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Applying an intersectional framework to understand syndemic conditions among young Black gay, bisexual, and other men who have sex with men

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Abstract

Syndemic theory has been useful in illuminating the co-existence and reinforcing nature of multiple health and social conditions that contribute to HIV risk. However, little research has examined syndemics among young Black gay, bisexual, and other men who have sex with men (GBM) or situated syndemics within the context of racism, homonegativity, and other intersecting social inequities. Applying an intersectional framework to syndemics can help demonstrate how social and structural inequities and oppression facing young Black GBM contribute to and reinforce syndemic health conditions. In 2018, we conducted 45 in-depth qualitative interviews with young Black GBM in Milwaukee and Cleveland. Our analyses examined how intersectional stigma contributes to syndemics and HIV disparities facing young Black GBM. Our findings demonstrate that broader systems of oppression and disadvantage facing young Black GBM contribute to syndemic conditions. Future conceptualizations and measurements of syndemics must capture these experiences to strengthen our understanding of syndemics among young Black GBM.

Keywords

Syndemics; Intersectionality; HIV risk; HIV disparities; Young, Black gay, bisexual, and other men who have sex with men (GBM)

In the United States, the HIV epidemic is concentrated at the intersection of age, race, and sexuality; young Black gay, bisexual, and other men who have sex with men (GBM) are disproportionately impacted by HIV. Between 2011 and 2015, HIV diagnoses among Black GBM aged 25 to 34 increased 30%. In 2017, 75% of Black GBM who received an HIV

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Author Contributions

KQ developed the methods for this study and oversaw data collection. She conducted all analyses for this manuscript and wrote the manuscript.

diagnosis were between the ages of 13 and 34.[1] Despite having fewer sex partners and engaging in fewer HIV-related risk behaviors than their White counterparts,[2] half of Black GBM are projected to acquire HIV in their lifetime, compared to just 9% of white GBM.[3]

Syndemic theory has been used to conceptualize and address the disproportionate burden of HIV faced by young Black GBM.[4] Syndemics refers to the co-occurrence and interaction of multiple psychosocial and health conditions at the individual- and population-level that synergistically contribute to an excess of disease burden.[5] he theory of syndemics has been useful in understanding the interconnected nature of substance use, depression, childhood sexual abuse, and intimate partner violence among GBM, and the ways in which these conditions can interact to enhance HIV risk and disparities between young Black GBM and other population subgroups.[6] These psychosocial health conditions co-occur and are mutually reinforcing,[7] creating or enhancing disparities in HIV that are social and structural in nature.[8] For example, the stress associated with HIV risk can contribute to anxiety and depression, discourage HIV testing, and encourage substance use, which can subsequently enhance HIV risk.[9]

Syndemic conditions do not emerge organically. Rather, syndemics are produced and shaped by various social and structural contexts including structural racism, systematic inequities, and oppression.[10] Over the past decade, syndemic research has evolved to recognize how stigma and social inequities contribute to clusters of epidemics and health conditions, increasing health disparities, particularly among Black/Latinx GBM and white GBM.[11] Research by Dyer and colleagues (2012) demonstrated how gay-related victimization, masculinity attainment, and internalized homonegativity were associated with greater HIV risk for Black GBM.[12] Additional research has demonstrated the syndemic nature of racism, homonegativity, and HIV status among Latino GBM, whereby men exposed to racism and homonegativity were more likely to report condomless sex and binge drinking compared to Latino GBM who had not experienced racism or homonegativity.[13]

Yet, one criticism of syndemic research has been its tendency to focus on GBM as a homogenous population, with little attention to power and oppression along the axes of race, ethnicity, class, geography, or sexual and gender identity.[14,15] Some of the most substantial research documenting the presence of syndemic conditions has occurred among white men. For example, in the Urban Men's Health Study, Stall et al. (2003) provided evidence of the interacting epidemics of substance use, depression, and violence and victimization in a sample of predominantly White GBM.[6] More recently, Mimiaga and colleagues (2015) studied syndemics in the EXPLORE study with a sample of over 4,000 GBM. Their results provide compelling evidence for the effects of syndemic conditions on HIV incidence and sexual behavior, demonstrating that the accumulation of syndemic conditions predicts HIV seroconversion among GBM. Yet, 72.5% of their sample was White and of relatively high socioeconomic status.[16] Researchers have also demonstrated the positive interrelationship between sexual compulsivity, depression, childhood sexual abuse, intimate partner violence, and substance use and the effect of these conditions on HIV risk behaviors among primarily White GBM.[17]

These prior studies have been instrumental in furthering our understanding of the role of syndemic conditions in enhancing HIV risk among GBM yet, given the nature of the HIV epidemic in the US, there is a need to examine syndemic conditions that contribute to HIV risk among young Black GBM.[4] Research by O'Leary and colleagues (2014) found evidence that syndemic burden was associated with increased HIV risk behavior and likelihood of HIV infection among a large sample of Black GBM.[18] Qualitative research with diverse samples of GBM also suggest similar associations, demonstrating how systems of oppression can overlap to increase risk of syndemic conditions and poor HIV outcomes.[19,20] However, recent data on the role of syndemics in contributing to HIV disparities has provided a more nuanced understanding of syndemic conditions. In a large sample of Black GBM, the POWER study found that men who experienced two or more syndemic factors were *more likely* to have received a recent HIV test as compared to men with no syndemic factors, suggesting syndemic factors may not adequately explain HIV testing disparities.[21] Additionally, Mustanski and colleagues (2017) studied the effects of syndemic conditions (substance use, violence, and mental health) on HIV risk behaviors in a sample of racially diverse young GBM. In their research, Black GBM reported fewer condomless anal intercourse partners and lower levels of polydrug use and binge drinking than White GBM. Importantly, their results also suggest that syndemic factors are unlikely to explain the racial disparities in HIV and individual-level HIV risk among young Black GBM.[2]

Given these seemingly contradictory feedings, research is needed to unpack the influence (or lack thereof) of syndemic conditions on HIV risk among young Black GBM. Understanding syndemic conditions among Black GBM may benefit from incorporating an intersectionality framework. Intersectionality is a conceptual framework rooted in Black feminist scholarship[22–24] that examines how multiple social identities intersect at the individual-level to reveal intersecting social-structural inequities (e.g. racism, heterosexism).[22,23] Similar to the ways in which syndemic theory posits that disease and health conditions do not exist in isolation from one another,[11] intersectionality highlights the interconnected nature of multiple social locations and oppressions along the axes of gender, race, ethnicity, class, and sexual identity.[22,25] Rather than viewing race, class, and sexuality as distinct categories, intersectionality postulates that these are mutually constituted systems of oppression that together produce inequality.[26,27] For example, the intersections of racism and homonegativity faced by Black GBM may negatively affect their interactions with the healthcare system; perceived and anticipated racism and/or homonegativity from health care providers can contribute to medical mistrust, disengagement from the healthcare system, and skepticism surrounding HIV pre-exposure prophylaxis (PrEP).[28]

Intersectionality can complement and enhance syndemic theory, as intersecting stigmas may be key drivers of syndemics among Black GBM. While both syndemic and intersectionality research enhance our understanding of oppression and disparities in public health, jointly, these theoretical frameworks can highlight the reinforcing nature of health and social conditions and the ways in which interlocking systems of oppression contribute to and uphold health and social inequities Syndemic conditions are created and reproduced within broader social contexts of intersectional stigma and oppression, which can contribute to disproportionate burdens of disease and health conditions, including HIV. Syndemic

conditions of community and personal violence and trauma, criminal justice involvement, substance use, and unaddressed mental health needs are all shaped by social and power structures and inequities. For example, Black men may face social and economic disadvantages and complex gender expectations rooted in historical trauma, racism, and homonegativity that heighten sexual risk factors, mental health burden, substance use, and exposure to violence.[29] Thus, the conditions that are typically used to comprise syndemics (mental health, substance use, violence) may present differently among young Black GBM and existing quantitative measures and approaches to syndemics may be insufficient to understand the experiences of young Black GBM.

Syndemic research has a tendency to overlook the intersections of different social categories, focusing instead on singular categories such as race and sexual identity separately and additively.[7,30–32] Furthermore, researchers tend to examine individual-level syndemic conditions (e.g. substance use, mental health) without adequately considering relevant structural factors such as oppression and marginalization.[4,33] Accordingly, an intersectional approach to syndemic research may be particularly useful to understanding the HIV epidemic among individuals with multiple disadvantaged social statuses, including young Black GBM. Intersectionality can advance syndemic theory by more explicitly acknowledging interlocking forms of oppression, highlighting the role such oppressions have in creating syndemics and helping to shed light on why and how syndemics are experienced differently by different subpopulations.

This qualitative study aims to characterize and understand psychosocial and structural conditions that have been shown to be part of a syndemic (i.e. childhood trauma, mental health, substance use) among young Black GBM by incorporating an intersectionality framework. Given the qualitative approach of this study and the limitations of qualitative methods in examining the interactive nature of epidemics, we apply a serially causal model of epidemics[34] through a lens of intersectionality. Intersectional stigma and experiences are difficult to quantify, and statistical models and assumptions do not reflect the complexities of the intersections of race, gender, socioeconomic status, and sexual identity.[24] Thus, qualitative methods are best suited for intersectionality, as they can shed light on the intersecting nature of oppression and provide needed context for understanding how people experience and are shaped by syndemic conditions. Intersectionality can help demonstrate how social and structural inequities and oppressions faced by Black GBM contribute to and reinforce syndemic health conditions. Examining social factors such as racism and homonegativity can provide the context needed to understand findings from quantitative syndemic research with Black GBM. Black GBM live in complex environments, and a broad range of intersecting stigmas that have been difficult to measure quantitatively contribute to their overall health and well-being and provide a needed context for syndemics. This qualitative study unpacks how intersectional stigma and systems of oppression and disadvantage contribute to syndemic conditions and HIV disparities experienced by young Black GBM.

Methods

This study was carried out by a long-standing community-academic partnership in Milwaukee, WI and Cleveland, OH. The interviews described here were conducted by a team of three research associates who were experienced in qualitative HIV prevention research and received in-depth training in conducting one-on-one in-depth interviews. Two research associates self-identify as Black gay men and one identifies as a Black transgender woman. In addition to conducting the interviews, they led recruitment efforts, provided significant input into developing the interview guide, and assisted with data analysis and interpretation. The lead author, who also led the data analysis, is a white, heterosexual, cisgender woman

Study design and sample

In 2018, we conducted 46 individual in-depth interviews with young Black GBM in Milwaukee, WI and Cleveland, OH. Inclusion criteria required that participants be Black or African American cisgender men; identify as gay, bisexual, or have had sex with another man in the previous 12 months; be at least 18 years old; and report HIV-negative or unknown HIV serostatus.

We used purposive sampling to recruit individuals through a multi-pronged approach. First, we partnered with LGBTQ service organizations and HIV testing sites. Key staff at these organizations hung flyers and distributed materials in person and electronically (e.g. via the organization's website, Facebook page, and other social media sites) to potentially eligible participants. Additionally, we asked participants to refer other individuals in their social networks. Recruitment materials highlighted the goal of the study, which was to understand younger Black gay and bisexual men's experiences with and perspectives on PrEP and other HIV prevention interventions. We continued recruitment and interviews until we reached theoretical saturation in both study cities. Weekly study team meetings provided opportunities to debrief, share major themes emerging from interviews in both cities, and identify new directions for interview probes and approaches. Interested participants were screened for eligibility by phone or in person, and eligible individuals were scheduled for an interview. Interviews were conducted at trusted community-based organizations. Given the sensitive nature of the study, we received a waiver of written consent. All participants provided verbal consent prior to the start of the interview and then completed a brief demographic questionnaire. Interviews lasted between 30 and 90 minutes.

Participants were compensated $50 for their time and received a resource guide with information on local community HIV, mental health, and LGBTQ services. The research protocol was approved by the Institutional Review Board at [Blinded for Review].

Interview content

A semi-structured interview guide was used to ensure consistency in topics addressed, while providing flexibility for probing and clarifying questions and opportunities to follow participants' narratives. There were six primary topic areas covered in the interviews: 1) general healthcare usage and experiences, 2) sexual health and current partners, 3)

perceptions of PrEP, 4) PrEP use among peers, 5) social and cultural factors, 6) friends and peer group. The interview guide was developed based on a thorough review of relevant literature and with significant input from the research associates at the academic and community institutions.

Data analysis

Interviews were audio-recorded, transcribed verbatim, and coded using MAXQDA qualitative analysis software. We used a team-based, multi-stage analytic coding strategy.[35] First, we coded all transcripts with participant characteristics (e.g. study city, age, sexual orientation, PrEP history, socioeconomic status). We then used open coding, coding randomly selected transcripts from both cities, line-by-line, generating an initial codebook. To enhance reliability, we used a team of three coders who began by independently coding three selected transcripts and generating lists of potential parent codes, subcodes, code definitions, and examples. Additionally, each coder individually wrote memos and detailed notes to identify nuances in the data and begin to identify themes. We met as a team to discuss discrepancies, clarify concepts, finalize code definitions, and begin to discuss patterns and themes in the data. Collectively, we created a single codebook that we then each applied to an additional three transcripts for further refinement and assessment of fit. The process of refining the codebook and reapplying to additional transcripts occurred two additional times, until we reached consensus on code definitions and reliability of code application. We assessed intercoder agreement in MAXQDA and continued to refine the coding process until we achieved 90% agreement in the codebook application across coders. Finally, we used axial coding to identify the dominant themes, combine or group codes, and draw connections among codes.[36] The final codebook included 35 parent (or primary) codes including perceptions of PrEP, homonegativity, racism, mental health, and substance use disorders and 79 subcodes that captured more specific experiences and phenomena (e.g. internalized homonegativity, mental health treatment, and perceived expectations of masculinity). The data analysis team then applied the final codebook to all 45 transcripts. All interviews were coded twice, by two different coders, to ensure adequate application of codes. In addition to coding text, coders also logged analytic memos and summaries[36] to note subtle variations in perspective among participants, highlight inconsistences within narratives, compare and contrast overall themes, and reflect on participants' experiences and narratives.

We then analyzed the data using inductive and deductive thematic content analysis,[37] wherein we identified primary themes and meaning within the data by grouping and organizing coded segments of the data. First, we inductively analyzed codes and memos in the data to examine potential relationships among codes, highlight salient ideas or themes within the data, and understand the relationships among codes.[38] We then conducted additional deductive analyses to characterize syndemics and intersectional stigma among this sample and examine how intersectional stigma influences syndemic conditions experienced by Black GBM. Specifically, we examined segments of text associated with particular codes of analytic interest relevant to syndemics or intersectionality theories including poverty, childhood trauma, exposure to community violence, internalized and experienced homonegativity, and experiences of racism. We then examined segments of text

that were coded with more than one these identified codes (e.g. racism and homonegativity or community violence and racism) to understand the co-occurrence of syndemic conditions, oppression, and stigma. Through these analyses, study team discussions, and examination of analytic memos and summaries, we identified major themes and excerpts of data that exemplified these themes. Through these theoretical frameworks, we identified how participants' narratives aligned with or departed from existing conceptualizations of these theories and sought to use data to provide greater nuance and context to experiences of young Black GBM.

Results

Our sample consisted of 46 young Black GBM in Cleveland (n=21) and Milwaukee (n=25). Among the total sample, participant age ranged from 19 to 37, with an average age of 25. The majority of participants identified as gay (n=36; 78%). There were few current or former PrEP users in the study; five participants in Milwaukee and four in Cleveland were currently using PrEP and two individuals in Milwaukee were former PrEP users. Seven participants (four from Milwaukee and three from Cleveland) had exchanged sex for money, drugs, or a place to sleep. Two individuals in Cleveland had never been tested for HIV.

Our data highlight the influence of intersectional stigma on various psychosocial conditions that have been known to be part of a syndemic and demonstrate how intersectional stigma and oppression, namely structural disadvantage, racism, and homonegativity contribute to syndemic conditions experienced by Black GBM. We begin by explaining how structural disadvantage rooted in racism, shaped the lives of young Black GBM. We then discuss how that contributes to cultural expectations of masculinity and homonegativity Black men face. Finally, we describe the nature of intersectional stigma in participants' lives and demonstrate how intersectional stigma influences the syndemic conditions of childhood trauma, mental health, substance use, and HIV risk. Excerpts from interviews are used to illustrate these themes and demonstrate how intersectional stigma influences syndemics among Black GBM. All participant names and identifying information have been removed to protect participant confidentiality.

Intersectional Stigma

There was evidence of intersectional stigma throughout participants' interviews. Narratives were filled with stories of the hardships and ostracization uniquely experienced by Black GBM. Intersectional stigma was evident at a structural level, as participants described the effects of racial neighborhood segregation, poverty, and institutionalized racism. Such conditions and experiences contributed to cultural expectations of masculinity, which was perceived to be in conflict with their sexual identities and contributed to homonegativity. As Black GBM, participants reported a lack of belonging in both Black and gay communities, which was rooted in intersecting racism and homonegativity.

Structural Disadvantage

Black GBM in this study described navigating racism and homonegativity within their communities, families, and peer networks. These experiences and narratives were rooted

within a larger sociopolitical environment of societal inequity and disadvantage. For example, not only did participants describe interpersonal racism, they were also exposed to the effects of structural racism and the consequences of racial neighborhood segregation. In describing the racially segregated gay community, one Milwaukee participant explained:

> Milwaukee is a segregated city in itself, where the majority of African American community is on the north side of Milwaukee. The majority of the Hispanic community is the south side of Milwaukee, Caucasian is generally west, and they have a good east backing as well near the lake and stuff. But for the most part we're segregated in ourselves. As far as me leaving my comfort zone, which is the north side of Milwaukee, to go and venture elsewhere, it was very few and far between.
>
> DJ, 29-year-old from Milwaukee

Milwaukee participants frequently repeated the well-known fact that Milwaukee remains one of the most racially segregated cities in America. Not surprisingly, that contributed to racial segregation in gay communities. As Black men, many participants lived in predominantly Black neighborhoods. Living in racially segregated neighborhoods led to concentrated disadvantage, various social and health consequences, and limited opportunities. For example, one participant described moving from a quieter neighborhood on the outskirts of Milwaukee to the northside of the city as a child:

> Growing up in Milwaukee, I pretty much lived with my mom most of my life… things kinda changed when we moved to the northside of Milwaukee and we were exposed to a different environment and different things were going on…There was more violence in the community on the northside and I seen more stuff that people would normally try to hide in [suburb of Milwaukee], like drug use and different stuff, drug sales. Violence, like, you know, not just domestic, there were all kinds.
>
> Quinten, 23-year-old from Milwaukee

Along with the racial segregation of neighborhoods came concentrated poverty, unemployment, violence, and drug use, which exposed participants to greater disadvantage and shaped their life circumstances.

P: To be a Black man means to be strong, to be independent, you kind of got the world against you being a Black man so.

I: What do you mean?

P: Did you ever get pulled over being a Black man? At that point you will understand no matter what car you drive or what kind of salary you make, how much does the necklace that you are wearing cost, they don't care. You are a black man, you are going to be put in handcuffs, you are going to be treated and talked to like dirt. - Johnny, 23-year-old from Milwaukee

As Johnny made clear, even outside of the segregated neighborhoods, Black men were still at a disadvantage regardless of income or wealth. Johnny went on to talk about how racial discrimination affected his ability to get a job.

> You can't go into jobs. I swear to God I had a job interview, the lady came and she saw me, she walked back to her office and she came about 30 minutes later she sat down and asked me one question and said that the interview was concluded. I couldn't think no other reason besides my skin color that she would deny me the job without even giving me a fair interview. So, it's just being a Black male, period. It's hard, like, you got Black women telling you that you are not good enough and you got white people telling you that you are not good enough.
>
> Johnny, 23-year-old from Milwaukee

The structural disadvantage participants faced manifested in experiences similar to what these participants described, including mistreatment by and over-involvement in the criminal justice system, limited access to jobs, and greater exposure to drugs and violence which, collectively, made it difficult to leave the highly segregated neighborhoods and cities in which they lived. They described these experiences to illustrate how their lives as Black men were fundamentally different than those of White men, regardless of sexual identity.

Pressures to conform to masculinity norms

In part, the challenges faced by Black GBM were rooted in cultural expectations of masculinity. Participants felt pressure to conform to gender norms within their communities and described the weight of these expectations. When asked what it meant to him to be a Black man, one participant explained:

> Living in the 'hood, you know, just so much just expected out of you. You're the man of the house. It don't matter how many men is in the house, you supposed to protect all women, at all times. It's just so much expected out us as men. And then being Black, gay men. It's just a lot, and sometimes, it can be overwhelming. And I think that's why a lot of young Black guys kinda fall into that lifestyle of being gay because it's so much put on a straight Black man. And I think when you're a gay male, a lot of that is released a lot of that stress is like lifted off of you because you're not really considered a man anymore. Because people feel like you're a sissy cause you're messing with the same sex.
>
> D'Angelo, 23-year-old from Cleveland

This excerpt highlights the weight of masculinity expectations and gender norms faced by some Black men. As D'Angelo explained, these expectations are complicated for gay men, whose sexual identities are seen as being in conflict with masculinity. Interestingly, he suggests that the weight of these expectations is so strong that it leads some men to "the lifestyle of being gay," as gay men are not "really considered a man anymore." Masculinity was seen as particularly important when "living in the 'hood." Another participant described how conforming to masculinity norms was essential to his survival growing up in the "hood."

> Growing up, I was really feminine. I had a really squeaky voice, I was a chubby little kid, just very feminine. So, growing up I was teased a lot for being feminine, and I couldn't help it, I mean it was just the way I felt … As a I started getting older, certain situations, certain violence, started roughing me up and showing me that I can't be as nice or soft spoken or as I really am. The environment does not

> fly with it. I went from being a little prissy boy to, as the years went on, roughing and toughing it up, going from being like a soft-spoken boy to like a drug dealer when I got older. So masculinity became way more of a thing I had to have in order just survive because you didn't want to be labeled like the gay guy when you are walking down the hood.
>
> Ricky, 22-year-old from Milwaukee

Thus, his gentle, soft-spoken nature was not only devalued, it put him at risk for violence and homonegativity. In response, he changed his demeanor so as not to be targeted or labeled as gay or feminine. For Ricky, and many participants in this study, gender expressions were often conflated with sexual identity. This was particularly evident when participants described childhood experiences prior to having any conceptualization of their sexual identity, wherein appearing too feminine (e.g. "nice or soft spoken" as described by Ricky) was seen as in conflict with masculine expectations in the "hood" and equated with being gay.

Participants understood the importance of masculinity early in life and similarly were aware of the consequences of being perceived as too feminine, as evident in another participant's experience:

> It's important in my community for me to be masculine 'cuz I don't wanna get discriminated against. This is only what I've been taught growing up, that I've to be this way or that way, or I'm gonna get gay bashed, or I'm gonna get stoned, or beat. So, for my community I feel that it's very important, but when I go out to different communities, as far as the gay community, then I'm able to relax and I'm able to be what I label myself to be in between. Like I'm able to be just who I am. Like, when I first walked into here, I had a different exterior on. But, when I came into the door and like, nobody can hear me now, and I feel like with you, I'm being myself. So it's different communities and different environments that I'm in that makes me feel I have to be more masculine over here or something is gonna happen. But then over here I can be a little more calm or relaxed or whatever, especially with my actions and who I am-be true to myself. I hate it that it's like that, but it's like that
>
> Martin, 25-year-old from Milwaukee

In order to minimize homonegativity and violence, many participants engaged in similar role flexing, the modification of behavior, mannerisms, or demeaner to adapt to non-gay-friendly environments or situations.[39] As Martin noted, he could "be who I am" in his gay community, but otherwise had his guard up until he could ascertain whether he was safe to be his true self. He even noted uncertainty walking into the interview, regarding whether he needed to portray himself as more masculine or heterosexual and did not relax until he was in the private interview room and had established some trust with the interviewer, another gay Black man.

Nowhere to belong

The structural disadvantage and masculinity norms faced by participants contributed to many individuals feeling excluded and marginalized from Black and gay communities. A

common thread throughout the interviews was the recognition that their white GBM peers benefited from white privilege that contributed to different life experiences and protected them from the structural disadvantages described earlier. Participants frequently described a hierarchy of identities in American society, putting Black GBM at the bottom of this system.

> To be a Black male is the worst thing that you can be in America. And then to be a gay Black male is like the worst of the worst that you could be. So, I feel like the gay white man's life is still valued way more than you know a Black woman, so Black people kind of judge us more than they would judge the gay white man, because the gay white man is still going to get that car and get that job before you would.
>
> Johnny, 25-year-old from Milwaukee

Participants described the challenges they faced in navigating multiple marginalized identities. Although GBM of all races may be subject to homonegativity, participants noted that race afforded white men opportunities not available to Black men. Being white in the United States bestows a host of privileges and affects one's societal value and position, even in the presence of other societal stigmas (i.e. homonegativity). This was echoed by another participant:

> A lot of white gay men think they've given up white privilege because they're gay. For some reason, white gay man think that they can own the struggle, you know, any kind of oppression struggle because they can see other white [straight] men around them not experiencing what they experienced. But then you have no idea when you add that layer of Black on there or if you add that layer of being a dark-skinned black person on there. Just like, fuck, white gay men have no idea how good they have it.
>
> Bryan, 25-year-old from Milwaukee

Throughout these interviews, participants in Cleveland and Milwaukee contrasted their experiences as Black GBM with those of white GBM. They noted that although white men may face similar oppression and stigmatization due to their sexual identity, white men retained and benefited from their white privilege, making their experiences as gay men quite different. Additionally, as Black men, their experiences of racism provided knowledge and understanding of what it was like to be marginalized, prior to identifying as gay or bisexual.

> It's almost like the deck was stacked against me from the beginning. It was already tough, so being gay didn't necessarily make it just that much tougher. Life was already tough as a Black man, so I already had thick skin. I already knew it was like being to be discriminated against. Before I was called faggot, I was called a nigger.
>
> Joshua, 35-year-old from Cleveland

As this participant noted, his race put him in a certain social position and made him vulnerable to name-calling and oppression early on in life. Although these experiences prepared him for homonegativity, they did not help him gain belonging or acceptance, and he still faced the individual and social consequences of exclusion and marginalization.

As individuals facing multiple marginalized social positions, participants expressed frustration over never being 'enough' of one identity or the other. They were not fully accepted in the gay community because of their race and not fully accepted in the Black community because of their sexual identity.

> To be a gay Black man is to be attacked on all sides and still expect to stand in on your own. In the Black community, people don't want to face this, but there's a hell of a lot of homophobia. Then you turn around and in the gay community, there's a hell of a lot of racism. One part of me is rejected here, one part of me is rejected here. That's what I feel it means to be a gay Black community. It means that there is no country for me. It was no place for me. Therefore, I have to build my own, carve out my own space.
>
> Bryan, 25-year-old from Milwaukee

This is the crux of intersectional stigma; multiple intersecting social stigmas create environments in which individuals are alienated and not fully realized. Black GBM were not fully accepted by the Black or gay communities and, as Bryan noted, they often had to create their own communities and safe spaces in response.

Syndemic conditions stemming from Intersectional Stigma

The intersection of racism and homonegativity and its consequences in the lives of Black GBM contributed to syndemic conditions of childhood trauma, poor mental health, substance use, and HIV risk. Participants' childhood traumas were closely intertwined with intersectional stigma and were often a symptom of structural racism and concentrated disadvantage. Similarly, the reinforcing nature of substance use, mental health, and HIV risk that has been documented in the syndemic literature, was rooted in intersectional stigma.

Childhood trauma

Reports of significant childhood trauma and abuse were common among study participants and were often intertwined with structural disadvantages. For example, experiences with the foster care system, the criminal and juvenile justice systems, poverty, absentee fathers, and housing instability were frequently linked to participants' trauma.

> I grew up in the projects of Chicago, at the Cabrini Green, and I got taken away from my mom at 8 years-old and went to the State of Child Services. I went through 14 different foster homes. So, I say that it made my growing up, from 8 to 23, it made it just difficult to keep moving and moving and moving like that or whatever. I'm making life the way that I want it to be now versus how it used to be, 'cuz it wasn't good at all.
>
> Robert, 25-year-old from Milwaukee

Although an extreme case, many of our study participants described similarly difficult childhoods of instability and uncertainty. For some, childhood traumas were a direct consequence of homonegativity and the negative reactions they received to their sexual identity. One Cleveland participant described his relationship with his parents after coming out:

> Me and my father's relationship is mostly non-existent. I know him and I know where he lives and all of that, but he's not very useful as a parent. My mother and I had been incredibly close. Then I came out when I was 12 and then 13. And we went from being incredibly close to like fighting every single day. She ended up kicking me out when I was 14, because she finally believed that I was gay and she says she can't have a no fags living under her roof, so I had to go live with my father, whom she knew actively was using drugs and an alcoholic. So, I was like, "you would rather me go there?" And that was when I just got my things and I left. And I was in and out of the house all high school.
>
> Joby, 28-year-old from Cleveland

Participants in both cities described family turmoil after telling their parents about their sexual identities, and many experienced housing instability as a result. After being forced out of his mother's house, Joby spent the next several years in unstable housing situations with his father, exposing him to substance use, violence, and homelessness at an early age.

Several participants also described being sexually abused as children and the emotional toll that has taken on them. For example, one young man described how he still struggles with understanding why he was abused, which he viewed as closely tied to his sexuality:

> I was [molested]. It was very, very hard for me to accept the fact that I was the chosen one. On a spiritual realm, I hear in church all the time. I hear that God will not put too much on you can't bear. He chose those ones in particular because they're the strong ones. Fortunately, I have been able to survive it. I was just talking to my sister about this, I always felt disconnected with men. I just never felt like I was man enough or I did not know how to use my testosterone correctly because of what happened to me. I was sexually, inappropriately touched.
>
> Marcus, 27-year-old from Milwaukee

While religion can provide comfort in the face of distress and trauma, for Marcus, church teachings around resilience and overcoming obstacles made it hard for him to understand and cope with his abuse. He went on to describe the depression and suicidal ideation that followed his abuse and the challenges he faced in not allowing his molestation to become central to his identity. Religion and the Church played a large role in many participants' lives, as it was a central part of their families and communities growing up. Yet, several participants also described homonegativity within the Church and challenges they faced in coming out within religious homes and communities.

Mental Health: Psychological distress from societal and internalized homonegativity

Depression and anxiety were common among this sample, particularly during adolescence. As noted earlier, from an early age many young men were acutely aware of masculine norms and expectations and the potential family and societal consequences associated with being gay Black men. As these young men started to understand and accept their identities as gay, bisexual, they faced significant internal turmoil and struggled to balance their identity with societal and family expectations. Many were still struggling with self-acceptance.

> I can't describe [my sexuality]. I mean, I like guys. Somedays I don't want to. Somedays I wish I was normal, somedays I am ok with it, somedays I'm not. I deal with chronic depression, so when it hits me, it hits me hard, and I really fall behind in life in general. It can be daunting sometimes but I am ok with it.
>
> Edward, 28-year-old from Cleveland

The notion that someone is not "normal" because of their sexuality is a reflection of internalized homonegativity that contributed to Edward's battles with depression and anxiety. Internalized homonegativity is often a reflection of societal views of sexuality and what is considered "normal" and how individuals are supposed to act. Men can internalize these negative views of homosexuality, contributing to chronic depression and struggles with self-acceptance. Another participant described his frequent suicide attempts associated with internalized homonegativity and self-hatred over his sexuality.

> I used to hate myself. From the age of seven up until 17 again, I used to try to commit suicide all the time. I knew my thoughts, I hated it. Even up until 17, I never thought I would come out. That was never part of the plan. I used to force myself to watch straight porn and, you know, like I felt so bad… I didn't want nobody knowing this, so just dealing with that by myself, like I battle with depression. For a while, I was on the depression pills.
>
> Matthew, 20-year-old from Milwaukee

Suicidal ideation was not uncommon among this sample, particularly during adolescence when individuals were starting to become more aware and ashamed of their sexuality. Another participant in Cleveland similarly described the suicidal ideation he experienced when he realized he was gay at age 16:

> I was in high school in the locker room and when we had swim class we were changing and I would look over and this guy was changing his clothes and I felt some type of way and I was like what in the world, so I told the teacher that I was sick and I didn't swim. After that, I went home and took a bottle of pills… I felt like my whole life everybody told me that I was gay, and I was like "no I'm not." And then I felt like at that point that I was gay and that my whole life was over. Everybody was right and everybody hated me, and I just wanted to die. Like, that was the worst day of my life. I remember everything about that day… my family really hated gay people. Like my brother hated gay people, my mom always had something negative to say about HIV and gay people and how they give each other HIV, and they would give it to girls and all kind of stuff. My grandfather is really all I had, and he despised gay people so it's like everybody hates me. I didn't want to live.
>
> Junior, 25-year-old from Cleveland

The reactions participants had toward realizing they were gay reflect the intersecting stigmas they had been exposed to their entire lives. Homonegative messages and masculinity norms had surrounded them since childhood and produced environments in which it seemed impossible to be loved or happy as a Black gay man. Homonegativity experienced by many of our participants was also closely intertwined with HIV stigma, or the stigmatization of

individuals living with or perceived to be at risk for HIV, including men who have sex with other men. The negative association with being gay was often at least partially rooted in conceptualizations of gay men as vectors of HIV, particularly for women.

Substance use as a coping mechanism for adversity

Substance use was a common theme throughout the interviews, as it was closely tied to childhood traumas, community disadvantage, and tumultuous relationships with parents. Substance use was also frequently used as a coping mechanism for experienced and internalized homonegativity. One participant described how his first sexual experiences required alcohol to cope with complicated feelings of being "bi-curious" and embarrassment about being attracted to other men in high school. He then recounted his first sober sexual encounter that occurred during college:

> That's when I had, you know, my first conscious experience… the first time I was sober, and I knew fully what I was doing, I was in college… one thing led to another. And it was the first time I can literally just like, I wasn't under the influence of anything. I could honestly just be true to myself and said, "I'm literally enjoying just having sex with this person."
>
> DeJuan, 20-year-old from Milwaukee

Sex under the influence of drugs and alcohol was a way that many young men were able to cope with complicated feelings about their identities and sexual attractions. When men felt comfortable with themselves and their identities, they did not need to use drugs and alcohol to facilitate sex.

For many participants, substance use was closely tied to mental health challenges and periods of depression and anxiety. One individual described losing his best friend at the age of 24 to complications from AIDS two years prior and how he used substances to cope with this loss:

> I've made some really big mistakes in the last two years of my life, too. Because when he first died, I think I wanted to die. So maybe I was doing drugs and I was doing all of this foolish shit to try to cope. And I found myself landing in bed doing the same thing that he was doing… it's fucked up the way that I feel about it, but I try to not let it fuck me up. I was so close to him for so, so, so long, and it was like I watched it all happen. I knew things that nobody else knew was going on with him. I knew when he would be sick, and he wouldn't go to the doctor. And afterward I blame myself. Like, I should have went and told his mom and have somebody make him go. But at that time, he was grown then. Nobody could make him go, you know?
>
> Robert, 25-year-old from Milwaukee

In an effort to cope with his friend's death and the self-blame he experienced, he turned to drugs and went on to describe frequent condomless sex with casual sex partners and random hook-ups; the same behaviors that contributed to his friend's HIV diagnosis. This narrative of substance use, mental health challenges, and unsafe sexual practices was not uncommon among this sample. Substance use was frequently cited as interfering with condom use and

other safe sexual practices. One participant described using alcohol to cope with a period of depression and noted that alcohol and stress contributed to inconsistent condom use.

> That was during a really big depression time in my life. I was drinking a lot… I will say, alcohol is a big one. I won't say you don't think about [using a condom], but you don't follow your steps like you normally would when you're sober. So, I would say alcohol has definitely been one of big ones, for real. Another situation [when I don't use a condom] would be, I would say stress. You want to do anything and everything at that moment just to feel some type of pleasure in a situation where you don't feel like that.
>
> DJ, 29-year-old from Milwaukee

While the lack of intimacy and minimized sensation associated with condom use is frequently noted as a reason Black GBM do not use condoms,[40] during periods of high stress or depression, the pleasure and intimacy of condomless sex may be particularly appealing.

The influence of intersectional stigma on HIV risk

As is well-documented in HIV syndemic literature, the substance use and untreated mental health conditions described above contribute to HIV risk. However, our analyses also reveal how intersectional stigma works to shape and reinforce the syndemic conditions and further contribute to HIV risk. This was evident in a conversation with a Cleveland participant:

> There's this whole feeling of wanting to have closeness and that oftentimes the only time that we can have closeness with another man is to have sex with him. And then afterwards we want to be away from him as quickly as possible. He wants to be away from us as quickly as possible because of whatever reasons. Primarily shame, but you wanted that closeness so badly. It's just physical, may not even be satisfying. And when I was younger, I would have sex with men just so that I could be close to someone, so I can be held, so I can feel some more… It just would validate something in me.
>
> Joby, 28-year-old from Cleveland

Sex was a way for men, particularly those who experience shame as a result of societal and internalized homonegativity, to feel validated. The physical closeness afforded by casual sex filled an immediate need for intimacy and validation, yet such feelings were fleeting, and Joby's encounters often ended with a desire to be "away from him as quickly as possible." Attempts to feel wanted and validated via casual sex contributed to HIV risk while only momentarily filling intimacy needs.

In addition to contributing to HIV risk behavior, participants cited several social factors that interfered in HIV testing and prevention efforts. For example, intersectional stigma was a noted barrier to PrEP, which participants described as a "gay pill". For many participants, taking PrEP was an outward expression of their sexual identity and put them at risk for greater homonegativity. The link between PrEP and sexual identity made it difficult for some men, particularly those who were on the "down low", to consider it a viable option for HIV prevention.

> Down low men, especially African American men, we will never get them to openly admit [to having sex with men]. So, if we can like, push it on to the women and kind of sort of, you know, like, oh, well, baby, you should take this too because this will save us. I don't know. Again, the stigma associated with it … [Because] nobody wants to say, 'I'm gay.' Men who believe they're heterosexual but sleep with men, they don't want to say, 'I'm gay.' And that's the gay pill.
>
> Collin, 25-year-old from Milwaukee

Homonegativity in the Black community made it difficult for some Black GBM to identify as gay, and taking PrEP was seen as an acknowledgement that one was gay. This was echoed by someone in Cleveland:

> A lot of the gay black males are not out of the closet. They don't want to take PrEP because they don't know that it exists and when you do tell them that it exists, they are like, 'I'm not going to no clinic and ask for a gay drug.' … A lot more white men are knowledgeable. They see doctors frequently more than gay people. Like me, if I didn't go get tested, I wouldn't have known about PrEP. Versus white men who go to the doctor every 3 months for no reason, just that they have good healthcare.
>
> Junior, 25-year-old from Cleveland

Homonegativity was also cited as a barrier to HIV testing:

P: I really wasn't going to go get tested as, as much as I should have because of the stigma of just going to go get tested… as a gay man who isn't really involved in the gay community, there is a stigma to going to the gay clinic and just seeing a whole bunch of gay guys going there. It's just something in the back of your head. When I was younger like I was more closed-minded to it, so I really didn't want to be around as much gayness. -Ricky, 22-year-old from Milwaukee

Homonegativity not only made it difficult for some men to be open about their sexuality, it also limited access to HIV testing and prevention services for Black GBM. When men are unable to openly identify as GBM, they often have more limited engagement with the LGBT community and community resources. This exclusion from the LGBT community may limit an individual's awareness of and access to PrEP. Additionally, given that PrEP is only available by prescription, men who are unable to talk to their healthcare provider about their sexual partners due to stigma are also less likely to be willing to ask about or acknowledge their need for PrEP. Ricky also noted the unique challenges for Black men, suggesting that white men are more knowledgeable about PrEP due to their increased engagement with the healthcare system and "good healthcare."

The structural racism and inequalities described earlier also shaped Black GBM's access to HIV prevention services. For example, several participants described how racial neighborhood segregation contributed to inequities in neighborhood resources and limited access to healthcare. One individual noted, "Clinics are more funded in Caucasian neighborhoods and I just feel like there is more money, and more access as far as good clinics to go to." [Rodney, 25-year-old from Milwaukee] Similarly, as Black men,

participants experienced structural barriers to establishing trusting relationships with physicians. One participant in Cleveland explained that although he received regular healthcare growing up, the power dynamics between physicians and patients, particularly Black patients, influenced his perception in health care.

> I never missed a shot. I had physicals and all that good stuff. I wasn't the kid who would ask my doctor questions or say whether I agreed with certain things they did. I never had that because my mother didn't do that either. My mother is very passive when it comes to dealing with any forms of authority. [Doctors have] perceived authority over a lot of lower income families, especially lower income Black families. So, we were kind of just at the whim of the doctor.
>
> Joby, 28-year-old from Cleveland

Interactions with the healthcare system are shaped not only by the hierarchy between patients and providers, but also by racism and classism. These structural inequities make it difficult for patients, particularly lower-income Black patients, to ask questions, advocate for themselves, and receive high-quality healthcare.

Discussion

This study demonstrates how intersectional stigmas experienced by young Black GBM act as harmful social conditions that contribute to syndemics. Our results suggest that the environments in which Black GBM live, namely, a society characterized by personal and structural racism and homonegativity, compound their social and HIV risks. These intersecting stigmas and oppressions produce and reinforce syndemics in a way that is fundamentally different than the syndemics faced by White GBM. Importantly, this study highlights why typical quantitative approaches to understanding syndemics may obfuscate the lived experiences of Black GBM and others living with multiple marginalized identities.[2] As evidenced in these narratives, such experiences are nuanced and complex, and the intersection of oppressions is difficult, if not impossible, to untangle. Furthermore, our data make clear that contextual factors, such as the environments in which people live, affect how syndemics emerge and persist.

Beyond this, however, our study also underscores the importance of applying an intersectional lens to syndemics among young Black GBM. As described earlier, recent quantitative research has demonstrated the presence of a syndemic of substance use, violence, and internalizing mental health among all GBM. However, researchers found this syndemic to have a greater association with condomless anal sex partners among young White GBM as compared to young Black and Latino GBM.[2] This research highlights the limitations of quantitative syndemic research that examines the additive effects of individual-level syndemic factors in explaining racial disparities in HIV.[2] Qualitative data on intersectional oppressions can reveal how overlapping social categories are rooted in and contribute to systems of oppression and syndemics among young Black GBM. For young Black GBM who are disproportionately affected by the HIV epidemic, intersectionality can help uncover how the HIV epidemic remains concentrated among individuals with multiple disadvantaged social statuses, by moving beyond singularly examining social

categories such as race, gender, and class. Research on syndemics among Black GBM must expand from typical conceptualizations and measurements of syndemic conditions to one in which the influence of individual and structural-level racism, experienced and internalized homonegativity, and expectations of masculinity are considered intersectionally. Disproportionate rates of HIV, poor mental health, and polysubstance use reflect GBM's social conditions and intersectional positions and thus, understanding Black GBM's experiences with these syndemic conditions requires an approach rooted in intersectionality.

Participants' experiences at the intersection of race, gender, sexuality, and for some, socioeconomic status, reflect broader systems of oppression faced by Black men at the social, structural, and political levels. As evident in their narratives, these multiple intersecting stigmas can increase one's risk of experiencing one or more syndemic conditions that contribute to HIV disparities. The syndemic conditions of childhood trauma, poor mental health, substance use, and HIV risk behaviors were evident among this sample, but emerged within the larger racial and sociopolitical environments in which they lived. Black GBM's risk for HIV and syndemic conditions is linked to structural racism and the effects of intersecting oppressions. Pervasive homonegativity, structural racism, and negative sociocultural environments made these young men particularly vulnerable to isolation, substance use, and sexual risk behaviors. Yet, marginalization and oppression are rarely measured and included as key components of syndemics, despite contributing to syndemic conditions and HIV outcomes.[8,41]

Masculinity norms are influenced by the intersection of race, sexual identity, and gender. Masculine ideologies and social scripts have been linked to the economically and social-politically constrained environments in which some Black men live. These masculinity norms may be characterized by HIV risk behaviors including hypersexuality and having multiple sexual partners,[30,42] and may reflect challenges Black men face in fulfilling traditional masculine expectations. Not only are such norms rooted in historical racial contexts,[43] but they also reflect homonegativity. For Black GBM, role-flexing and sexual risk behaviors may be strategies used to distance themselves from stereotypical perceptions of homosexuality as being effeminate or less manly.[44] Gender role norms conflate masculinity and heterosexuality such that deviations from masculine expectations were viewed as an indication of one's sexuality and something to be suppressed. Expectations of masculinity emerged in childhood and those who did not conform to masculine ideals faced violence, family rejection, and stigma. During adolescence, as many participants began to identify as gay or bisexual, masculine socialization contributed to distress, shame, and suicidal ideation.

A prominent theme in our research was the ways in which Black GBM felt isolated from both the Black and gay communities. The experience and effects of stigma can vary depending on the source. For our participants, stigma and oppression from their communities (i.e. the Black and gay communities), contributed to isolation, depression, and marginalization. Participants felt neither Black nor gay 'enough' to be welcomed into either community, creating a unique experience of isolation. The white privilege maintained by White GBM allows them to avoid the depth of isolation and marginalization experienced by Black men not only at an interpersonal level, but at a structural level as well. For example,

as Black men, study participants were disproportionately impacted by the child welfare and criminal justice systems, subject to the negative consequences of neighborhood racial segregation, and expected to conform to expectations of masculinity.

As documented throughout, participants' narratives revealed numerous adverse childhood events and significant life hardships. Despite those experiences, many of these young Black GBM were thriving, had learned adaptive coping strategies, and had positive self-identities. Our study did not adequately examine resilience resources, yet there is a need for research that examines how young Black GBM cope with intersectional stigma and explores how, despite pervasive racism and homonegativity, only some men experience syndemics.[10] Interventions that enhance resilience and focus on Black GBM's strengths in high-risk situations and environments may help men cope with intersectional stigma and avoid syndemics. Additionally, our findings suggest that interventions aimed at addressing syndemic conditions among Black GBM would benefit from incorporating an intersectional perspective. Intervening in the syndemic conditions affecting Black GBM requires an understanding of the context in which the syndemic conditions emerge,[4] which necessitates an examination of the intersecting experiences of racism and homonegativity. For example, HIV prevention interventions rooted in critical consciousness and empowerment theories may help young Black GBM more positively cope with experiences of intersectional stigma,[45] reducing the mental health, substance use, and sexual risk consequences described by participants in this study. Furthermore, interventions that address societal inequities including poverty, trauma, violence, and neighborhood segregation may be essential in reducing HIV disparities. Future research on syndemic conditions would benefit from incorporating an intersectional lens, qualitatively and quantitatively assessing how intersectional oppressions contribute to syndemic conditions.

This study has limitations. First, there are challenges to conducting qualitative research on syndemic conditions. While qualitative data can demonstrate the co-occurrence of epidemics and individual- and structural-level health and social conditions, it is unable to untangle the interactions or reinforcing nature of syndemic conditions.[34] Furthermore, qualitative methods are unable to assess the extent to which psychosocial experiences (e.g. mental health or substance use conditions) interact to magnify HIV risk.[7] However, quantitative approaches risk over-simplifying syndemics and do not capture the context in which syndemics occur,[46] highlighting the importance of including qualitative data in conversations about syndemics, despite limitations in the analyses.[34] Our study may also be limited by recruitment bias. In both cities, much of our sample was recruited through networks of LGBTQ service providers and stakeholders, or HIV-testing clinics. Black GBM who are younger, have more limited engagement with the LGBTQ community, are not open about their sexual identity, or are unable to access service organizations may have experiences not represented here. Similarly, Cleveland and Milwaukee are similar mid-size midwestern cities and our findings cannot necessarily be extended to Black GBM in other areas of the United States. Finally, our study only included Black GBM. Thus, it is unclear how these experiences converge with or differ from GBM of other racial or ethnic backgrounds.

Intersectionality provides needed context to understand syndemics and contextualize the behaviors and circumstances that contribute to HIV disparities. Future research should continue to examine how syndemics affect Black GBM and the potential influences of cultural, social, and political structures and oppressions that create and maintain syndemics. With a better understanding of the mechanisms of influence, we can better intervene at the social and structural levels to reduce HIV disparities.

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Highlights

- Intersectional stigma and oppression contribute to syndemic conditions and HIV risk
- Black GBM contend with racism, homonegativity, and masculinity norms
- Intersectional stigma is intertwined with substance use, mental health challenges
- An intersectional examination of syndemics can improve HIV prevention