of, and alleviate socio-cultural myths and misconceptions about their community. The following section describes activities and practices that these young men engaged in that support and foster positive connections among young Black MSM.

Many of the participants were formally involved in some capacity with work in the HIV service field (e.g., outreach workers, testers, and counselors). A handful of participants were members of Young Brothers United, a group funded to conduct outreach to the 16-24 year old LGBT community. YBU members attend a 6-month intern process where they gain leadership skills, essential life skills, learn about HIV, and learn to conduct outreach. In addition to their HIV/STI outreach activities, YBU members design, plan, and conduct HIV prevention curricula as a part of Mpowerment Detroit (Miller et al., 2012). Still other participants were members of Rec Boyz, another group that, at the time of data collection, was an HIV prevention project in Detroit for young men of color who have sex with men.

The young men who were involved in the HIV prevention and treatment field experienced a sense of pride associated with their work. They felt a calling to help their community. They derived meaning from "*trying to do as much as I can*" for their community. Their work precipitated a sense of pride in their sexual orientation identities (see pride section). For example, a young man who was involved in HIV outreach activities explained why he felt proud to be a gay man; he attributed his positive sense of self to "*The work that I do. Would be the main thing as far as helping the community, and, helping out being a part of serving the community that I'm a part of.*"

Participants who were not involved in local HIV service organizations engaged in less formal means of community health promotion. These young men encouraged others'

safer sex practices through the provision of condoms, promotion of risk reduction strategies, or role modeling behavior. They worked to establish peer norms of condom use or safer sex, monogamy in relationships, and testing. For example, they encouraged testing in their community by holding group testing events with their friends. Friend groups would "*get tested together*" or participate in "*testing parties*." Participants described how they coordinated, hosted, or advertised the events in an effort to increase others' comfort with testing or encourage people to test more often. These efforts were independent of testing events at HIV service organizations, and related to a desire to "*give back to*" "*provide for*," or "*help people like me*."

Young men also described efforts to increase their own knowledge on HIV and safer sex practices so that they would be equipped to answer others' questions. These young men reached out to local HIV experts when they needed advice or wanted to stay up-to-date on new developments in HIV/S research. Participants also brought their friends with them to prevention activities and events in the community. For example, one young man helped his friends learn to take care of their health by insisting that they attend local seminars, meetings, and safer sex programs with him. He and others who act as guides to prevention programs and activities help their friends be "a*s healthy as possible*." As these examples show, young men are attempting to influence their friends in a variety of ways in an effort to promote their health.

Young men also challenged negative stereotypes of their communities. They live in a social milieu in which people commonly endorse incorrect assumptions about them and about HIV. Yet, they spoke openly and unapologetically about issues that they face as young gay and bisexual men. Young men gave examples of how they spoke to women and community members to debunk "*myths and misconceptions*" about HIV. They spoke up when others falsely assumed HIV was a "*gay disease*" or that HIV infection was equivalent to HIV

disease. They corrected others' false beliefs about HIV testing procedures and AIDS diagnoses.

Participants also expressed how being "out" as a gay man meant that they were constantly being thrust into the position to explain and teach others about sexual orientation related issues. As one young man described, when people find out he is gay, it is often the case that "they *actually wanna learn more about it. Once I'm open and out about it, they usually treat me the same, they just wanna learn more about it."* Participants did not describe these interactions disdainfully, but rather as opportunities to teach others about the realities of being a gay or bisexual man. They saw these interactions as opportunities to correct misconceptions, alleviate others' fears, and share their experiences as a Black gay or bisexual man.

Participants also created alternative families, thus helping provide for and protect other members of the gay and lesbian community. They were gay mothers and fathers who started alternative family groups that served as safe and welcoming kinship networks for gay youth. These gay families were described as being developed to assuage the difficulties of living as a young Black gay man (e.g., see section on social support). The following quotes describe the ways that these constructed families serve to help and protect gay and bisexual youth:

> *Like my kids of choice, I actually consider them as my own kids. Like they come, they come to me whenever they have a problem and when they need anything and you know they call me, we talk and I make sure they go to school, make sure they have clothes, make sure they're eating and all of that in the end. Because they're young, like 15/16. … So it's very, it's like a real actual family.*

This quote and others suggest that gay parents specifically help gay youth come to terms with their sexuality and to find pride in their identities as gay and bisexual men:

> *I: What have you heard, umm, you know among your kids of choice about homosexuality.*
>
> *R: Well, I actually tell them….they ask questions and I have this book, it's called, I think It's called 'young, gay and proud' and I have all of them read the same book and it really, really helps them understand okay well you're not alone…It really helps them understand okay you're not alone, how to tell your parents, how to accept yourself and everything. And I always tell each one of them, you have to accept yourself first before you can have others do it.*

These participants are thus influential in helping gay youth craft affirming sexual orientation identities and to learn skills that help them survive and thrive as young gay and bisexual Black men. Participants who started these gay families or who have "*kids of choice"* also detailed how they specifically aim to promote the health of the people who are a part of their constructed families. They purposefully picked people to be a part of their families who they thought both needed help and who were in a position to receive it. Here, one house father described how he decides who can be a member of this gay family: "I *take the ones who actually want and need help. Not the ones who don't wanna help themselves or do anything with their self*." There is a selective process of gaining acceptance into his family. Gay parents also described supporting their "*kids of choice's*" health by providing them with safer sex advice, holding testing parties as a family network, and being an example of an older Black gay man who is comfortable talking about relationships, sex, and sexuality among men. These young men are themselves serving as role models and community builders; they engage in activities and practices that serve to provide support for other LGBT persons, facilitate the health of their family members, and address oppressive beliefs about their

community. Through the construction of alternate families, they provide mechanisms of support for people who may otherwise lack it, or for youth who require a stronger support network to thrive amidst an oppressive social milieu.

Summary

Table 3 provides a convenient overview of the assertions related to this sample of young men. The young men who do not evince syndemic production exhibited a number of similarities suggesting that they have nurturing and supportive relational lives.

Table 3: Assertions related to men lacking evidence of syndemic production

	Men Lacking Experience with Syndemics
Pride	Black gay and bisexual males who do not evince syndemics, exhibit pride in their sexual identities and recognize that there are benefits associated with being gay and bisexual. Additionally, these men experience identity integration such that being Black or being a man is not mutually incompatible with being gay or bisexual. They are proud Black gay and bisexual men.
	Black gay and bisexual males who do not evince syndemics used three primary stigma management strategies to counter others' attempts to shame them: cognitive reframing, being dismissive of stigma, and the strategic avoidance of people and places that perpetuate heterosexism/homophobia. Young men used the aforementioned stigma management strategies to help them integrate facets of their sexual and religious identities.
Social Support	Black gay and bisexual men who do not evince syndemics received sexuality-related social support from their families or origin.
	Black gay and bisexual males who do not evince syndemics were initiated into gay culture through friendship networks and involvement in gay-community settings such as LGBT service centers, and AIDS service organizations; through these social service organizations, they further developed friendship networks, become a part of a gay culture that promotes health, and developed a healthy sense of group solidarity and connection.
Social Action	Black gay and bisexual males who do not evince syndemics supported their community through advocating for LGBT rights, working with HIV prevention and care efforts, or constructing supportive communities where gay and bisexual youth can find support and acceptance. They are actively working to affect change in their communities.

Men who evince syndemics

These young men were relationally distinct from the young men who did not experience syndemics in a number of key ways. They were also more likely to describe socio-structural inequities such as growing up in single parent homes, economic hardships, imprisonment, homelessness, and institutional discrimination. Socio-structural issues in the lives of these young men are not surprising given the relationship between socio-structural disadvantage and poor health outcomes. Additionally, these young men's interviews were permeated with descriptions of how their lives were challenging as a consequence of interlocking oppressions such as heterosexism, rigid gender roles, racism within their sexual partnerships, and biphobia in the gay community. Additional ways in which these young men differ from the first subsample may be seen in table 4 (see summary section), where it is evident that they have drastically different identity-related experiences and attitudes, ways of thinking about and relating to other gay and bisexual men, and levels of family and community support.

Shame

Assertion 1: Young men experiencing syndemics believe two or more of their identities (e.g., sexuality, gender, race, class) to be mutually incompatible. Some young men have constructed identity narratives intricately tied to their sexual assault histories and believe that their childhood sexual abuse caused them to be gay. In contrast to men who did not evince syndemics, this sample exhibited and expressed identity-related confusion and discomfort. Most exhibited characteristic attitudes and behaviors associated with internalized homophobia (e.g., aggressive denial of sexuality, sexuality shame, being closeted, and dislike of other obviously gay persons). These young men "*don't really like being gay"* "*don't want to be gay*" and "*can't get away from it."* They view coming to terms with their sexuality as

"*a learning process*." Their discussions of their sexual orientation and desires give the impression that they wish that they could have more control over their sexuality. Young men who did not evince syndemics believed that they were born that way, made the way God intended, or that their sexuality was "*natural*." In contrast, these young men described feeling "*consumed by gayness*" in a way that they could not control. They desired to "*figure out how to control my feelings*," wished that they could "*change [their] mind…not be that way*," or lamented that they could not just wake up one morning and be "*like everybody else*." A handful even intuitively connected their identity uncertainty to unhealthy, "*self-destructive*" behaviors:

> *like you always know when something's up with yourself and, you know being bullied a lot when I was younger and then, trying to conform into something that I wasn't, led me on a self-destructive way which led to drugs, alcohol, and then to sex and, other crazy stuff that you shouldn't do.*

For some young men, their beliefs about their sexuality were intricately connected to their childhood sexual abuse experiences. These young men came to believe that their current sexual identity or same-sex behavior was attributable to their sexual assaults. For example, one young man described how he wavers back and forth on whether he is "*supposed to be gay*," and describes how his confusion largely emanates from his family, especially his mother, who insinuates that his early childhood sexual abuse explains why he is gay. In and out of his life while he was a child, his mother frequently conveys to him that she feels "*guilty*" or at "*fault*" for both his abuse and his sexual orientation:

> *My momma, like right now, she feel guilty like or uncertain. She be thinking like it's her fault. And the older I get, I be like 'you know, mom. It's not your fault.' …. I could see her like this one year and I would say like I was dating. I was in a relationship*

and like a whole year me and her didn't talk 'cuz she's so like.. she's still like really guilty. Like this the part of me why I'm gay.

She believes her son's sexual orientation is a consequence of the abuse for which she feels guilty. He goes on to describe how she cannot handle seeing any evidence that he is gay because she is so wracked with guilt. As a consequence, this participant continues to associate his sexual desires with a traumatic experience. Additionally, he has been thrust into the position of trying to comfort and reassure his absentee mother, a situation that has left him wondering "*what's really going on with me*?"

Another young man, "*tortured*" by his male cousins for not acting appropriately masculine, also described how his early emotional and sexual abuse experiences created a current identity conflict. Repeatedly sexually abused by his older cousin who "*knew better*," this young man described being confused by how his cousin could "*touch on me at night*" and "*fool around with me at night*" but then "*beat me up and call me all kinds of a sissy and cupcake"* when around his brothers. His early childhood abuse experiences made him question the origins of his sexual orientation:

I think about it like I used to be like really into females like way more than I was into guys….I wonder am I gay because they told me I was? Like, I coulda just been you know one of them kinda guys that liked to dress well and get his hair cut and stay clean and sharp, but because that wasn't an image of, that's not what a man is supposed to be, that's weak , that's gay,…then that's who I became, you know

These young men constructed identity narratives that were tied to their experiences of sexual assault.

Other young men felt that their future possible selves were limited by virtue of being gay. They felt that to be a gay man meant that they would always be "*vulnerable*" or "*a target for someone*." Some felt that they could only be safe and happy if they were able to move elsewhere to a place where it was more acceptable to be a gay or bisexual Black man. They also thought that it was impossible to be a gay man and to have the kind of future that they desired:

> *I wouldn't have to worry about how I'm gonna have a child or, you know, if my gay relationship is going to last past 6 months. 'Cause it's just, you know, heterosexual people, I mean, you get married, you start a family, it's like normal. It's not really normal for gay people to have a family….I think the only thing that bothers me about being gay is the, I guess, the possibility of actually having a family. 'Cause I don't really know too many gay Black couples that are together and you know, are happy.*

Evident in this young man's excerpt is a fear about future relationship prospects that he describes as existing because he lacks happy, healthy relationship role models.

Some participants described their dual identities as Black men and gay men as at odds. These young men felt doubly affected by the amalgamated effects of racism and heterosexism. They also described how in the Black community "*it's really looked down upon if I'm African American and also gay*" because of preconceived notions of Black male masculinity that are at odds with stereotypes and misconceptions of being gay. Not all of these men wished that they could change their sexual orientations as a consequence; rather, some wished that they were white: "*Sometimes I wish I was white…I'm like oh my God I wish I was white because it was like white people just get their life as treated like gold*." They thought that they would be safer and more respected if they were white. Alternatively, they thought that being white would afford them more freedom to express themselves in ways that

they desired ("*it's easier for a white person to be gay and happy*"). For example, this young man wished that he could safely dress more like white gay men: "*What is the difference between me and him [a white man] wearing skinny jeans*?" He felt limited in his gender expression because he did not want to be treated like *"a fag."* To these young men, being Black was at odds with their sexuality and they felt that being both Black and gay limited their freedom of expression. Infused within this dialogue about Blackness being at odds with young men's sexuality was also evidence of class. It was the young men who described growing up "*in the hood*" or the "*ghetto*" who were particularly cognizant of how their gender expression may be perceived or were concerned about how they would be treated for violations of masculinity expression.

Finally, some of these men felt that their religious and sexual identities were at odds with one another. They internalized many of the negative messages about sexuality and HIV that they heard in conservative churches; did not attend accepting and affirming churches. Rather, they continued going to churches where they felt a need to hide their sexual orientation, or stopped attending church because they felt hypocritical attending. The other sample of young men stopped attending churches because they became atheistic, grew disenchanted with religious institutions, or were seeking out affirming churches. In contrast, these young men who stopped attending church did so because they felt they did not belong and that their gay identities were at odds with religious teachings (i.e., internalized homophobia). The following excerpt from a young man in Benton Harbor depicts this dilemma between his desire to be gay and his desire to attend church:

> *once I start going to church, I wanna really be 110% serious about giving my all to God and leaving behind my sexuality and everything else. …You know how we deal with things where we be like 'man, I don't want to be a hypocrite'. You know what I'm sayin'? I don't want to be going to church and still doing the same thing right*

after I get out of church. I don't wanna be like that…. Where I can just go in and say I'm done God, I give myself to you. I just hope it don't be too late before I get a chance to do that.

Here, it is evident that this young man feels a need to give up religion if he is gay, or give up being gay if he wants to attend church. He has internalized a belief that these facets of his identity are mutually exclusive. Young men who felt alienated and ceased attending religious institutions lamented that they did not feel safe and welcomed in their previous churches ("*I just threw it [my church] away*").

Lack of social support

Assertion 2: Unless they had older family members who were known to be gay, young men experiencing syndemics experienced extreme family conflict and alienation.

"*Fucked up*," that is how one participant concisely described his relationship with his family of origin. Others were equally as unforgiving in the language that they used to describe their relationships with their families. "*War*." "*Horrible*." "*Neglect*." "*Miserable*." "*Rocky*." "*Nasty*." These were the terms that participants used to describe their family relationships. Many participants described their entire family as having "*disowned*" or "*turned against*" them. Others distanced themselves from large portions of their family (e.g., all the men, their father's side) rather than be faced with a barrage of "*intolerance*," "*ignorance*," and "*discrimination*," and "*hate*."

Young men described their issues with their family as intricately connected to their sexuality. Growing up in families who spoke openly about their dislike for gay men made them fearful of coming out to family members; they described extreme apprehension about the decision to come out to their families. After coming out, they faced negative consequences: people in denial, verbal abuse, ongoing arguments, loss of support, and being

forced to leave home. Many also reported feeling like family members derided their masculinity by calling them names insinuating that they were effeminate, poking fun at their gender expression, blatantly telling them that they were "*less than a man*," or trying to get them to act in more traditionally masculine (i.e., tough and dominant) ways:

> *I said before earlier in the interview, as a Black man I'm considered to be this strong leading dominant character and me sleepin' with other men is seen as, you know, kind of less than a man or kind of as a weakness… some people in my family they don't necessarily think that makes me a strong character…[my male cousins] used to like literally torture me… I had to walk a certain way I had to eat a certain way I had to talk a certain way*

This young man went on to detail how his male family members would bully, physically abuse, and chastise him when they thought he was not adhering to traditionally masculine forms of gender expression; experiencing masculinity stress, he tried to avoid these relatives, attempted to follow their rules, and experienced extreme anxiety in their presence. Other participants reported similar expectations about their gender expression and comparable feelings and reactions. These young men grew to expect that they would be treated antagonistically and described chronic stress associated when interacting with particular – usually male- relatives.

Intolerant family members were not content to be silent on the matter of gender and sexuality, instead, young men were treated "*like I'm a joke*," were constantly "*criticized*," and in families where their sexual orientation could "*activate an argument out of just nowhere.*" Participants described their family lives as chaotic and people in their families as disrespectful toward them. A lack of family -and especially parental- acceptance was a key theme across the interviews; in reference to their sexuality, young men decried how people

"*didn't accept it at first*," "*accept me but [don't] really like it*," "*will never accept me*," and *"didn't accept me for who I was*."

Participants detailed a number of ways that their interactions with their families affected them. They described feeling guarded, unsafe, and disrespected when at home, some even to the point that they preferred to leave home as teenagers. They would lie about where they were going to avoid an onslaught of questions and ridicule; they would lie or suggest that their sexual orientation had changed and that they were again dating women. Others heart wrenchingly described the emotional toll that their family's intolerance or abandonment has taken on them:

> *So sometimes I feel like I wanna die… But it's like, not in a negative way, it's like, if I was to die or something like that then maybe they would realize, like, you know, that was my son, or that was my brother, and like I really shouldn't have treated him like that….and maybe it would make them be better to other people. Or, like better to themselves, like learn how to respect other people because they don't respect me…. it's like, I feel like I can help them by actually dying. Like they will start respecting people and respecting themselves.*

In the case above, the participant grew up in a family where he experienced sexuality-related problems with every member of his family and now does not communicate with anyone in his immediate family. This young man has given up on the idea that members of his family will ever respect and accept him. Rather, he views his premature death as the only way to get his family to change their beliefs and behavior.

He and other participants insinuated that they would be very different people were it not for the way that their families have treated them. As described in the following quote,

participants believe that they would be "*totally different*" if they had love, respect, and acceptance from their families.

> *I feel like if they would've accepted me for who I am instead of tellin' me how who I was wasn't right, then I could be a totally different person…. there was a point of time in my life where I didn't think about HIV at all. I just did whatever I wanted to do. So a lot of times, um, because I felt bad, or, like how the way my family's treating me, I just felt like the only thing I could turn to was sex. So I didn't care.*

In this example, the participant voices his belief that the negative treatment from his family is directly related to his sexual decision-making. Other participants described tuning out family members who would discuss sexual health matters because young men had lost respect for their opinions.

Two men described accepting family members. Both of these young men had older relatives (a biological father in one case; a grandmother in another) who provided them with sexuality-specific social support. Fears about coming out to their families were alleviated because they witnessed how their families interacted with other gay members. These young men reported family relationships similar to the sample of men who did not evince syndemics.

Assertion 3: <u>Young men experiencing syndemics are socially and relationally disconnected from other Black gay and bisexual males.</u> In contrast to the young men who were not experiencing syndemics, these young men were disconnected from or disenchanted with the gay community and struggled to develop, or avoided, platonic relationships with other Black gay and bisexual men. Whereas the men who did not evince syndemics developed friendship networks, these participants described themselves as "*kind of a loner*," "*not really a people person*," "*usually by myself*," and as a "*007, basically a free*

agent…available to no one." They are young men who prefer to "*ride solo*" and thus chose to avoid the gay community and others who are gay, or who "*feel like I'm in my own little world*" and are not accepted as a part of the local gay community. Social disconnect took an emotional toll on young men who wished either that there was more of a community to connect with (Outstate participants) or that the local gay community (Detroit) was more welcoming, safe, and diverse. As this young man described, being unable to connect with other gay men made him feel profoundly alone:

> *…it can mess with somebody's self-esteem. You know? It can make you feel by yourself. I have had those things happen to me before. You know you feel alone, feel like there's no one there just because of you being gay…it has forced me to go be, I mean go and become a loner.*

Participants who limited their interactions with other gay males or the gay community did so to protect themselves or because they did not feel safe and respected when around other gay people. Some of these young men, repeatedly physically and verbally abused due to their sexuality, chose not to associate with the gay community as a means of self-protection, as they worried that it would make them a target of anti-gay violence. The following young man explains why the only place he ever feels truly safe is at home by himself:

> *when it come to the end of the day, I'm by myself and don't gotta worry about hearin' nothin' from nobody. I can't handle the straight people, or gay people, I just hope my Black ass in my car, and I get the hell out, and I don't gotta worry about nobody saying shit to me or whatever…*

Whereas some participants feared anti-gay violence, others indicated a preference for being a loner because they had a difficult time trusting anyone:

…after my trust has been battered a lot…it makes me more guarded and so I don't let anyone in. And, you know, and it's hard because you can't trust people that you think you could trust …Just 'cause the way you look, the way you act. And if you're a vulnerable person like I was -I mean I still am- People are gonna take advantage of the situation.

This young man, sexually, verbally and physically abused throughout his life, feels a need to be alone to protect himself from further abuse.

Still other men did not trust how they would handle situations that they might encounter. The following excerpts describe cases in which participants were concerned about their potential to become angered:

I like being by myself. It's less bullshit. Less chance of me having to fuck somebody up.

I don't feel safe [in the gay community] because I have a lot of triggers. And if the trigger goes off, I'm gonna spiral out of control. I have done it before.

These young men -one with a history of imprisonment and the other with a history of institutionalization- rather than fear what others may do to them, feared what they might do to others in retaliation.

Other men, particularly those from Detroit and Benton Harbor, did not like what the gay community had to offer and did not feel accepted as a part of it. They described the local gay scene as one filled with "*drama"* and "*chaos*" and "*fighting,*" where someone was "*always trying to stab you in the back*." Others felt like it was "*too gay, gay as fuck*" and indicated that they did not like associating with stereotypical and effeminate gay men. On the opposite end of the spectrum, young men grew disenchanted with the gay community when

they felt like they were being stereotyped by other gay men. They felt as if they did not fit into the gay community:

> *I'm not like them. The gay community tries to make me feel guilty 'cause I don't know a damn thing about fashion, can't give relationship advice to females, and cause I'm not like in the gay scene*

This young man felt that to be accepted by the gay community, he had to be a stereotypical gay male. As a light-skinned, highly educated young man, he felt unaccepted in the gay and Black community because people think he is "*not Black enough and not gay enough*."

A sense of being betwixt and between was especially evident in the narratives of bisexual participants. They described how they and other bisexuals "*get it from both sides*" or "*get flak from the heterosexual community….[and] get flak from the homosexual community.*" They described envying gay people who could more easily find an accepting community to join. Bisexual people often feel they are "doubly closeted" due to their cultural invisibility (Zinick, 2000); these young men, however, felt misunderstood, "*persecuted*" and as if others were "*jealous*" of their ability to pass as heterosexual. Additionally, they felt that there was a lot of misunderstanding about bisexuality and that they were falsely aligned with men who were "*discreet*" or "*on the down low.*" Common cultural misconceptions about down low men at the time tended to paint them as sexually indiscriminate, promiscuous men who were likely to be HIV-infected. In contrast with the bisexual men in the other sample, these young men were ostracized as if they were on the down low and wished that "*people had like a better understanding of bisexuality in relationship to the down low*."

Though men did not feel safe with or accepted by other Black gay and bisexual males, some forged strong friendships with lesbians. A handful of participants, most of whom were from Outstate, described close personal friendships with gay women. They described feeling

safer around "*butch women*" than "*effeminate men*" and felt that they had more in common with lesbians. Those from Outstate also felt like there were more openly gay women because it was more culturally acceptable for them to be gay than it was for men.

Since many of these participants were not actively a part of a gay community, they could not explain how they became initiated into gay culture. When young men did describe how they became aware of or were initiated into the gay community, it was through a variety of high-risk venues: bars, parks, strip clubs, and websites such as Manhunt (i.e., a gay hook-up site). In the few instances in which participants described the friends that they had made through these venues, they described how their friends were bad influences:

> *Um, very bad ones I think. People who are very sexual. People who are alcoholics, drug-oriented, kleptomaniacs, users. The list goes on-and-on. Just very very bad people.*

Relational disconnect

Assertion 4: Young men experiencing syndemics are highly critical, disparaging, and mistrustful of other Black gay and bisexual males. These participants had a difficult time trusting people, particularly other Black gay and bisexual males. They described heightened states of anxiety in social situations with other gay and bisexual men where their "*guard is always up*" and they "*can't trust people*" or "*don't know who to trust.*" They attributed this lack of trust to their histories of abuse: "*you don't know who to trust 'cuz there's people out there that personally try to stomp on your heart, play games with you, personally try to hurt you, and abuse you.*"

These young men also held extremely negative stereotypes of other gay and bisexual males. They described Black gay and bisexual men as "*sluts*," "*hounds*" and people who are "*promiscuous.*" Some of these stereotypes they explained had been substantiated by their

peers and previous sexual partners who they described as having multiple concurrent sex partners, lying to their partners about their status and their other relationships, and being sexually indiscriminant. A few gave examples of friends who had purposefully refrained from informing their sexual partners about being HIV positive:

> *Well this one friend I had, he said that the reason why he doesn't tell people is because …he don't wanna have to build a relationship with them and then end up having to tell them and then reject him or turn away from him and then his business be on the streets*.

Some young men also held stereotypical and critical beliefs about Black men who were "thugs" or who appeared to be on the down low. According to these participants, the fact that there were so many down low, or DLs, in the Black community meant that it was difficult to trust that any Black man could be trusted to be faithful and not "*be double dipping*."

Participants felt like in their previous sexual experiences that they had been objectified; they described being hurt by former sexual partners who had just "*used [them] for [their] body*." They had encountered people who had "*played on stereotypes*" and had only wanted to "*have sex because you're Black*." These young men described how stereotypes about Black men being well endowed, being sexually adventurous, or having great sexual stamina made them feel fetishized and degraded. As one young man described, sex partners had treated him like "*an aphrodisiac, and not someone that [they] could possibly date*." Another participant described how he had been with "*people who have this….fetish, for, you know, dating people who are Black and is calling us slaves and all that crazy shit*." He and other men described how these encounters had left them feeling sexually objectified and treated like "*I was nothing to them*." They lamented that sex partners did not genuinely "*try to get to know me for who I really am*" and admitted that these experiences had "*hurt my*

feelings a lot." They also described how these experiences left them mistrustful of the intentions of new partners or people who appeared interested in them.

Lastly, these youth intimated a connection between their experiences of sexual abuse and their avoidance of gay male social venues and distrust of gay males. They described how previous experiences now made them feel unsafe around "*older*" Black men, men who tried to act like "*thugs*," or men who tried to act "*harder than other people*." The excerpt below aptly describes one man's avoidance of gay social venues as connected to his fear of further sexually violation:

> *some of them guys can get outa control. They wanna do certain shit whatever they get horny and shit. Especially like the older ones. They see a young looking boy or whatever walking past or whatever and they think it's ok to say whatever they can or they feel like they can touch whatever they can touch and they don't know it's not right. So that can be dangerous as well.*

This young man depicts the gay social scene as "*dangerous,"* a place where older predatory males act sexually entitled and harassingly.

Summary

Table 4 provides a convenient overview of the assertions related to this sample of young men. The young men who evince syndemics exhibited a number of similarities suggesting that they are profoundly relationally disconnected.

Table 4: Assertions related to men experiencing syndemic production

	Men Experiencing Syndemics
Shame	Young men experiencing syndemics believe two or more of their identities (e.g,. sexuality, gender, race, class, religious identity) to be mutually incompatible. They also construct identity narratives that are intricately tied to their sexual assault experiences.
Lack of Social Support	Unless they had older family members who were known to be gay, young men experiencing syndemics experienced extreme family conflict and alienation. Having another 'out' gay relative was an important contingency, as these young men did receive sexuality-related social support from their families of origin.
	Young men experiencing syndemics are socially and relationally disconnected from other Black gay and bisexual males. When initiated into gay culture, it was through high risk venues such as hook-up websites, bars, parks, and strip clubs.
	Young men experiencing syndemics are highly critical, disparaging, and mistrustful of other Black gay and bisexual males.

CHAPTER 4: DISCUSSION

In this study, I examined the relational lives of young Black MSM who have avoided syndemic production to understand how they differ in their socio-cultural relational characteristics from men who manifest syndemic production. To my knowledge, this is the first study to look at the relationship between protective resilience and syndemic production among young Black gay and bisexual men. To do so, I focused on the relational elements of these men's lives to elucidate community and interpersonal protective factors that may function beyond the individual-level to help these young men develop resilience.

The young men who avoided syndemic production all had rich, fulfilling, supportive relational lives (see figure 2). They described numerous providers of sexuality-specific social support. Across a variety of social contexts (e.g., family of origin, community based organizations, churches, and gay community), they reported relationships with empathic others who supported them as young Black gay and bisexual men, helped them develop a strong sense of personal identity, and provided them with opportunities to give back to their communities. These men sought out affirming environments, suggesting that they yearn for growth-promoting relationships. Living in Detroit, they were fortunate that community organizations, HIV service providers, and racially homogenous gay communities were available and accessible to them. They also reported a variety of affirming others who specifically supported their health behaviors. They had diverse relational networks of people –particularly family members, male friends, and men in the gay community- promoting pro-social norms about health behaviors. Armed with a strong cadre of empathic others, they were able to further define and appreciate their sexual orientation and develop strategies to mitigate the socio-environmental stressors they face as young Black gay and bisexual men.

In contrast, the young men who experienced syndemics described problematic relational lives (see figure 2). They described numerous forms of trauma and oppression across a variety of social contexts. Unlike the men who did not experience syndemics, these young men lacked relationships with others who might encourage and empathize with their identities as young Black gay and bisexual men. They lacked access to affirming social environments or did not experience gay-related venues as welcoming and nurturing. Rather, when these young men sought out what they hoped to be accepting environments, they experienced further marginalization. Their lives were defined by various forms of oppression that created and sustained shame, identity incongruence, isolation, relational disconnect, mistrust in other men, and an expectation of rejection and discrimination. For these young men, their previous experiences, coupled with systemic oppression, created a chronic apprehension about further marginalization. Lacking a cadre of empathic others, they were not able to define and appreciate their sexual orientation, develop strategies that may mitigate the socio-environmental stressors they face as young Black gay and bisexual men, or connect with diverse people who might promote pro-social norms about health behaviors.

The figure below displays two eco-maps. Eco Maps are visual representations highlighting the strength and quality of relationships between people and their microsystems. The figure depicts the high quality, supportive, diverse relationships that young men not experiencing syndemics described. These relationships were also defined by reciprocity, as indicated by the arrows in the figure. These young men engaged in various forms of social action that provided others with sexuality-related social support and promoted the health of their community. These young men's relational lives, as depicted, were in stark contrast to the tenuous, vulnerable, and abusive relational lives of the young men who exhibited syndemics.

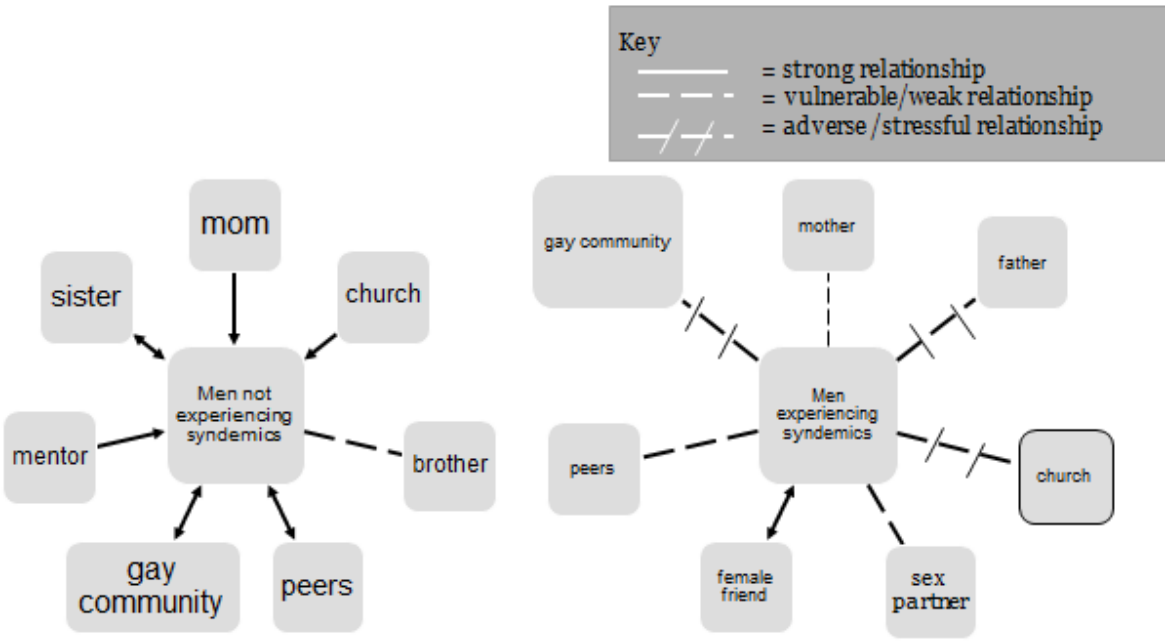

Figure 2: Representative eco-maps of young men's relationships

In the following discussion, I review key findings from this study relative to prior research on gay and bisexual men. Then, I will present a summary of the main limitations of this study, followed by implications for future research and practice.

Establishing well-integrated identities influences men's well-being

A key feature distinguishing men experiencing syndemics from men who did not experience syndemics concerned their achievement of an integrated identity. Given the challenge of integrating multiple socially devalued social identities, the ability of young Black gay and bisexual men to develop well-integrated identities is indicative of resilience (Harper et al., 2007). Though the men lacking syndemic production were significantly younger than the men experiencing syndemics (and sexual identity formation is a developmental process), they not only viewed their identities positively, but were able to cite numerous benefits of being young Black gay and bisexual men. Reasons why young Black gay and bisexual men viewed their identities positively correspond with constructs Herrick et

al. (2012) suggested may be indicative of resilience among MSM. Young men appreciated that their sexual orientation identities afforded them enhanced social connectedness, outlets for social creativity, and avenues of social activism. This finding suggests that social support, social creativity, and social activism contribute to a positive sense of self among these participants (see next sections). Additionally, it suggests that for young Black gay and bisexual men, there is a relationship between Herrick and colleagues' (2012) resilience constructs.

In contrast, the young men experiencing syndemics described various challenges integrating facets of their identities. Due, in large part, to racism, sexism, and heterosexism, young Black gay and bisexual males often have difficulty integrating various facets of their social identities related to sexuality, race/ethnicity and gender (Bowleg, 2012; Battle et al., 2002; Harper et al., 2004; Malebranche, 2003; Wilson & Miller, 2002). Identity development and integration is difficult due to pervasive societal messages denigrating their identities and cultural ideologies that suggest aspects of their identities are mutually exclusive (e.g,. conflating Black masculinity with heterosexuality; see Bowleg et al., 2011; Wilson et al., 2010).

Complicating the identity development process is the fact that young Black gay and bisexual males often face multiple types of oppression not only related to their sexuality and gender, but also to their race and economic situation (Harper et al., 2004). The young men experiencing syndemics reported experiences of heterosexism within Black communities and families, institutionalized heterosexism in churches, racism including from sexual partners, biphobia in the gay community, rigid gender role norms in their families, negative stereotypes of Black gay and bisexual men, early abuse experiences tied to their gender expression, and trauma-related identity conflict. These findings largely mirror those from other research with Black gay and bisexual males finding that their lives are challenging as a

consequence of interlocking forms of oppression and marginalization (Bowleg, 2012; Wilson et al, 2010). Because men experienced forms of social marginalization across numerous social contexts, these findings also suggest that Black MSM experiencing syndemics may have nonexistent or tenuous sources of support during a critical stage of their identity development.

Family sexuality-related support influences young men's well-being

These data provide examples of affirmative, sexuality-related support that is present within some Black families. Importantly, young men who avoided syndemic production had family environments in which they felt safe, accepted, and supported. They described how families provided sources of social and emotional support. Family members, implicitly and explicitly, taught them about gender roles, relationships, and sexuality. Family members actively conversed about participants' sexuality, advised them on how to remain safe, and spoke up against heterosexist and homophobic comments. Female relatives and gay relatives helped participants come to terms with and define their own sexual identities. Participants also described ways in which their families influenced their decisions to practice safer sex. Family members, particularly females, provided these participants with a great deal of sexual education information and made it clear to the young men that they were available for questions and advice. Young men often cited family these members as influential in their sexual decision-making; as such family was an important influence on their health and well-being.

For all young people regardless of their sexual orientation or identity, positive family relationships are associated with several healthy developmental outcomes through promoting psychological and emotional health and serving as a protective factor against drug use and high-risk sexual behaviors (Garofalo et al., 2008; Mustanski et al., 2012; Ryan et al., 2009).

Indeed, a systematic review of the literature on parental influences on the health and well-being of sexual minority youth showed that family relationships defined by support, acceptance, and connectedness are generally associated with improved mental health outcomes, lower risk of substance abuse, and protection from violence and victimization (Bouris et al., 2010). However, unlike their heterosexual peers, YMSM often cannot turn to their families for support, or fear turning to their families, because they espouse heterosexist beliefs and convey sexual prejudice. Fearing sequelae such as invalidation, discrimination, or rejection to disclosures of sexual identity, youth may choose to conceal their sexuality from family. As the analysis of the young men experiencing syndemics indicates, in these situations, youth often find themselves feeling relationally disconnected or isolated from their families, and mistrustful of any advice they may have to offer.

Young men infrequently mentioned male family members as sources of sexuality-related social support. Indeed, many of the most hostile and tenuous relationships that young men described were with the males in their immediate and extended families. Young men often described male family members as perpetuating theologically driven homophobia, maintaining rigid gender ideologies, and verbally and physically abusing them for reasons related to their sexuality and gender expression. Male family members' intolerance and abuse toward their non-heterosexual relatives was unfortunately unsurprising. Research literature shows that Black males have more negative attitudes towards gay males than do Black women (Herek & Capitano, 1995) and that male family members are less tolerant and accepting of male relatives who are gay than are females (D'Augelli, et al., 1998). Additionally, there is a rich literature on the social shaming, gender policing, and violence that men perpetuate against other males who are gender non-conforming and/or non-heterosexual (Connell, 1987:1995; Diaz, 1998).

It was often women in the lives of young men not experiencing syndemics that played identity-affirming and health promoting roles. Historically, women have played key roles in drawing attention to the HIV crisis in Black communities and have played keys roles in the prevention of HIV among gay and bisexual men (Cohen, 1999; Hill Collins, 2004). Females are also typically more accepting of gay and bisexual men than are males (Dube, & Savin-Williams, 1999; D'Augelli, et al.,1998; Garofalo et al., 2008; Mays, et al., 1998); some gay and bisexual men even cite close knit friendships and bonds with woman as among the key advantages of being gay (Harper et al., 2012). Furthermore, other than their peers, mothers are frequently cited as a primary means of social support, including sex-specific social support, for young gay and bisexual men (Doty et al., 2012). Recent research also suggests that Black mothers are as likely as Caucasian mothers to be accepting or tolerant of their child's sexual orientation (Garofalo et al., 2008).

That young men described families as influencing their identity development and sexual decision-making suggests that family support and acceptance may be an important influence over young Black gay and bisexual men's psychological well-being and sexual behavior. The research literature offers a few explanations as to why family support may be particularly protective for young Black MSM. First, studies consistently show that factors protecting Black youth from sexual risk behavior originate in the family (Brody et al. 2001, 2002; Murry and Brody, 1999). Researchers who study the effect that parents and family members have on Black youth's sexual behavior argue that African American's family-centered orientation and the cultural primacy emphasizing the family is what makes the family environment serve such a powerful protective role in buffering Black youth from engaging in sexual risk behavior. Second, from a developmental perspective, young Black gay and bisexual men may have fewer other venues and communities through which to validate and develop healthy, integrated identities as young gay and bisexual Black men.

Third, Black YMSM face challenges integrating their sexual, racial, and cultural identities (Tremble, Schneider, & Appathurai, 1989). As these data indicate, and research substantiates, the need to manage more than one stigmatized identity can increase youths' vulnerability and stress (Harper, 20007), particularly when identifying as or expressing one facet of identity (e.g., sexuality) may jeopardize their acceptance by their family or in other communities. As such, identity-related support and affirmation from one's family may help facilitate identity integration and alleviate or buffer identity-related dissonance that young men may experience. From a developmental perspective, this type of family sexuality support may be particularly important for adolescents still reliant upon their families for alternate forms of support and who may have limited access to gay community networks.

Affiliation with gay communities defined by peer norms for health influences well-being

The young men who did not evince syndemics desired participation in the gay community and had access to gay-specific community organizations that they experienced as accommodating of their needs. For these young men, groups and organizations that enhanced interconnectedness and friendships functioned as important social supports. Involvement in gay community meetings, social events, and community-building opportunities were a way for these young men to build positive connections with other youth and adults who helped them cope with health-related stressors, taught them that their sexual identities were natural, and showed that life as a Black gay man can be fulfilling and fun.

The young men who lacked syndemic production also discussed how formal LGBT and HIV service organizations functioned to provide them with pro-social avenues of community involvement. Young Black gay and bisexual men have a desire to facilitate the health and well-being of their community and to engage in community building activities. Ramirez-Valles & Diaz (2005) demonstrated an empirical link between community

involvement and self-esteem and social support among adult gay Latino men. Likewise, these data suggest that the venues that these young men frequented afforded them community involvement opportunities and sexuality-related social support. Young men appreciated that their sexual orientation identities afforded them enhanced social connectedness and avenues of social activism, further suggesting that communal social support and social activism contributed to a positive sense of self among these participants.

For the men who did not experience syndemics, HIV service organizations, gay families, LGBT centers, and gay friendship networks function as "counterspaces," or settings that enable adaptive responding in marginalized individuals (Case & Hunter, 2012).Counterspace settings have a long history in both Black and gay culture, serving as non-oppressive spaces where marginalized individuals can connect with a community of others who share similar experiences and who engage in mutual support. In these counterspaces, young men can amass resources to help them deal with or buffer oppressive experiences and develop a group affiliation that can help them develop and situate their identities that are largely socially devalued. These data suggest that these settings served as alternative spaces in a number of key ways that might facilitate men's identity development and health behavior. In these settings, they developed kinship networks that helped reduce feelings of isolation and exclusion. They engaged in identity-affirming activities and events that celebrated aspects of their identities. They learned to be critical of hegemonic constructions of sexuality and masculinity, which may have helped them make sense of negative experiences (Wexler, DiFluvio, & Burke, 2009). Developing group affiliations also may have helped them develop a sense of purpose that contributed to their community-building and social action desires and activities. As others have noted, establishing and building community affiliations with supportive groups may help young men identify larger purposes and goals, which is important for supporting resilience (Wexler et al., 2009). In

short, these relational connections helped young men reconceptualize their experiences of oppression, provided them with a group-based identity, and instilled in them a broader sense of purpose.

Young men also described these settings and the relationships forged with peers and mentors within them as facilitative of positive sexual health norms such as condom use, HIV testing, and monogamy. A recent literature review on HIV among Black MSM showed that studies consistently show that strong peer norms for condom use and other safer sex behavior among black MSM strongly predict less frequent sexual risk behavior (Maulsby, et al., 2014). In these groups, young men developed perceptions of normative health behavior among other men; perceptions of other men's health behavior –particularly men who are perceived to be like them- provide information about health behaviors to adopt or not adopt. Belief that gay men's perceptions of other men's normative health behavior influences HIV risk behaviors was the impetus behind Kelly and colleagues' (1991) popular opinion leader intervention, as well as other HIV interventions, such as MPowerment, that utilize community-mobilization and peer-based strategies (Kegeles, Hayes, & Coates, 1996; Kegeles, Hayes, Pollack, & Coates, 1999). For these young men, supportive mentoring and peer support for condom use and safer sex practices were key relationships facilitative of their sexual health.

These findings align with and extend Ramirez-Valles' (2002) conceptual framework delineating the protective effects of community involvement for gay and bisexual men. Ramirez-Valles' (2002) model suggests that involvement in the gay community and HIV-related groups and organizations promotes men's health by reducing alienation, promoting positive peer norms, developing self-efficacy, and enhancing positive sexual identity. These data suggest that involvement in the gay community and HIV-related groups and organizations also serves to ignite young Black men's drive to engage in social action, thus providing them with new pro-social opportunities for community engagement. While

Ramirez-Valles' model is based on literature with adult (largely white) MSM, its alignment with these data implies that it may be useful to consider its adaptation as a framework for conceptualizing the broad protective effects of community involvement and social engagement for young Black gay and bisexual men. However, such an adaptation may need to conceptualize social action broadly to account for differential participation that may be a function of development; in this study, older men participated in more formal capacities within LGBT and HIV service organizations and were often in roles akin to those of role models and mentors; in contrast, younger men participated in forms of community engagement in less formal capacities. This finding may reflect developmental differences in availability or accessibility to (or the desirability of participating in) gay community networks.

Men exhibiting syndemics experience heightened minority stress and social isolation

The young men experiencing syndemics recounted numerous instances of trauma and marginalization, experienced identity-related conflict, were rejected by their families of origin, lacked social connectedness, and were avoidant of opportunities to establish relational connections with other Black gay and bisexual men. They experienced social marginalization across numerous social systems that was perpetrated by multiple people (e.g., family members), communities (e.g., gay community), and institutions (e.g., churches). These findings largely align with and extend Dyer and colleagues' (2012) study of syndemic antecedents among Black MSM. Dyer et al. (2012) found that factors associated with syndemics among Black MSM included: victimization, a lack of social connectedness in childhood, masculinity struggles, and internalized homophobia. In my study, findings also suggest that social disconnection follows men into adolescence and young adulthood, identity-related struggles are not confined to issues related solely to young men's gender and

sexuality, identity-related issues may be strongly tied to men's early victimization experiences, and familial discord and isolation may be additional precursors to syndemic production.

Young men experiencing syndemics had early socialization experiences and psychosocial issues that may attenuate their desire or ability to form strong or healthy relational connections. Is it any wonder that young men experiencing syndemics are relationally disconnected and socially isolated? In the literature on relational resilience, syndemic participants might be said to be living in a state of condemned isolation, an experience of aloneness that occurs when repeated shame, humiliation, and marginalization occur (Hartling, Rosen, Walker, & Jordan, 2000). The participants experiencing syndemics faced numerous barriers to relational connection. First, the psychosocial issues that they experience – depression, substance abuse- tend to be associated with social isolation. Second, sexual abuse, trauma, and marginalization have taught them that it is difficult to trust other people, especially men. Repeated shaming, rejection, and abuse due to their sexuality has led them to believe that being gay or associating with other sexual minorities is dangerous and unsafe. Amidst this backdrop, further alienation, marginalization, and abuse within gay spaces thought to be safe havens may be particularly detrimental to young men's desire or willingness to connect with others. Third, young men still struggling with their sexuality – as these young men were- do not want to be gay and have developed internalized homophobia and problems integrating various facets of their identities. This internalized homophobia is not only associated with a sense of being different and alone, but also a devaluation and criticism of other gay and bisexual males. As such, sexuality-related support systems, even if available and deemed safe, likely do not hold much appeal for these young men.

These findings suggest that stigma, marginalization and trauma are primary causes of the low sense of self-worth that young Black MSM experience. Theoretical frameworks such

as the minority stress model provide hypotheses as to why increased exposure to abuse and marginalization may be associated with syndemics. Meyer's (1995; 2003) minority stress model examines social minorities within a social and community context and emphasizes the impact of stigma and marginalization on gay men's development and health. The minority stress model attributes the higher prevalence of psychosocial health issues found in sexual minority youth as compared with heterosexual youth to the additive stress resulting from nonconformity with prevailing sexual and gender norms. This model posits that internalized homophobia (i.e., self-appraisal that adopts society's negative attitudes about sexuality), expectations of stigma (i.e., anticipation of rejection and discrimination), and experiences of marginalization and trauma (i.e., physical, verbal and sexual abuse due to a person's identity) have detrimental impacts on sexual minorities. In these data, young men experiencing syndemics exhibited not only internalized homophobia, but other identity related stressors. They all had histories of trauma, with many having experienced numerous forms of trauma within a variety of social environments (e.g., family church, Black community, gay community). Their continuous vigilance, avoidance strategies, and stated fears of future violence suggest that they live a guarded existence whereby they have grown to anticipate rejection and abuse.

These data, considered in light of the social minority stress model, suggest a variety of different pathways through which marginalization and trauma may have negative consequences on the health of Black MSM. For men who so closely relate their sexuality (and perhaps others' sexuality) to their childhood sexual assault experiences, the coming out process may be even more complicated. If in men's minds their sexuality is a consequence of sexual abuse, then the thought of coming out may be coupled with the fear of admitting to being a victim of sexual abuse. Minority stress may keep men from desiring or establishing alternative sources of support, particularly support that may be affirmative of their identities

as gay and bisexual men; in these data, men were largely avoidant of other MSM, critical of large portions of the gay community, apprehensive about 'stigma by association,' and disinterested in being a part of the gay community. Additionally, minority stress may precipitate distrust not only of other men, but of families, peers, and health care professionals. Indeed, the possible connection between marginalization and the reduced likelihood of young Black MSM engaging in health-seeking behaviors or being receptive to health-related advice is cause for alarm. Minority stress may make it difficult for men to form healthy relationships –platonic, sexual, or otherwise, - with other men. These men exhibited a propensity to prefer and feel safer in the company of lesbians and other women, a finding that makes intuitive sense given that it is often men who are the perpetrators of violence (and women who are more accepting of sexual minorities). It may be particularly difficult for them to form relationships with men who promote healthy norms due to their propensity to avoid places that attract men whose relationships are defined by positive sexual health norms. Additionally, men who experience childhood abuse or abuse perpetrated by much older men may be avoidant of older MSM who might otherwise serve as role models or mentors. Finally, minority stress may lead men who do desire to have relationships with other men to seek them out in discrete, high-risk social environments where they might be afforded some degree of anonymity. Findings indicating that young Black MSM frequent diverse locations, have diverse friendship and peer networks, and become initiated in the gay community via very different venues implies a need for studies that examine young Black men's sexual network characteristics (Millett et al., 2007).

Participants lacking syndemic production lived in Detroit

It is notable that Detroit participants accounted for 97% of the participants in the YMHS who exhibited a lack of syndemic production. Considering the analytic findings in

tandem with Detroit's geography provides a few plausible reasons why living in Detroit may limit syndemic production among young Black gay and bisexual men. The following are a few explanations as to why young men in Detroit represented the majority of participants who avoided syndemic production.

None of the participants from Detroit described racism or racial micro aggressions within gay community settings. Lack of racism in gay community settings likely makes social services and friendship networks more welcoming and affirming to young Black gay and bisexual men. Unlike most of the rest of the state, Detroit's population is relatively racially homogenous. Most of Detroit's residents are Black (82.7%) and this demographic make-up has a few possible implications for young Black MSM (U.S. Census Bureau, 2010). First, as a function of these demographics and the devastating toll that the HIV epidemic had on Black MSM in the city, Detroit is among the few places in the state that has evidence-based interventions specifically tailored to the cultural needs of young Black MSM (see below). Detroit's racial make-up may also mean that racism and heterosexism/homophobia (structural barriers to health) manifest differently in Detroit. Racism, in particular, may be less widespread in a city that is predominantly Black, as the gay community would be likely to reflect city demographics. Racism within gay communities and in gay settings is frequently experienced by Black gay and bisexual men (Bowleg, 2012; Malenbranche, Peterson, Fullilove, & Stackhouse, 2004) and is one reason why Black MSM find the gay community exclusionary (Bowleg, 2012; Kraft, Beeker, Stokes, & Peterson, 2000).

Young men in Detroit exhibited a heightened sense of awareness about HIV within their community and had availability to prevention programming (see below) specifically tailored to Black MSM. Indeed, many of the young men who lacked syndemic production were involved in HIV prevention and testing activities, suggesting that they took advantage of these community resources. Ggeographically, Detroit is the place where the HIV epidemic

is concentrated in the state. Nearly two-thirds of HIV-infected MSM reside in the Detroit Metropolitan area (Michigan Department of Community Health, 2010). High HIV prevalence concentrated in the Detroit area has resulted in increased HIV prevention programming and funding directed to the Detroit Metropolitan area; the Michigan Department of Community Health allocates nearly three-quarters of the their prevention funds to the Detroit Metropolitan area (Michigan Department of Community Health, 2012c). Areas outside of the Detroit Metropolitan Area lack HIV prevention programming, which was identified as a significant service gap in the most recent Michigan HIV Prevention Comprehensive Plan (Michigan Department of Community Health, 2012c).

Young men who did not exhibit syndemics attended many of Detroit's LGBT and MSM-specific advocacy and community-based organizations, including organizations and programs culturally tailored to the needs of Black MSM. At the time of this data collection, Mpowerment Detroit had operated in Detroit's Greek Town for 5 years. Mpowerment Detroit was an HIV intervention adapted for Black MSM based on the CDC's evidence-based intervention, The Mpowerment Project; Mpowerment Detroit also helped create the HIV prevention infrastructure for Detroit's Black MSM population (Miller, et al., 2012). We interviewed many of the Detroit participants at Mpowerment Detroit (and similar service centers). A number of participants attended Mpowerment events or were active members of the Mpowerment Project, meaning that they had access to an intervention culturally tailored to their needs. Additionally, attending Mpowerment related events put them into contact with other young Black MSM who may be likely to support positive health-related norms and provide sexuality-related social support; program participation also provided them with social action opportunities. Indeed, Mpowerment's community-mobilization emphasis, peer-based prevention strategies, and attentiveness to sexual orientation identity issues means that it is a

probable conduit for promoting multiple forms of resilience (e.g.,. pride, sexuality-related social support, social action) in its members and program participants.

Young men who avoided syndemic production described not only participating in alternative families, but creating gay families for other Black sexual minority youth. These alternative family structures may be more likely to develop in locations such as Detroit where there is historical model for them embedded in both gay and Black culture. As described above, Detroit is a predominantly Black city and Black persons have a collective social orientation whereby individuals often rely on extended and constructed family networks for managing risk and adversity (Utsey, Bolden, Lanier, & Williams, 2007). Detroit also has a thriving house/ball community (Miller, et al., 2012) which provides a family-like structure for racial minority MSM (Arnold & Bailey, 2009). Gay or alternative families often develop within the house/ball scene. Young men in such an environment may well have models upon which to base the development of alternative families.

Detroit is a location seeping with socio-structural barriers to health such as violence, poverty, broken families, political turmoil, and poor educational opportunities. Yet amidst these structural barriers to health, a number of young Black gay and bisexual men have managed to remain healthy, thriving young men set on community building. The picture that these analyses paint of Detroit is one of an environment that offers peer and community-based support, supplies community-based resources that serve as 'counterspaces', and provides incentive and opportunities for social action. Indeed, the racially homogenous construction of Detroit, coupled with the devastating toll that HIV and other social issues has had on Detroit residents, makes the city a prime location for the development of indigenous prevention approaches (Arnold & Bailey, 2009). As a result of historical injustices and research-based mistreatment, one of the main strengths of the Black community is the tendency to develop their own culturally-specific protective and preventive strategies to

address health and social injustices (Wyatt, 2009). It may well be in places such as Detroit where socio-structural challenges are rampant and achieving health seems bleak, that innovative and resourceful health-promoting strategies among marginalized groups are the most apparent. In these locations, researchers and evaluators might evaluate homegrown interventions targeting young Black gay and bisexual men.

Syndemics and the psychological sense of community

Stall originally hypothesized that as gay men access gay community networks, they must balance the stressors and resources that come with participation in a new setting. These data show that not all MSM experience the gay community in the same way. Some may experience it positively and derive numerous benefits from involvement; others experience the gay community negatively and seek to avoid it or limit their contact with people who are involved with it. These men's divergent experiences with the gay community may be viewed in terms of community psychology's concept of the psychological sense of community.

For men who have avoided syndemics, involvement with the gay community appears to have afforded them all of the benefits associated with a positive psychological sense of community: a feeling of belonging and membership in a group; mutual influence or the ability to impact the community and visa versa (e.g., social action); fulfillment of their needs; and a sense of shared emotional connection with other men (McMillan & Chavis, 1986). This possibility suggests that in the study of syndemics, there is a need to explore men's positive psychological sense of community as a moderator of adversity. Typical measures in health-based research regarding participation in the gay community often include measures of involvement in events, or even single-item measures asking whether people consider themselves as part of the gay community (Frost & Meyer, 2012). These measures do not account for the cognitive/affective components of how men experience their community

involvement. The fact that men who avoided syndemics described their gay community experiences in a way that approximates a positive psychological sense of community suggests that in the empirical study of syndemics, it may be more appropriate to use measures of community connectedness such as the psychological sense of community among gay men scale (Proescholdbell, Roosa, & Nemeroff, 2006).

Second, research on the psychological sense of community may also shed light on the apparent relationship in these data of the coexistence of sexual identity pride, gay community connectedness, and social action. Developmentally, many gay men initiate contact with the gay community after self-identifying as sexual minorities; open participation in the gay community is therefore often precipitated by passing through some gay identity developmental milestones (Stall et al., 2003). Regarding a positive psychological sense of community, research suggests that there is a bidirectional relationship between a stronger sense of community and proactive involvement in that community (Florin & Wandersman, 1984; McMillan & Chavis, 1986). In other words, as men are afforded opportunities for social action consistent with their emerging identities as gay and bisexual men, it may promote a higher sense of community; relatedly, a higher sense of community (which may be related to one's sexual identity development at the individual-level) may promote social action. Identity-related theories would suggest that more investment in and commitment to a group would, in turn, translate into enhanced salience of one's personal identity (Stryker, 1980; Tajfel & Turner, 1986).

Research by Brodsky and colleagues (1999) also shows that people's sense of community is associated not only with individual-level characteristics (e.g., identity development, abuse history), but also with characteristics of the community itself (Brodsky, O'Campo, & Aronson, 1999). Put another way, there are individual level correlates, as well as community level correlates, of a positive psychological sense of community. Because all

the men who avoided syndemics and reported positive community involvement were from Detroit, it suggests that there are indeed community-level factors associated with men's sense of community. These data only allow for conjecture to be made as to what community-level factors may promote a positive sense of community among young Black MSM (e.g., racial homogeneity, norms of sexual identity and gender identity inclusivity, youth-specific resources, heightened awareness of a social problem- such as HIV- around which to rally). Importantly, the fact that there are ostensibly community level correlates of a sense of community among young Black MSM suggests that it is not merely men's early experiences that affect community involvement. As such, future research should identify community-level factors associated with a sense of community among young Black MSM so that community interventions can be designed in ways that promote a positive sense of community.

Research on the psychological sense of community may also provide an explanation as to why family sexuality-related support and a positive sense of community occurred concurrently. Brodsky (2009) implies that the understanding of an individual's sense of community must take into account one's relationship to other communities (notably, Brodsky also conceptualizes families as a community). Brodsky's research implies that familial disapproval of one's involvement in another community often requires that a choice be made between one's family and one's alternative community. For young men who did not experience syndemics, such a choice may be unnecessary given that they received family acceptance of their sexual identities. For these young men, gay community involvement may not require breaking with family or result in a loss of family support. For young men who evinced syndemics, such a choice may be necessary given that they received little or no familial support for their sexual orientation identities. If expression of their sexual orientation identities is met with discord, dissatisfaction, and hostility within their families (often their primary support systems when young), then men at a developmentally tenuous time in their

lives may feel a need to choose between family support and expression of their identities. As there may be an association between men's relationships with their families and their relationships with the gay community, it is even more imperative to assess men's relational experiences, support, and resources across contexts.

As the narratives of the young men experiencing syndemics imply, men's interactions with the gay community are not always positively reinforcing experiences. Brodsky conceptualized the psychological sense of community as being either positive or negative (Brodsky, 1996:2009). It can be argued that men evincing syndemics experience a negative psychological sense of community. Brodsky's (1996) analysis of low-income single mothers in physically dangerous neighborhoods suggested that for many women, identifying with and depending upon communities was perceived to be threatening; in response, they isolated themselves and their children as a protective strategy. These women saw withdrawal from community life as having benefits that outweighed the awards of membership (i.e., a negative psychological sense of community). Likewise, the young men in this study who avoided or kept a wary distance from the gay community largely avoided it for self-protective reasons. Like the young women in Brodsky's (1996) study, these men may not receive the benefits of community support and resources. If these young men's goal is to protect their safety and avoid further marginalization, then their decisions are adaptive responses given that they have experienced oppression, marginalization, and violence across numerous settings. Examined from this perspective, these men are also resilient. Brodsky describes people who are developmentally thriving and people who adapt to negative circumstances as both being resilient. The men who chose to become social isolates or avoided gay community life may thus be conceived of as resilient in that they are attempting to protect themselves from further marginalization.

Limitations

I conducted this analysis retrospectively using a secondary data source. As a needs assessment, the YMHS was designed to give a broad perspective on the HIV prevention needs among Michigan's young Black gay and bisexual men and to identify factors associated with the health and well-being of this community. Ideally in a qualitative study, data collection and analysis occur iteratively so that researchers can examine emergent themes more thoroughly in subsequent cases; that is to say, data collection and analysis are inextricable. This process allows researchers to strengthen the evidentiary warrant for, and identify further key linkages between, their assertions. Using an iterative approach, I could have examined a key topics in a more nuanced manner.

For the purposes of these analyses, the data also did not examine, in a nuanced way, participants' sexual assault experiences. Indeed, many participants did not allude to their history of sexual assault until the end of the interview when asked quantitative questions (e.g., age, perpetrator) regarding their experience. Where qualitative data describe participants' experiences with sexual assault, this information was not elicited by the interview protocol. I based assertions related to sexual assault a small subsample of participants who chose to disclose this information. It was evident among a handful of participants that they had a strong desire to discuss their sexual abuse experiences. Some participants' current difficulties accepting their sexual orientation identities and relating to other gay and bisexual men were tied to their early abuse experiences. Because we did not ask open-ended questions about assault experiences, it is unknown whether participants aside from those who organically spoke on the topic experienced similar difficulties as a function of early abuse. This limitation, coupled with the paucity of research on the sexual abuse

histories of young Black gay and bisexual men, indicates a critical need for future research to replicate and extend these findings.

There are a few limitations due to the YMHS sampling approach that are relevant to the current analysis. In the larger YMHS study, we attempted to use respondent driven sampling as our primary sampling technique. As data collection progressed, we shifted to a convenience sampling approach (a typical methodological limitation in samples of sexual minority youth). In Detroit, many of the venues where we recruited young men were social service agencies. In contrast, many of the venues where we recruited young men in other locations were from higher-risk venues such as gay bars. This approach may have interjected sampling bias into our sampling pool in a couple of ways. Our ability to recruit from social service agencies in Detroit may have led us to a characteristically distinct subset of young Black MSM youth who: 1) are more formally engaged with the gay community via established social service and community based organizations, 2) are more informed on and committed to working on issues related to and affecting young Black MSM, and 3) are more comfortable with and accepting of their sexual orientation identities Recruiting from higher-risk venues in other locations may have led us to more high-risk participants. However, it was not uniformly true that we solely recruited from high risk venues outside of Detroit. We did recruit in HIV service and LGBT-serving agencies outside of Detroit; however, outside of Detroit, these agencies were not exclusively youth serving. That the agencies in Detroit were youth-centered in orientation and focus may thus represent another key distinction that sets them apart when it comes to working with and serving the needs of young Black MSM.

In addition, the YMHS recruitment approach and eligibility criteria limit the extent to which findings can be generalized to the larger population of young Black MSM. Our sample favors young men who would respond to an invitation to be in a study about young Black MSM. Respondent driven sampling was conceived of a way to locate and interview harder to

reach subsamples of MSM such as those who were on the down-low, engaged in sex work, or transgender. We had limited success in tapping into these subcultures. Additionally, all of the participants who avoided syndemic production were from Detroit, a large urban city that is mostly Black and contains a large gay and bisexual male community. Demographically, and in terms of resources, Detroit thus represents a unique urban center for young Black gay and bisexual men. Whereas this finding is a limitation in terms of generalizability, it also points to the necessity of appreciating contextual differences when studying protective factors and syndemic processes in the lives of young Black MSM.

Finally, the present effort was cross-sectional in design, so caution in interpreting causal relationships among identified assertions and the production or avoidance of syndemics is warranted. This analysis represents a thin slice in the relational lives of these young men. My study and methodological approach represents an appropriate starting point given the absence of an empirical basis for the study of resilience among young Black MSM. However, this design does not allow us to form confident conclusions about the causes of syndemics of the avoidance of syndemics among young Black gay and bisexual men.

Implications for research

This study holds a number of implications for the study of syndemic mechanisms among YMSM. One of the stories worth celebrating in these data is that marginalized men from a place such as Detroit are developmentally thriving. Though only conjecture can be made as to why Detroit may serve as protection from syndemics among Black MSM (e.g., racial demographics, availability of resources), this finding shows the importance of considering geography in studies of syndemics. The syndemics conceptual literature (e.g. Singer et al., 1996; Singer & Clair, 2003) articulates syndemics as the temporal and locational co-occurrence of epidemics; these authors argue that because syndemics are

largely socially produced phenomena, they must be considered in context. Stall and colleagues' (2008) original conceptualization of syndemics, likewise, suggests that location matters because it influences the availability and accessibility of resources. Yet much of the empirical literature has avoided assessing how location may affect syndemic production, syndemic maintenance, or the experience of syndemics. In empirical population-based studies, it has often been the case that samples are compiled across varied geographical locations (Dyer at al., 2012; Herrick et al., 2012; Stall et al., 2003). For example, Stall and colleagues' (2003) original empirical paper outlining their syndemic framework among MSM utilized a sample from Chicago, Los Angeles, New York, and San Francisco. Yet it is likely that these locations may differentially influence susceptibility to syndemic conditions. Researchers studying syndemics empirically might begin to account for the influence of place by studying syndemics in isolated communities and locations, assessing geographic differences in syndemic production within similar communities, or looking at how factors such as migration affect syndemic susceptibility.

Findings from this study regarding young men's identities have implications for the study of syndemic mechanisms. In the syndemic literature, researchers have found that identity-related constructs (e.g., internalized homophobia, masculinity attainment) are significant independent variables associated with syndemic production (e.g., Dyer et al., 2012; Herrick et al., 2012). However, these data suggest that using identity related variables in isolation as predictors of syndemic production may paint too simplistic a picture of the struggles that these young men experience. For example, a novel finding of this study is the suggestion that young men's early experiences of abuse influenced their current identity-conflicts. The finding that young men's abuse and trauma experiences are influencing identity-development and integration suggests a need for more complex causal modeling in quantitative studies of syndemic antecedents.

An important limitation of Stall et al.'s (2008) model is that it was developed based on research with middle-class, American, gay-identified men. This limitation, coupled with findings from this study, suggest, there are a few additional ways in which the syndemic literature may more aptly account for the complexity of identity-related issues that racial minority MSM may experience. As this study showed, these men's lives are rooted in structural inequalities such as racism, classism, sexism, and heterosexism. Their identity-related conflicts are not solely related to their sexual identities, but rather to the intersection of their race, gender, class, and sexual identity. As these studies tenuously suggest, race, class, ender presentation and/or sexual orientation may intersect among Black MSM in ways that influence vulnerability to syndemics. Empirical studies of syndemics among Black MSM have not yet accounted for other identity salient factors such as race (Dyer et al, 2012). At the least, studies inclusive of racial minority men should consider racism and racial identity formation as precursors of syndemic production. Second, it may be useful to further examine how young Black gay and bisexual men experiencing syndemics describe and experience the multiple intersections of their race, gender, and sexuality. Third, as these data suggest, these young men have differential experiences, opportunities, and access to resources based on their sexual orientation, class, gender expression, geographic location and/or appearance. For example, in these analyses, young bisexual men may experience the gay community differently than young gay men; or, there may be class-based differences in regards to masculinity norms and experiences of masculinity stress. These findings suggest that in studies of syndemics, it may be important to consider within-group differences, or to examine syndemic production or resilience among particular subsamples of young Black MSM such as those who are bisexual, on the down-low, or who are gender nonconforming. Additionally, given that there are elevated HIV prevalence rates among gay men of color, an expansion of

the syndemic model to include effects of and responses to alternate types of stigma (e.g., racism) is warranted.

This has been the first study using a syndemics framework to consider family as a source of resilience among young Black MSM. In fact, only one other study to my knowledge has examined family-related variables in relation to syndemic production (Herrick et al., 2012). Herrick and colleagues found that parental substance abuse and parental domestic violence were each independently associated with syndemic production among adult MSM. This empirical oversight is a glaring omission from the syndemics literature given that syndemic production is conceptualized as a developmental theory and family is a primary socializing setting for youth. Additionally, this omission is glaring given the preponderance of family related factors that have been associated with outcomes related to sexual health and HIV transmission among YMSM (Mustanski et al., 2011; Mustanski & Hunter, 2012) and other syndemic issues among LGBT youth (Bouris et al., 2011). This omission may be due to the predominant macrosystemic orientation of syndemic frameworks and a concomitant empirical literature that has emphasized identifying individual-level (e.g., internalized homophobia) and macrosystemic (e.g., discrimination) predictors of syndemic production. The empirical syndemic literature has not yet evolved to examination of relational or microsystemic variables that may influence syndemics among MSM. However, this oversight is problematic given that many of these structural issues (e.g, racism, homophobia, discrimination, structural violence) MSM face are experienced within relational environments (e.g., family, peers, sex partners, romantic dyads). Without studying the experience of macrosystemic issues within relational context, it remains unclear a) the extent to which MSM experience similar issues across multiple ecological systems; b) how experiences with one system (e.g., family) may influence experiences in another (e.g, gay community); and c) in what varied ways MSM are affected by these experiences. Empirical

examinations of syndemics should therefore begin accounting for how various microsystems (e.g, family, peers, dyads, community) or relational processes may moderate the relationship between structural adversity and syndemic production. As the case of the young men experiencing syndemics suggests, such an analytic emphasis is especially called for given that MSM are liable to experience structural adversity across numerous ecological systems. Additionally, as a developmental framework, a relational resilience emphasis on MSM's microsystems is necessary to ascertain whether certain microsystems matter more at one developmental stage than another, or in light of certain contexts and events.

Consistent with Stall's original conceptual formulation of syndemic production among MSM, this analysis suggests that participation in the gay community may be an important moderator between adversity and syndemic production. This study showed that young men have very different experiences within gay community networks. Men who did not experience syndemics described a positive psychological sense of that may be protective against syndemic production. In contrast, the men experiencing syndemics described a neutral relationship with the gay community or a negative psychological sense of community. Future research into syndemics among YMSM should expand upon this exploratory study, and go back to the conceptual roots of the syndemic model, by empirically testing the association between adversity, a multi-faceted conceptualization of sense of community, and syndemic production. Additionally, this study suggests that young men experiencing a positive sense of community also experience sexuality related social support within their families whereas those young men reporting a negative psychological sense of community lacked similar family support. As such, family sexuality-related support, in addition to psychological sense of community, may moderate the pathway from adversity to syndemics. Future research should also examine in more depth, the relationship between family support and gay community involvement.

Resilience and syndemics

This study offers an initial glimpse into resilience among young Black gay and bisexual men and to the growth-promoting relational experiences of young men who have avoided syndemics. Greater emphasis needs to be placed on developing a more nuanced understanding of growth-promoting connections, relational processes, and resilience in their lives. Study of the considerable strengths, assets, and resources that Black gay and bisexual men manifest is important to the study of their health. A continued focus on resilience and strength by Black gay and bisexual men in the face of adversity will yield important insights into how to maintain their health. In this section, I identify a few key ways that research on syndemics might be attentive to resilience.

The syndemic literature suggests that syndemics influence people along the HIV care continuum (Safren et al., 2010), meaning that similar psychosocial factors influence sexual behavior, HIV/STI testing behavior, linkage and adherence to care, and intervention effectiveness. As both the syndemic and continuum of care literature are flourishing, it is likely that researchers will begin to look more closely at how syndemic exposure affects people along the HIV care continuum. I examined sexual risk behavior as an outcome in this study. Might similar factors (e.g., pride, family social support, social action) protect people along the care continuum? These data suggest a number of ways in which the identified assertions may influence participants' testing behavior. As the syndemic literature proliferates, researchers should consider protective factors, and whether those that are protective against HIV exposure are similar to or distinct from those that are protective along the HIV care continuum.

Resilience is typically conceived of as the process by which marginalized individuals maintain psychological well-being despite oppressive conditions. The use of this

definition, in this current analysis, considers resilience to be indicated by a lack of psychosocial health outcomes typically associated with heightened HIV risk. Other definitions provide alternate lenses by which to view these data. My focus, on protective relational resilience, limited analysis to those young men who did not experience, at the time of data collection, psychosocial health outcomes associated with heightened HIV risk. This analysis sheds light on factors associated with participants' well-being. Future research might consider looking at compensatory resilience (Stevenson and Zimmerman, 2005), or those resources and assets that may counteract syndemic exposure. Research along these lines would examine how men with multiple syndemic conditions remain sexually safe and HIV negative.

A constructivist definition of resilience provides another way to conceptualize and examine resilience among young Black gay and bisexual men. According to Unger, resilience is the outcome from negotiations between individuals and their environments for the resources to define themselves as healthy amidst adverse conditions (Unger, 2004). Resilience from this perspective is the negotiation by individuals for the resources to develop and sustain health, as understood as their preferred constructions. This definition assumes that people place particular values upon their health and that health is context specific. I and others may assume, even if only implicitly, that health and well-being are indicated by the presence or absence of a particular ailment. According to Unger, this is a cultural bias, one that is not attentive to alternate discourses on health and well-being that may stem from marginal voices. Unger's definition of resilience affords that there are situations and circumstances which may appear to indicate vulnerability (e.g., social isolation), but that may be preferred to the alternative (e.g., further marginalization). As such, future research that assesses resilience from a constructivist standpoint among young Black gay and bisexual men may examine what young men themselves discern as healthy functioning or how resilience

can be achieved through alternate pathways thought by the dominant discourse to indicate vulnerability.

Implications for practice

Resilience focused researchers argue that interventions that focus on enhancing strengths and resources may be more effective in promoting health than interventions that focus specifically on negative health outcomes (e.g., HIV transmission, substance use) (Herrick et al., 2012). These analyses provide justification for a number of strength-based intervention strategies that researchers may utilize not just in HIV prevention programs, but also in addressing antecedent psychosocial health conditions (i.e., syndemics) that increase vulnerability to HIV.

Clinical interventions

A syndemics orientation to the prevention of HIV and other sexual health issues necessitates an intervention emphasis on the psychosocial issues associated with heightened HIV risk. As such, results of these studies have several implications for mental health providers working with young Black gay and bisexual men with mental health concerns, substance abuse issues, or histories of trauma. First, mental health professionals must be sensitive to the unique confluence of issues facing young Black MSM. These studies in tandem provide insight into how societal messages, relational experiences, and trauma play a role in young Black gay and bisexual men's self-perceptions. Stigma and trauma represent primary causes of the low sense of self-worth and isolation that many Black MSM experience, thus complicating the identity integration process and preventing Black MSM from connecting with supportive and accepting others. To facilitate treatment planning, clinicians and therapists would be wise to consider how men's presenting psychosocial health issues (e.g., mental health and substance abuse) may be precipitated and maintained by socio-

cultural factors such as discrimination, marginalization, and oppression. In particular, mental health providers must understand how young men's self-perceptions are influenced by messages they receive about their sexuality, race, masculinity, and history of trauma. This cultural awareness and sensitivity is necessary in order for mental health professionals to help young Black gay and bisexual men develop a healthy, integrated sense of self (Harper et al., 2007; Harper et al., 2012).

These data suggest that two gay-affirmative counseling approaches with young Black MSM may include the promotion of cognitive reframing strategies and an emphasis on the positive conceptualizations of being gay or bisexual Black men. Cognitive reframing can be taught by offering education about heterosexism and teaching young men to deconstruct heterosexist assumptions (Chernon & Johnson, 2002; Lebolt, 1999); this gay-affirmative counseling strategy is an important tool for aiding the emotional well-being of sexual minority youth (Johnson & Chernon, 2002). As multiply marginalized persons, learning cognitive reframing strategies may help young men develop a critical eye toward understand the manifold affects that racism, sexism, and heterosexism have on their daily lives. Previous research has suggested that cognitive reframing strategies are often used among sexual minority youth of color (McDavitt, Iverson, Kubicek, Weiss, Wong, & Kipke, 2008; Reed & Valenti, 2012; Wilson & Miller, 2002). Wilson & Miller (2002) interviewed 37 Black gay and bisexual men about the strategies that they use to deal with heterosexism. The authors contend that cognitive reframing strategies may be common among Black gay and bisexual men due to their ability to generalize strategies for coping with racism to coping with heterosexism. As a therapeutic strategy with young Black gay and bisexual men, cognitive reframing may be a particularly effective tool given its cultural salience. The young men in this study who did not experience syndemics oft cited cognitive reframing strategies, which again suggests that it is a useful and culturally congruent stigma management strategy.

Based on these analyses, a second gay-affirmative therapeutic recommendation for work with young Black gay and bisexual men may be to help them identify and focus on the positive aspects of their sexual orientations. Harper and colleagues (2012) contend that teaching sexual minority youth to focus on positive conceptualizations of their sexual identities is a key way in which they develop well-developed, integrated identities. Indeed, HIV prevention interventions for young gay and bisexual men often highlight participant's positive identity conceptualizations to enhance young gay and bisexual men's acceptance of their sexual orientation. These data suggest that young Black gay and bisexual men who avoid syndemics have identified and found ways to celebrate positive facets of their identities; further, much of what they tend to value –increased social support, opportunities for social engagement- tends to be related to other forms of resilience associated with well-being. As there appears to be a cyclical relationship between identity acceptance, sexuality-related social support, and opportunities for social action, mental health and health care providers should also be aware of local community connections and opportunities that may support young Black gay and bisexual men's healthy identity development.

A final recommendation for mental health professionals concerns the case of young men with histories of sexual abuse. The data were sparse concerning how young men's sexual abuse experiences influenced their current sexual orientation identities; however, the available data suggest that sexual abuse problematized participants' sexual identity development and decreased their desire or willingness to connect with other young Black gay and bisexual men. Previous research suggests that childhood sexual assault is associated with sexual identity confusion among gay and bisexual men (King, Coxell, & Mezey, 2002). Further, the only qualitative study on Black gay and bisexual men's experiences of sexual abuse substantiates that men may blame their same-sex desire on their childhood sexual abuse experiences (Fields, Malenbranche, & Feist-Prince, 2008). As such, mental health

professionals may consider examining young men's associations between sexual abuse and their current constructions of sexual (and gender) identity.

Family interventions

For heterosexual youth, families are frequently enlisted in family-based interventions designed to prevent and treat HIV (McBride, Berkel, Pantin, & Prado, 2000). Even though family factors are among the correlates of sexual risk among YMSM, the same cannot be said for gay and bisexual youth (Mustanski & Hunter, 2012). In a review of the literature to assess parental influences on sexual minority youth's health, Bouris et al (2011) also note that despite the positive influence of supportive parents and family sexual minority youth's health and well-being, that there is a dearth of family-based interventions that address mental health issues, substance use, and sexual behavior. For YMSM, family-based approaches to preventing HIV and substance abuse and promoting mental health have not yet been developed and tested (Bouris et al., 2011; Mustanski & Hunter, 2012). However, researchers are beginning to suggest that efforts to develop such programs should be prioritized given their potential to increase sources of resilience and address multiple syndemic issues experienced by young gay and bisexual males (Bouris et al., 2011; Harper & Riplinger, 2012; Garofalo et al., 2008; Mustanski et al., 2012; Mustanski & Hunter, 2012; Ryan et al., 2009).

Family members can play important roles in comprehensive HIV prevention for gay and bisexual men (Garofalo, et al., 2008; Mustanski et al., 2011; Mustanski & Hunter, 2012). The lack of family-based interventions for young gay and bisexual males to date may reflect the misconception that families are unavailable for interventions because they are not involved in the lives of sexual minority youth or they are unaware of their child's sexual identity (Garofalo et al., 2008). Emerging research indicates that many parents are aware of their child's sexual orientation (Garofalo et al, 2008), aware of the unique needs of gay youth,

(Kubicek, et al., 2010; LaSala 2007), open to understanding how their responses influence their child's well-being (Ryan et al. 2009), and want assistance in supporting their child's health (LaSala, 2007). These findings suggest that family interventions may be a relevant modality for health promotion among young gay and bisexual males.

From a resilience perspective, researchers should develop interventions to draw on the existing resources and strengths that exist in Black families and communities. These data indicate that some young Black gay and bisexual men have supportive family relationships, particularly with female members of their families. As such, these supportive family members may be feasible routes through which to deliver family-based prevention efforts or programs for young Black gay and bisexual men. This alternative intervention approach would draw on the strong kinship networks in Black families and deeply engrained community ethos of protecting the health and well-being of Black boys and men. Given the protective role that mothers and other women play in young Black men's lives and their esteemed role in Black families and communities, women should be considered as potential targets of family-based interventions. Women are not typically thought of as targets of intervention when it comes to promoting the health of gay and bisexual men. These data suggest that women's inclusion in health promotion efforts for young Black gay and bisexual men may be warranted, a finding that represents a significant conceptual shift in the current prevention literature among young Black gay and bisexual men. In addition, further research should address how supportive family members can most effectively be leveraged in delivering family-based prevention programs (for HIV and issues related to HIV) for young Black gay and bisexual men.

Peer interventions

These data suggest that peer-led and social network-based prevention approaches may be an effective way to engage young Black MSM. Many of the young men who did not exhibit syndemics actively recruited their friends and peers to attend HIV-related events and programming, receive HIV counselling and testing services, and join LGBT-supportive groups and organizations. These young men exhibited a drive to engage in social action that might facilitate the health and well-being of their community. Recent research evidence substantiates that peer-based HIV prevention and outreach strategies may be an effective approach to engaging young Black MSM in prevention services. For example, Outlaw and colleagues (2010) conducted a randomized control study to assess whether motivational interviewing conducted by Black YMSM peer educators led to increases in HIV counseling and testing in 188 Black YMSM, compared to traditional field outreach methods. They found that intervention group participants were significantly more likely than control group participants to receive HIV counseling and testing services and to return for the test results. Additionally, d-up!, one of the few evidence-based HIV interventions specifically designed for young Black MSM, uses a peer-based approach to promote positive norms that encourage safer sex (Jones et al., 2008). Given the strong communal ethos among the Black community and within some sexual minority-communities, researchers might consider developing peer-based interventions along the continuum of care.

Community interventions

Interventions that strengthen young Black MSM's communal support systems may be useful for disrupting syndemics, particularly if they focus on developing or strengthen a positive psychological sense of community among young men. Wyatt (2009) discusses aspects of culturally congruent intervention strategies for preventing HIV among African

Americans and recommends that a key intervention strategy should be the enhancement of interconnectedness. Further, Wilson and Moore (2009) interviewed 71 leaders who worked in community-based organizations and AIDS programs that serviced Black MSM about their perceptions of barriers to and facilitators of prevention within this community. Participants identified community-building efforts that connect Black MSM to each other as an important way to reduce social isolation and facilitate prevention responses. In interviews with 76 African American MSM about the perceptions of community, men also noted that a way to strengthen their community is through the creation of nonsexualized meeting spaces (Kraft, Beeker, Stokes, & Peterson, 2000). Building sexuality-specific communal support systems may be a particularly relevant intervention strategy for young Black MSM.

Though these participants largely described community involvement in formal LGBT and HIV service organizations, there are other innovative ways that communal support systems may be developed that provide important sources of support for young Black gay and bisexual men struggling with social isolation. Black gay social groups, sports teams, or faith-based groups may all provide ways for young Black gay and bisexual men to build positive connections with others. Given the importance placed upon religious life in the Black community, strengthening the viability of faith-based groups where men can grow spiritually and personally may be a particularly relevant modality for creating and enhancing interactions among Black MSM (Kraft et al., 2000). LGBT service centers, community based organizations, gay social groups, and HIV service centers may consider providing young men with opportunities to engage in meaningful, identity-congruent social action. Additionally, older Black MSM can be encouraged to serve as role models and mentors. However, the developmental needs and struggles of youth and the hesitance some youth exhibit when interacting with older MSM suggest that the creation of youth-specific social events and opportunities may be especially necessary.

There should be efforts to ensure that existing sexuality-related groups and organizations are welcoming to Black sexual minorities, people of various gender expressions, and people of diverse sexual orientations. Young Black gay and bisexual men experience interpersonal rejection across a variety of social systems. Access to the gay community can provide opportunities, as the young men who lacked syndemic production experienced, for obtaining social support, developing a sense of community, and developing a healthy sense of being gay. However, when gay community groups or organizations are exclusionary, then access to the gay community leads to interpersonal rejection, further marginalization, continued identity related shaming, and a heightened sense of social disconnection. Men who experience interpersonal rejection or identity-related oppression within gay community settings are not afforded the opportunity to develop important relational connections or gain freedom from oppressive social environments. It is important, therefore, to make gay spaces and communities welcoming, to reduce factions among young Black MSM, and to develop ways of enhancing a sense of community. In Black MSM communities, it may be particularly important to address myths and misconceptions about bisexuality, examine and deconstruct stereotypes of men on the "down low," and critique norms and expectations regarding masculinity and gender expression. Such efforts may enhance the sense of "macrobelonging" or the sense of community that incorporates all members of the larger community (Weisenfeld, 1996).

Conclusion

This research represents a significant departure from the literature on young Black gay and bisexual men due to its focus on resilience. Many scholars purport that interventions are most likely to succeed when they are culturally congruent and designed to support and enhance organically occurring sources of resiliency and strength in communities. The lack of

information about resilience among young Black gay and bisexual men is thus a serious gap that hinders intervention efforts. Interventions should build on resiliency factors, from family acceptance to community involvement to social activism, which may alleviate the negative consequences of socio-structural barriers to health.

A relational resilience emphasis on syndemic processes is one way of taking an ecosystemic approach to the study of contextual influences that shape the development and well-being of young Black gay and bisexual men. Syndemic frameworks fundamentally call attention to the important fact that macrosystemic structural adversity and violence precipitates poor development and negative health outcomes among MSM. Yet the fact that men experience these structural stressors across multiple relational and socializing environments suggests a need for a more contextualized and ecosystemic empirical focus in the study of syndemics among MSM. While structural interventions that address the marginalization, trauma, and oppression that young men of color face are needed for quelling syndemic processes, this study also suggests that such approaches must be complemented by peer-based, family-based, community-based, and clinical interventions. As means of attenuating men's socio-structural barriers to health and addressing comorbid psychosocial health issues, interventions must address young men's social isolation, identity-related issues, and sense of community.

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