HHS Public Access

Author manuscript

Pediatr Clin North Am. Author manuscript; available in PMC 2021 December 21.

Published in final edited form as:

Pediatr Clin North Am. 2020 April ; 67(2): 293–308. doi:10.1016/j.pcl.2019.12.003.

The Health Challenges of Emerging Adult Gay Men Effecting Change in Health Care

Perry N. Halkitis, PhD, MS, MPH[a,b,c,*], **Anthony J. Maiolatesi, BA**[a,d,e], **Kristen D. Krause, MPH**[a,f]

[a]Center for Health, Identity, Behavior & Prevention Studies, Rutgers School of Public Health, One Riverfront Plaza, Newark, NJ 07102, USA

[b]Department of Biostatistics, Rutgers School of Public Health, 683 Hoes Lane West, Piscataway, NJ 08854, USA

[c]Department of Urban-Global Health, Rutgers School of Public Health, 683 Hoes Lane West, Piscataway, NJ 08854, USA

[d]Department of Social and Behavioral Sciences, Yale School of Public Health, 60 College Street, New Haven, CT 06510, USA

[e]Center for Interdisciplinary Research on AIDS, Yale University, 135 College Street, New Haven, CT 06510, USA

[f]Department of Health Behavior, Society, and Policy, Rutgers School of Public Health, 683 Hoes Lane West, Piscataway, NJ 08854, USA

Keywords

Health disparities; Gay men; Sexual minority men; Gay men's health; Health challenges; Healthcare challenges

INTRODUCTION

In the United States, lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals experience a preponderance of health disparities.[1] These health challenges are predicated on the chronic marginalization and discrimination,[2,3] some of which are state sanctioned,[4,5] experienced by the population, coupled with a health care workforce that is inadequately prepared to effectively address the specific health needs of the population. These challenges continue even though policy makers have drawn attention to these matters in recent years.[6,7] In effect, it is imperative that health care providers are adequately prepared to meet the health needs of this population.[8]

Addressing the health needs of the LGBTQ population necessitates a thorough understanding of matters related to both sexual identity (also known as sexual orientation) and gender identity.[9] Using and understanding the correct language and terminology as it

*Corresponding author. Departments of Biostatistics, Epidemiology and Urban-Global Health, School of Public Health, Rutgers University, 683 Hoes Lane West, Piscataway, NJ 08854. perry.halkitis@rutgers.edu.

relates to the identities of LGBTQ people is an essential initial step in providing competent and compassionate medical care. In this regard, it is critical that providers distinguish sexual orientation from gender identity, as these terms are often conflated with one another. Gender identity refers to "a person's innate, deeply felt psychological identification as a man, woman, or something else, which may or may not correspond to the person's external body or assigned sex at birth (ie, the sex listed on the birth certificate)."[10] Terms that are commonly associated with minority gender identities include genderqueer, gender nonconforming, and gender bender, all of which can be used to refer to gender variations that are not typically associated with the dichotomous view of male and female. Sexual orientation refers to "a person's enduring physical, romantic, emotional, and/or spiritual attraction to another person."[10] Examples of sexual identity include gay, lesbian, heterosexual, bisexual, pansexual (ie, a person's attraction toward people regardless of their sex or gender identity), and asexual (ie, a lack of sexual attraction to others). Sexual identity encompasses both attraction and behavior, and is not limited solely to the sexual acts in which one engages. In this regard, ancient Athenian men engaged in same-sex behavior with young boys, but did not espouse a gay identity. As noted by classicist Eva Keuls[11] (pp. 1–2), "homosexuality as practiced by the Athenians was not about an identity, community, or movement; rather, it was part of a larger syndrome which included men's ways of relating to boys, wives, courtesans, prostitutes, and other sexual partners, and, in a larger sense, to both the people of Athens and to the other city-states." In a sense, Athenian homosexuality was about a patriarchy rooted in male dominance, misogyny, and power, and nothing akin to the gay rights movement of the twentieth century. In the end, homosexual behavior is only one sliver of gay identity, an identity that intersects with many other identities that gay men possess.[12,13]

Over the past 30 years and directed by the acquired immunodeficiency syndrome (AIDS) epidemic, there has been an evolution of terminology associated with sexual orientation labels. The term men who have sex with men (MSM) was coined in 1994 by the Centers for Disease Control and Prevention and has often been used in the human immunodeficiency virus (HIV) literature.[14] The argument for its initial use was driven by 2 perspectives: (1) epidemiologists sought to avoid complex social and cultural connotations that may hinder an epidemiologic investigation of disease by using identity-free terms, and (2) social construction suggests that sexualities are products of social processes and that a more textured understanding of sexuality does not assume alignments among identity, desire, and behavior.[14] MSM and, more recently, WSW (women who have sex with women) have become dominant terms in health-related programming and research for sexual minorities.[14] However, using these umbrella terms often implies a lack of gay or lesbian identity with an absence of community and networks in which same-gender relationships mean something more than just sexual behavior.[14] Moreover, the use of these behavioral/epidemiologic terms fails to address the complex synergy that exists between identity and social conditions, effectively diminishing the significance that identity plays in affecting health, and ultimately framing sexual and gender minority individuals as vectors of disease.[14-16] Inherently, being gay is different from being bisexual or pansexual, although the sexual behavior may be the same, the feelings and salience can be quite distinct.

In addition, the umbrella term LGBTQ is limited in considerations of health and health care for this population recently estimated to constitute approximately 4.5% of the US population.[17] The population is not monolithic, and there is great diversity in the life experiences of L, G, B, T, and Q people.[18] Indeed, across these populations, there is even greater diversity when these identities are considered in relation to age, race, ethnicity, culture, gender identity, national origin, and social class, among other factors. In this regard, conceptualizations and frameworks that seek to target the entirety of the LGBTQ population often fail to address the specific and nuanced health challenges and health care needs of subpopulations within the LGBTQ population. For example, it would be inadequate and false to state that HIV is a health disparity that disproportionately affects the LGBTQ population; rather, it is a health disparity in the United States that overwhelmingly burdens gay and bisexual men and transgender women,[19] who are part, but not the totality, of the LGBTQ population.

It is with this idea in mind that the authors further contextualize the ideas presented in the pages to follow. Given the particularities of health challenges facing various segments of the LGBTQ population, efforts herein focus on one segment of the population: gay men. In particular, the authors consider the health challenges faced by gay men who are emerging adults, recognizing that it is during this period that a vast majority of gay men emerge into their sexual identities,[13,20] and that this developmental period is often fraught with risk behaviors[21] that might impact the health profile of these men in the immediate and set the foundation for health issues across the life course.[22]

ADOLESCENCE AND EMERGING ADULTHOOD IN GAY MEN

The psychologist Jeffrey Arnett (2000) conceptualized the developmental state of emerging adulthood to differentiate the period between adolescence and adulthood, which, in Western industrialized nations, encompasses approximately ages 18 to 25. More recently, the period has been expanded to age 29 so as to capture demographic and educational shifts and also due to the financial realities of Millennials, including Millennial gay men, brought about by the economic crash of 2008 to 2009.[23,24] The group that has come to be known as the Queer Generation[13] is challenged to achieve the financial stability and economic security of generations that preceded them. The demarcation of these years as a developmentally significant period emerged from such demographic trends as an increase in the median age at marriage, lengthier periods of formal schooling, and later ages for having a first child. Some 30% of those graduating high school do not attend college,[25] compounded by those who do not complete high school, makes this a challenging period of exploration and selfdiscovery. Black and Latino emerging adults are especially challenged during this developmental period because of sociocultural stereotypes about the competencies of minority youth.[26] There has also been a sharp decline in employment opportunities for those with only a high school education, and recent data note that 65.8% of those ages 20 to 24 do not have a college degree.[27] Although there is no longer a lock-step pattern to this period of development, those who successfully negotiate more of the tasks as they transition from the adolescence period, including their education, will experience greater well-being than those who falter and stall.[28]

For gay men, the period of emerging adulthood is a highly vulnerable period in which the confluence of sexual risk taking, drug use, mental health burden, incarceration, and other risk conditions,[29-31] precipitated by experiences of homophobia and discrimination[32,33] from society at large, as well as racism and hegemonic notions of masculinity within the gay population,[13] compromise health and well-being that may last throughout adulthood.[34,35] All in all, these conditions necessitate that health care providers be adequately prepared to address the health needs of this population; to date, there is evidence that such preparation is lacking,[36] first documented in the seminal work of the National Academies.[37] The lack of health care workforce preparation often leads to conditions in which these young gay men forgo care.[38] Although the provision of care for emerging adult gay men has improved relative to past generations of gay men, who were pathologized due to their sexual identity being categorized as a mental illness, invisible to health care providers because of fear of discrimination, or neglected because they were afflicted with AIDS, the conditions are still far from ideal.[39]

HEALTH CHALLENGES FACED BY YOUNG AND EMERGING ADULT GAY MEN

The emergence of the AIDS epidemic in the later twentieth century engendered an unprecedented public health focus on the health and health care needs of gay men.[40] Accordingly, a wave of biomedical and social science emerged that clearly demonstrated the extent to which gay men, including emerging adult gay men, are disproportionally affected by a host of health-related challenges relative to their heterosexual peers.[37,41]

Health disparities among young and emerging adult gay men are well-documented[37,41]; however, the mechanisms and pathways (eg, biological, psychological, and/or sociologic mediators) linking sexual orientation to differential health outcomes remain poorly understood. These health challenges can be conceptualized within a *minority stress framework*,[42-44] which postulates that sexual minority men evidence higher rates of suboptimal health outcomes, relative to heterosexuals, largely because of stress processes stemming from their minority status (eg, sexual identity) membership and the chronic stigmatization of that identity. That is, in addition to general life stressors, emerging adult gay men experience qualitatively unique social stressors because of their sexuality, which accumulate to negatively impact the health profile of this population. For instance, relative to young heterosexual men, young gay or sexual minority men are significantly more likely to experience childhood victimization (eg, parental psychological and physical abuse),[45,46] school-based/peer victimization,[47] low levels of parental support,[48] and forced homelessness because of their sexuality.[49] As such, the health challenges and inequalities addressed in this article are not causally related to homosexuality or gayness, but, instead, are the reflection of noxious social conditions (eg, social marginalization, exclusion, and structural stigmatization) that work in concert to corrode the health profile of young and emerging adult gay men.[41,50-52]

Mental Health

To date, substantial disparities in mental health have been documented in populations of emerging adult gay men.[43,44,53,54] Indeed, past research suggests that gay men evidence higher rates of psychiatric diagnoses and greater lifetime risk for mood-anxiety-substance use disorders relative to heterosexual men.[55] That is, some studies have shown differential rates or levels of suicidal ideation,[56] suicide attempts,[57-60] social anxiety,[61] self-esteem,[61] body image dissatisfaction,[62-64] alcohol use,[65] eating disorders,[66] cigarette smoking,[67] and illicit substance use[68] as a function of sexual orientation. For instance, in a systematic review of mental health disorders and sexual orientation, King and colleagues[68] documented that, across studies, gay men evidenced greater risk for lifetime prevalence of suicide attempts, lifetime prevalence of depression, and lifetime prevalence of anxiety relative to heterosexuals.

Although many emerging adult gay men may struggle with adverse mental health outcomes and reduced psychological well-being, it is critical to note that certain subpopulations (ie, those who are multiply disadvantaged because of intersecting marginalized identities) may be more at risk than others. For instance, the intersection of racial and sexual identity may predict adverse mental health risk insofar as Choi and colleagues[69] documented an association between discrimination and mental health outcomes such that experiences of racism in the past year were positively associated with adverse mental health outcomes (eg, depression and anxiety) in a population of 1196 African American, Latino, and Asian Pacific Islander MSM. These data highlight the degree to which one marginalized identity (eg, nonheterosexual sexual identity) coupled with a second marginalized identity (eg, nonwhite racial identity) may increase the risk for adverse mental health outcomes.

In addition, Gallo and Matthews' *Reserve Capacity Model* postulates that socioeconomic status (SES) is a worthwhile predictor of health disparities due to the well-documented associations among SES, stress, and health.[70-72] As such, emerging adult gay men from lower SES backgrounds may evidence significantly fewer social and psychological resources with which to manage general and minority stressors, thereby amplifying the risk of adverse mental health outcomes. In support of Gallo and Matthews' model,[72] Storholm and colleagues[73] documented the buffering effect of SES on mental health outcomes in emerging adult sexual minority men, such that sexual minority men of higher SES reported lower scores on depression and posttraumatic stress disorder scales relative to lower SES respondents.

Holistically, these data highlight the degree to which young and emerging adult gay men are susceptible to adverse mental health outcomes; however, clinicians must realize that the susceptibility is not uniform across subpopulations of gay men. Instead, the relation between sexual orientation and adverse mental health susceptibility is significantly moderated by identity intersectionality and the degree of disadvantage stemming from the intersections (for more comprehensive reviews on the application of intersectionality to clinical practice, see van Mens-Verhulst J, Radtke HL, Intersectionality and health care: support for the diversity turn in research and practice, unpublished paper, 2006).[74]

Sexual Health

The most documented and researched health disparity among gay men is HIV. Indeed, gay men make up fewer than 5% of the overall US population,[17] yet account for more than half of those currently living with HIV,[75] and approximately 70% of new HIV infections annually.[76] In addition, sexual minority men are the only population within the United States where rates of new HIV infection remain stable, in lieu of decreasing, each year.[19] For example, in a meta-analysis of US population-based surveys, disease rates of HIV (38–75 times as high) and primary and secondary syphilis (63–109 times as high) were significantly higher for gay men, relative to other men.[74] In addition to HIV and syphilis, gay men are disproportionally burdened by other sexually transmitted infections (STIs),[77] such as bacterial STIs (eg, chlamydia and gonorrhea),[78] human papillomavirus,[79,80] Hepatitis B and C,[81,82] and herpes simplex virus (HSV)-2.[83] STI comorbidity remains a common problem among gay men, with syphilis and HIV coinfection being the most documented comorbidity among this population.[52] Within the population, the preponderance of new infections manifests in black and Latino adolescent and emerging adult gay men (13–24 and 25–34) with a decrease in infection among men in their mid-30s.[84]

Physical Health

A focus on physical health disparities among populations of gay men has lagged behind research in other domains, namely mental and sexual health. Despite this notable lacuna in the literature, recent findings have found sexual orientation to be a robust predictor of adverse physical health outcomes, such as migraine headaches,[85] asthma,[86] cancer-related risk behaviors,[87] and cardiovascular health.[88] Indeed, adolescent gay men are significantly more likely to engage in behaviors that amplify lifetime cancer risk and have long-term physical health consequences relative to heterosexual men, such as smoking, consuming alcohol, using illicit drugs, engaging in risky sexual behaviors, reporting little physical activity, and consuming a diet low in fruits and vegetables.[87] As Rosario and colleagues[87] highlight, many of these health and cancer-related risk behaviors emerge early in the life course of sexual minority men (ie, adolescence), effectively increasing lifetime cancer risk among certain subpopulations of gay men due to earlier engagement in cancer-related risk behaviors.

In addition to behavioral risk factors, gay men have been documented to report lower levels of perceived physical health and higher rates of adverse physical health outcomes. In fact, a Netherlands-based study found that, relative to heterosexual men, gay men reported significantly lower perceptions of general health.[89] Similar findings have been replicated in the United States, with Conron and colleagues[86] documenting that, relative to heterosexuals, sexual minorities were more likely to report asthma, smoking, tension and worry, and activity limitation. More recent work has documented associations between sexual orientation and cardiovascular health such that MSM exhibited elevated cardiovascular risk factors and biomarkers.[88] For instance, MSM exhibited elevations in diastolic blood pressure, C-reactive protein, and pulse rate when compared with heterosexual men. Notably, differences in cardiovascular risk as a function of sexual orientation and gender emerged early, with the mean age of the participants being 28.9 years.[88]

It is important to note that research examining the influence of sexual orientation on physical health is still in its infancy, highlighting that the true magnitude of physical health disparities as a function of sexual orientation remains unknown. However, the preceding data offer preliminary support for the extent to which sexual orientation may be a robust predictor of physical health outcomes and, thus, a clinical focus on gay men's physical health is warranted.

HEALTH CARE CHALLENGES

The myriad health challenges faced by emerging adult gay men are magnified due to hardships in accessing adequate and competent health care that serves the unique needs of this population.[37] Contributing factors to inadequate care include overall lack of provider knowledge on health care needs,[90,91] history of stigmatizing experiences in the health care setting, and discomfort around discussing sexual orientation and/or sexual behaviors.[92-94] Because of these conditions, 18% of LGBTQ Americans avoid receiving health care in fear of being discriminated against or treated poorly by health care providers.[95]

As a result of the discomfort and distrust of health care providers, fragmentation of care is common; research indicates that sexual minority men separate their sexual health care from other forms of health care,[96,97] which can lead to inconsistent and inadequate preventive and/or tertiary care. Integrative models using counseling psychologists have been proposed as a means of ameliorating the effects of this schism in health care access.[98-100] It is for this reason that one goal of the Healthy People 2020 campaign is to "improve the health, safety, and well-being of lesbian, gay, bisexual, and transgender (LGBT) individuals."[101] However, the threatened reversal of protective policies (eg, threats to repeal the Affordable Care Act [ACA] and reinterpret the ACA's antidiscrimination mandate)[102-104] and the removal of sexual and gender identity questions from national health-related surveys by the federal government of the United States since 2016 are clear barriers that undermine the efforts that are sought in the goal of Healthy People 2020.

Negative attitudes toward the LGBTQ population and limited expertise on the particularities of gay men's health create these substandard conditions as emerging adult gay men navigate the health care system. For some, there may be a period of failing to access health care as they emerge into adulthood and migrate from their pediatricians and/or family physicians to providers of their own. Indeed, one study identified that 18.7% of California-based physicians indicated discomfort providing care to gay men,[105] harkening back to the early days of the AIDS epidemic when many gay men were abandoned by their health care providers.[106] These realities emerge in medical school; one study indicated that 15% of medical school students reported mistreatment of LGBT students at their schools, whereas 17% of LGBT medical students reported a hostile learning environment.[107] Implicit preferences for heterosexual people versus lesbian and gay people are pervasive among heterosexual health care providers. Sabin and colleagues[108] report that implicit preferences for heterosexual people versus lesbian and gay people are pervasive among heterosexual health care providers; that implicit preferences for heterosexual women were weaker than implicit preferences for heterosexual men; and that heterosexual nurses held the strongest

implicit preference for heterosexual men over gay men. Such implicit bias is also noted in public health and other health professions, as has recently been reported by Halkitis.[109]

Moreover, a number of studies indicate that medical schools are inadequately preparing students to enact effective LGBTQ health care provisions.[110] LGBTQ health care training in undergraduate medical education is limited to approximately 5 hours,[111] ranging from a minimum of 3 to a maximum of 8 hours. Compounding the conditions nested within the health professions are the attitudes of the general public: 30.4% of those polled in one study indicated that they would change providers if they discovered that their provider was gay or lesbian, demonstrating the pervasiveness of LGBTQ stigma in American society.[112]

The aforementioned health care challenges experienced by emerging adult gay men are echoed by the results from a recent mixed-methods study conducted by some of the authors.[90] The study participants, all of whom were emerging adult gay men, sought providers who possessed knowledge of the specific health care needs of gay men, especially with regard to same-sex sexual health, which are deficient in most medical school curricula[113]: "*I definitely could've used a doctor to talk to like a – yeah, a doctor to talk to just about what's healthy, and what's not with gay sex*." These findings also underscore the extant literature regarding negative provider attitudes: "*The doctor wasn't knowledgeable with the LGBT community… She's never really had gay patients so for her it's kinda new and her reaction* was *kinda like oh, you're young, right now you shouldn't be having anal sex…It wasn't the reaction I was expecting."* The social conditions experienced by some of the gay men were indicative of the homophobia of health care providers: *"He's [the doctor] a Muslim… So his thing is he doesn't wanna hear too much about sex with guys on guys. So it really makes it really uncomfortable to talk about it because all I'm gonna get is 'Marry a girl'- …It just comes up all the time because he knows I am gay."* As a result of such situations, many young gay men turn to sources outside the medical profession for knowledge about their health: "*I've always gotten knowledge of gay men health and about risk and HIV and stuff through outside sources…I feel uncomfortable speaking to my doctor."*

LGBTQ health care centers such as Callen-Lorde in New York City and Fenway Health in Boston provide an important service to emerging adult gay men: *"When I visited the gay center, then they taught me a whole new vocabulary and certain different aspects of myself that I should pay attention to more, which helped me out."* This perspective underscores the need for not only more robust, thorough, and tailored education and training on gay men's health care for medical providers, but it also underscores the need for health care spaces and settings that are affirming of sexual minority individuals.

In addition, economic circumstances might compound the aforementioned matters that undermine the health of gay men. Indeed, LGBT individuals experience higher levels of poverty compared with their heterosexual counterparts.[114,115] Thus, LGBTQ health care access is an economic justice issue.[116] For young emerging adult gay men of the Millennial generation, financial worries reside alongside their concerns about their health and their experiences of loneliness and isolation that function to undermine their health.[117]

ADDRESSING THE HEALTH CHALLENGES OF EMERGING ADULT GAY MEN

Emerging adult gay men are disproportionally burdened by and at an increased risk for health challenges and inequalities spanning multiple health domains (eg, mental, physical, and sexual).[37,41] These health burdens do not occur in isolation; instead, the health profile of emerging adult gay men is defined by a set of co-occurring, comorbid, and mutually enforcing health problems.[118] As conceptualized by Singer and colleagues[119,120] and adapted for gay men by Stall and colleagues,[118] the *syndemic paradigm* postulates that multiple co-occurring epidemics interact synergistically to modify disease risk, transmission, and progression, and that these syndemic conditions are directed by psychosocial burdens, often emanating from experiences of homophobia and discrimination, experienced by this population. These health disparities are largely directed by social and sexual stigma[6]; when laws and policies, such as marriage equality, are enacted, health conditions, including HIV, are projected to improve for the population of emerging adult gay men.[121]

A holistic health care paradigm has applicability to addressing the health of gay men across the lifecourse.[122,123] In this view, health care services for the LGBTQ population broadly, and for emerging adult gay men specifically, must be (1) holistic in nature addressing the multiplicity of health burdens; (2) understood in relation to the social conditions that exacerbate these health disparities, including the transmission of pathogens (ie, a biopsychosocial perspective); and (3) attend fully to sexual and gender identities in the delivery of care. With regard to the latter, it is imperative that emerging adult gay men do not continue to be invisible to health care providers,[124] as they had been before and for years following the Stonewall Riots, which ignited the LBGTQ civil rights movement.[39] One critical step in ensuring this visibility and chipping away at the otherness young gay men feel is the inclusion of sexual and gender identity on all health care intake forms and electronic records.[125,126] Inclusion of these elements function (1) to communicate openly to the provider the identity of the patient, thus directing the provider to tailor services as needed; (2) to validate the life/lived experiences of the patient; and (3) to diminish the stigma and shame too often felt by LGBTQ people. For emerging adult gay men who are in the process of developing their own sexual identity and enacting strategies to disclose who they are, the addition of these 2 questions on any and all health care forms will function to alleviate the already undue burden of a lifetime of “coming out.”[13]

Numerous resources and guidelines[127,128] have emerged in recent time in response to the mounting evidence on the numerous health disparities burdening the lives of emerging adult gay men and the LGBTQ population more broadly, much informed by the approaches postulated by leading medical providers and advocates such as Harvey Makadon and colleagues[129] and organizationally through the National LGBT Health Education Center at the Fenway Institute.[10,129] These efforts advance a set of domains that might impact a positive change in the health care delivery to emerging adult gay men: (1) addressing and developing polices that attend to the well-being of LGBTQ people within health care facilities; (2) creating health care environments that are welcoming; and (3) training staff fully and thoroughly to become more adept at addressing the health of the population. These

recommendations are enumerated more fully in the aforementioned guidelines. Briefly, policy strategies include the development or adoption of nondiscrimination polices to protect patients as well as recruiting and/or identifying health care providers and staff with expertise working with sexual minority gay men. Welcoming environments would include the creation of gender-neutral bathrooms and the clear display of relevant LGBTQ literature. Finally, ongoing staff training to address biases (eg, homophobia and heterosexism), intersectionality, and tailored education on gay men's health are essential. All of these elements should be complemented by the development and implementation of intake forms that include the collection of sexual and gender identity information.

SUMMARY

Ultimately, effective health care for emerging adult gay men must be cognizant of the fact that these young gay men are grappling with their sexuality during this period of emerging adulthood, which compounds and exacerbates the multitude of developmental issues that emerge during this stage of life. Second, a holistic approach to the health of emerging gay men must use a biopsychosocial frame[15,130] in understanding health challenges with an eye to how social conditions may shape health and how social and emotional well-being are critically tied to physical well-being. Third, skilled and competent health care providers must further recognize that the population of emerging adult gay men is not monolithic, and that all possess intersectional identities,[3,122,131] necessitating tailored approaches to care that fully consider the role of race, ethnicity, culture, social class, and nation of birth, among other factors. Finally, and importantly, the health of emerging adult gay men is not solely defined by HIV; and although the disease continues to persist in the population, the health of young gay men must be envisioned with a broader and less stigmatizing frame if the nation and those that provide care to gay men are to advance the well-being of current and future populations of gay men.

Acknowledgments

DISCLOSURE

Research reported in this publication was supported by the National Institute on Drug Abuse of the National Institutes of Health under awards R01DA025537 and 2R01DA025537. The National Institute on Drug Abuse of the National Institutes of Health had no role in development of the study design, collection, analysis, or interpretation of the data, writing of the manuscript, or decision to submit the manuscript for publication. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

Additionally, Anthony Maiolatesi's contribution to manuscript preparation was supported in part by The Yale Center for Interdisciplinary Research on AIDS training program, funded by the National Institute of Mental Health under award number T32MH020031-20.

REFERENCES

1. Meyer IH, Northridge ME. The health of sexual minorities: public health perspectives on lesbian, gay, bisexual and transgender populations. New York: Springer; 2007.
2. Bostwick WB, Boyd CJ, Hughes TL, et al. Discrimination and mental health among lesbian, gay, and bisexual adults in the United States. Am J Orthopsychiatry 2014;84(1):35–45. [PubMed: 24826824]

3. Halkitis PN, Wolitski RJ, Millett GA. A holistic approach to addressing HIV infection disparities in gay, bisexual, and other men who have sex with men. Am Psychol 2013;68(4):261–73. [PubMed: 23688093]
4. Hatzenbuehler ML. Structural stigma and the health of lesbian, gay, and bisexual populations. Curr Dir Psychol Sci 2014;23(2):127–32.
5. Hatzenbuehler ML. Social factors as determinants of mental health disparities in LGB populations: implications for public policy. Social Issues Policy Rev 2010;4(1):31–62.
6. Lim FA, Brown DV Jr, Justin Kim SM. Addressing health care disparities in the lesbian, gay, bisexual, and transgender population: a review of best practices. Am J Nurs 2014;114(6):24–34 [quiz: 35, 45].
7. Mulé NJ, Ross LE, Deeprose B, et al. Promoting LGBT health and wellbeing through inclusive policy development. Int J Equity Health 2009;8(1):18. [PubMed: 19442315]
8. Rossi AL, Lopez EJ. Contextualizing competence: language and LGBT-based competency in health care. J Homosex 2017;64(10):1330–49. [PubMed: 28467155]
9. Mayer KH, Bradford JB, Makadon HJ, et al. Sexual and gender minority health: what we know and what needs to be done. Am J Public Health 2008;98(6):989–95. [PubMed: 18445789]
10. Fenway Health. Glossary of gender and transgender terms. Boston: Fenway Community Health Cent; 2010.
11. Keuls EC. The reign of the phallus: sexual politics in ancient Athens. Los Angeles (CA): Univ of California Press; 1993.
12. Bowleg L “Once you’ve blended the cake, you can’t take the parts back to the main ingredients”: black gay and bisexual men’s descriptions and experiences of intersectionality. Sex Roles 2013;68(11–12):754–67.
13. Halkitis PN. Out in time: from Stonewall to queer, how gay men came of age across the generations. New York: Oxford University Press, USA; 2019.
14. Young RM, Meyer IH. The trouble with "MSM" and "WSW": erasure of the sexual-minority person in public health discourse. Am J Public Health 2005;95(7):1144–9. [PubMed: 15961753]
15. Halkitis PN. Reframing HIV prevention for gay men in the United States. Am Psychol 2010;65(8):752–63. [PubMed: 21058777]
16. Khan S, Khan OA. The trouble with MSM. Am J Public Health 2006;96(5):765–6 [author reply: 766].
17. Newport F In US, estimate of LGBT population rises to 4.5%. In: Gallup: Politics. 2018. Available at: https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx. Accessed June 29, 2019.
18. Stults CB, Kupprat SA, Krause KD, et al. Perceptions of safety among LGBTQ people following the 2016 Pulse nightclub shooting. Psychol Sex Orientat Gend Divers 2017;4(3):251. [PubMed: 29159198]
19. Centers for Disease Control and Prevention. Diagnoses of HIV infection in the United States and Dependent Areas—2017, vol. 24. Atlanta (GA): HIV Surveillance Report; 2018.
20. Moreira AD, Halkitis PN, Kapadia F. Sexual identity development of a new generation of emerging adult men: the P18 cohort study. Psychol Sex Orientat Gend Divers 2015;2(2):159.
21. Steinberg L A social neuroscience perspective on adolescent risk-taking. Developmental Rev 2008;28(1):78–106.
22. Sawyer SM, Afifi RA, Bearinger LH, et al. Adolescence: a foundation for future health. Lancet 2012;379(9826):1630–40. [PubMed: 22538178]
23. Arnett JJ. Emerging adulthood. A theory of development from the late teens through the twenties. Am Psychol 2000;55(5):469–80. [PubMed: 10842426]
24. Arnett JJ, Žukauskienė R, Sugimura K. The new life stage of emerging adulthood at ages 18–29 years: implications for mental health. Lancet Psychiatry 2014;1(7):569–76. [PubMed: 26361316]
25. Bureau of Labor Statistics USDofL. College enrollment and work activity of 2013 high school graduates. Washington, DC: Economic News Release; 2014.

26. Eccles JS, Wigfield A, Byrnes J. Cognitive development in adolescence. In: Weiner IB, editor. Handbook of psychology: developmental psychology, Vol. 6. Hoboken (NJ): John Wiley & Sons Inc; 2003. p. 325–50.
27. Kroeger T, Cooke T, Gould E. The class of 2016: the labor market is still far from ideal for young graduates. Report. Washington, DC: Economic Policy Institute; 2016.
28. Schulenberg JE, Bryant AL, O'Malley PM. Taking hold of some kind of life: how developmental tasks relate to trajectories of well-being during the transition to adulthood. Dev Psychopathol 2004;16(4):1119–40. [PubMed: 15704830]
29. Halkitis PN, Kapadia F, Siconolfi DE, et al. Individual, psychosocial, and social correlates of unprotected anal intercourse in a new generation of young men who have sex with men in New York City. Am J Public Health 2013;103(5):889–95. [PubMed: 23488487]
30. Halkitis PN, Moeller RW, Siconolfi DE, et al. Measurement model exploring a syndemic in emerging adult gay and bisexual men. AIDS Behav 2013;17(2):662–73. [PubMed: 22843250]
31. Halkitis PN, Singer SN. Chemsex and mental health as part of syndemic in gay and bisexual men. Int J Drug Policy 2018;55:180–2. [PubMed: 29661572]
32. Hatzenbuehler ML, Nolen-Hoeksema S, Erickson SJ. Minority stress predictors of HIV risk behavior, substance use, and depressive symptoms: results from a prospective study of bereaved gay men. Health Psychol 2008;27(4):455–62. [PubMed: 18643003]
33. Mays VM, Cochran SD. Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. Am J Public Health 2001;91(11):1869–76. [PubMed: 11684618]
34. Halkitis PN, Kupprat SA, Hampton MB, et al. Evidence for a syndemic in aging HIV-positive gay, bisexual, and other MSM: implications for a holistic approach to prevention and healthcare. Ann Anthropol Pract 2012;36(2):365–86.
35. American Psychological Association, APA Working Group on Health Disparities in Boys and Men. Health disparities in racial/ethnic and sexual minority boys and men. Washington, DC: American Psychological Association; 2018.
36. Gayles TA, Garofalo R. Exploring the health issues of LGBT adolescents. In: Schneider JS, Silenzio VMB, Erickson-Schroth L, editors. The GLMA Handbook on LGBT Health. Praeger: Santa Barbara (CA); 2019. p. 133.
37. Graham R, Berkowitz B, Blum R, et al. The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding. Washington, DC: Institute of Medicine; 2011.
38. Griffin-Tomas M, Cahill S, Kapadia F, et al. Access to health services among young adult gay men in New York City. Am J Mens Health 2019;13(1). 1557988318818683.
39. Halkitis PN. The stonewall riots, the AIDS epidemic, and the public's health. Am J Public Health 2019;109(6):851–2. [PubMed: 31067104]
40. Jonsen AR, Stryker JE. The social impact of AIDS in the United States. Washington, DC: National Academy Press; 1993.
41. Wolitski RJ, Stall R, Valdiserri RO. Unequal opportunity: health disparities affecting gay and bisexual men in the United States. New York: Oxford University Press, USA; 2008.
42. Lick DJ, Durso LE, Johnson KL. Minority stress and physical health among sexual minorities. Perspect Psychol Sci 2013;8(5):521–48. [PubMed: 26173210]
43. Meyer IH. Minority stress and mental health in gay men. J Health Soc Behav 1995;36(1):38–56. [PubMed: 7738327]
44. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychol Bull 2003;129(5):674. [PubMed: 12956539]
45. Balsam KF, Rothblum ED, Beauchaine TP. Victimization over the life span: a comparison of lesbian, gay, bisexual, and heterosexual siblings. J Consult Clin Psychol 2005;73(3):477. [PubMed: 15982145]
46. Cochran BN, Stewart AJ, Ginzler JA, et al. Challenges faced by homeless sexual minorities: comparison of gay, lesbian, bisexual, and transgender homeless adolescents with their heterosexual counterparts. Am J Public Health 2002;92(5):773–7. [PubMed: 11988446]

47. Toomey RB, Russell ST. The role of sexual orientation in school-based victimization: a meta-analysis. Youth Soc 2016;48(2):176–201. [PubMed: 26997680]
48. Needham BL, Austin EL. Sexual orientation, parental support, and health during the transition to young adulthood. J youth adolescence 2010;39(10):1189–98.
49. Kruks G Gay and lesbian homeless/street youth: special issues and concerns. J Adolesc Health 1991;12(7):515–8. [PubMed: 1772888]
50. Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a fundamental cause of population health inequalities. Am J Public Health 2013;103(5):813–21. [PubMed: 23488505]
51. Link BG, Phelan J. Social conditions as fundamental causes of disease. J Health Soc Behav 1995;Spec No:80–94. [PubMed: 7560851]
52. Wolitski RJ, Fenton KA. Sexual health, HIV, and sexually transmitted infections among gay, bisexual, and other men who have sex with men in the United States. AIDS Behav 2011;15(1):9–17. [PubMed: 20490909]
53. Mustanski BS, Garofalo R, Emerson EM. Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. Am J Public Health 2010;100(12):2426–32. [PubMed: 20966378]
54. Plöderl M, Tremblay P. Mental health of sexual minorities. A systematic review. Int Rev Psychiatry 2015;27(5):367–85. [PubMed: 26552495]
55. Cochran SD, Sullivan JG, Mays VM. Prevalence of mental disorders, psychologyical distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. J Consult Clin Psychol 2003;71(1):53. [PubMed: 12602425]
56. Cochran SD, Mays VM. Lifetime prevalence of suicide symptoms and affective disorders among men reporting same-sex sexual partners: results from NHANES III. Am J Public Health 2000;90(4):573. [PubMed: 10754972]
57. Garofalo R, Wolf RC, Wissow LS, et al. Sexual orientation and risk of suicide attempts among a representative sample of youth. Arch Pediatr Adolesc Med 1999;153(5):487–93. [PubMed: 10323629]
58. Herrell R, Goldberg J, True WR, et al. Sexual orientation and suicidality: a co-twin control study in adult men. Arch Gen Psychiatry 1999;56(10):867–74. [PubMed: 10530625]
59. Howard J, Nicholas J. Better dead than gay? Depression, suicide ideation and attempt among a sample of gay and straight-identified males aged 18-24. Youth Stud Aust 1998;17(4):28.
60. Paul JP, Catania J, Pollack L, et al. Suicide attempts among gay and bisexual men: lifetime prevalence and antecedents. Am J Public Health 2002;92(8):1338–45. [PubMed: 12144994]
61. Pachankis JE, Goldfried MR. Social anxiety in young gay men. J Anxiety Disord 2006;20(8):996–1015. [PubMed: 16500074]
62. Carper TLM, Negy C, Tantleff-Dunn S. Relations among media influence, body image, eating concerns, and sexual orientation in men: a preliminary investigation. Body Image 2010;7(4):301–9. [PubMed: 20739233]
63. Frederick DA, Essayli JH. Male body image: the roles of sexual orientation and body mass index across five national US Studies. Psychol Men Masculinity 2016;17(4):336.
64. French SA, Story M, Remafedi G, et al. Sexual orientation and prevalence of body dissatisfaction and eating disordered behaviors: a population-based study of adolescents. Int J Eat Disord 1996;19(2):119–26. [PubMed: 8932550]
65. Corliss HL, Rosario M, Wypij D, et al. Sexual orientation disparities in longitudinal alcohol use patterns among adolescents: findings from the growing up today study. Arch Pediatr Adolesc Med 2008;162(11):1071–8. [PubMed: 18981356]
66. Austin SB, Ziyadeh NJ, Corliss HL, et al. Sexual orientation disparities in purging and binge eating from early to late adolescence. J Adolesc Health 2009;45(3):238–45. [PubMed: 19699419]
67. Corliss HL, Wadler BM, Jun H-J, et al. Sexual-orientation disparities in cigarette smoking in a longitudinal cohort study of adolescents. Nicotine Tob Res 2012;15(1):213–22. [PubMed: 22581940]
68. King M, Semlyen J, Tai SS, et al. A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. BMC Psychiatry 2008;8(1):70. [PubMed: 18706118]

69. Choi K-H, Paul J, Ayala G, et al. Experiences of discrimination and their impact on the mental health among African American, Asian and Pacific Islander, and Latino men who have sex with men. Am J Public Health 2013;103(5):868–74. [PubMed: 23488483]
70. Gallo LC. The reserve capacity model as a framework for understanding psychosocial factors in health disparities. Appl Psychol Health Well-Being 2009;1(1):62–72.
71. Gallo LC, de los Monteros KE, Shivpuri S. Socioeconomic status and health: what is the role of reserve capacity? Curr Dir Psychol Sci 2009;18(5):269–74. [PubMed: 22210579]
72. Gallo LC, Matthews KA. Understanding the association between socioeconomic status and physical health: do negative emotions play a role? Psychol Bull 2003;129(1):10. [PubMed: 12555793]
73. Storholm ED, Siconolfi DE, Halkitis PN, et al. Sociodemographic factors contribute to mental health disparities and access to services among young men who have sex with men in New York City. J Gay Lesbian Ment Health 2013;17(3):294–313.
74. Purcell DW, Johnson CH, Lansky A, et al. Estimating the population size of men who have sex with men in the United States to obtain HIV and syphilis rates. Open AIDS J 2012;6:98–107. [PubMed: 23049658]
75. Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 US dependent areas—2010. Atlanta, Georgia: HIV Surveillance Report; 2012.
76. Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 Dependent Areas—2016. HIV Surveill Supplemental Rep 2018;23(4):1–51.
77. Mojola SA, Everett B. STD and HIV risk factors among US young adults: variations by gender, race, ethnicity and sexual orientation. Perspect Sex Reprod Health 2012;44(2):125–33. [PubMed: 22681428]
78. Benson PA, Hergenroeder AC. Bacterial sexually transmitted infections in gay, lesbian, and bisexual adolescents: medical and public health perspectives. Paper presented at: Seminars in pediatric infectious diseases. 2005.
79. Dunne EF, Nielson CM, Stone KM, et al. Prevalence of HPV infection among men: a systematic review of the literature. J Infect Dis 2006;194(8):1044–57. [PubMed: 16991079]
80. Halkitis PN, Valera P, LoSchiavo CE, et al. Human papillomavirus vaccination and infection in young sexual minority men: the P18 cohort study. AIDS Patient Care STDs 2019;33(4):149–56. [PubMed: 30932696]
81. MacKellar DA, Valleroy LA, Secura GM, et al. Two decades after vaccine license: hepatitis B immunization and infection among young men who have sex with men. Am J Public Health 2001;91(6):965. [PubMed: 11392942]
82. Memon M, Memon M. Hepatitis C: an epidemiological review. J Viral Hepat 2002;9(2):84–100. [PubMed: 11876790]
83. Xu F, Sternberg MR, Markowitz LE. Men who have sex with men in the United States: demographic and behavioral characteristics and prevalence of HIV and HSV-2 infection: results from National Health and Nutrition Examination Survey 2001–2006. Sex Transm Dis 2010;37(6):399–405. [PubMed: 20473245]
84. Centers for Disease Control and Prevention. HIV and African American gay and bisexual men. Published 2019. Available at: https://www.cdc.gov/hiv/group/msm/bmsm.html. Accessed October 17, 2019.
85. Strutz KL, Herring AH, Halpern CT. Health disparities among young adult sexual minorities in the US. Am J Prev Med 2015;48(1):76–88. [PubMed: 25241194]
86. Conron KJ, Mimiaga MJ, Landers SJ. A population-based study of sexual orientation identity and gender differences in adult health. Am J Public Health 2010;100(10):1953–60. [PubMed: 20516373]
87. Rosario M, Corliss HL, Everett BG, et al. Sexual orientation disparities in cancer-related risk behaviors of tobacco, alcohol, sexual behaviors, and diet and physical activity: pooled Youth Risk Behavior Surveys. Am J Public Health 2014;104(2):245–54. [PubMed: 24328632]

88. Hatzenbuehler ML, McLaughlin KA, Slopen N. Sexual orientation disparities in cardiovascular biomarkers among young adults. Am J Prev Med 2013;44(6):612–21. [PubMed: 23683979]

89. Sandfort TG, de Graaf R, Bijl RV. Same-sex sexuality and quality of life: findings from the Netherlands Mental Health Survey and Incidence Study. Arch Sex Behav 2003;32(1):15–22. [PubMed: 12597268]

90. Griffin M, Krause KD, Kapadia F, et al. A qualitative investigation of healthcare engagement among young adult gay men in New York City: a P18 cohort sub-study. LGBT Health 2018;5(6):368–74. [PubMed: 30048197]

91. Rowan D, DeSousa M, Randall EM, et al. "We're just targeted as the flock that has HIV": health care experiences of members of the house/ball culture. Social Work Health Care 2014;53(5):460–77.

92. Brooks H, Llewellyn CD, Nadarzynski T, et al. Sexual orientation disclosure in health care: a systematic review. Br J Gen Pract 2018;68(668):e187–96. [PubMed: 29378698]

93. Coleman TA, Bauer GR, Pugh D, et al. Sexual orientation disclosure in primary care settings by gay, bisexual, and other men who have sex with men in a Canadian city. LGBT health 2017;4(1):42–54. [PubMed: 27996376]

94. Petroll AE, Mosack KE. Physician awareness of sexual orientation and preventive health recommendations to men who have sex with men. Sex Transm Dis 2011;38(1):63. [PubMed: 20706178]

95. National Public Radio, Robert Wood Johnson Foundation, Harvard TH. Discrimination in America: experiences and views of LGBTQ Americans. Chan School of Public Health; 2017. Available at: https://www.npr.org/documents/2017/nov/npr-discrimination-lgbtq-final.pdf.

96. Koester KA, Collins SP, Fuller SM, et al. Sexual healthcare preferences among gay and bisexual men: a qualitative study in San Francisco, California. PLoS One 2013;8(8):e71546. [PubMed: 23977073]

97. Schneider JA, Walsh T, Cornwell B, et al. HIV health center affiliation networks of black men who have sex with men: disentangling fragmented patterns of HIV prevention service utilization. Sex Transm Dis 2012;39(8):598. [PubMed: 22801341]

98. Butler M, Kane RL, McAlpine D, et al. Integration of mental health/substance abuse and primary care. Evid Report Technol Assess (Full Rep) 2008;173:1.

99. Dickson GL, Rinaldi AP. Preventing disparities in primary healthcare for LGBT patients. Prev Couns Psychol Theor Res Pract 2012;4:15–20.

100. Tucker CM, Ferdinand LA, Mirsu-Paun A, et al. The roles of counseling psychologists in reducing health disparities. Couns Psychol 2007;35(5):650–78.

101. Lesbian, gay, bisexual, and transgender health. 2019. Available at: HealthyPeople.gov. Accessed August 1, 2019.

102. Barbot O, Durso LE. Promoting a policy and research agenda to protect lesbian, gay, bisexual, and transgender health in the new political era. LGBT Health 2017;4(4):241–3. [PubMed: 28708449]

103. Cahill SR, Makadon HJ. If they don't count us, we don't count: Trump administration rolls back sexual orientation and gender identity data collection. LGBT Health 2017;4(3):171–3. [PubMed: 28453387]

104. Gonzales G, McKay T. What an emerging Trump administration means for lesbian, gay, bisexual, and transgender health. Health Equity 2017;1(1):83–6. [PubMed: 30283837]

105. Smith DM, Mathews WC. Physicians' attitudes toward homosexuality and HIV: survey of a California Medical Society-revisited (PATHH-II). J Homosex 2007;52(3–4):1–9. [PubMed: 17594969]

106. Bayer R, Oppenheimer GM. AIDS doctors: voices from the epidemic: an oral history. New York: Oxford University Press; 2002.

107. Hollenbach AD, Eckstrand KL, Dreger AD. Implementing curricular and institutional climate changes to improve health care for individuals who are LGBT, gender nonconforming, or born with DSD: a resource for medical educators. Washington, DC: Association of American Medical Colleges; 2014.

108. Sabin JA, Riskind RG, Nosek BA. Health care providers' implicit and explicit attitudes toward lesbian women and gay men. Am J Public Health 2015;105(9):1831–41. [PubMed: 26180976]
109. Halkitis PN. Stonewall riots — 50 years later, has anything changed? Washington, DC: TheHill.com; 2019.
110. Wittenberg A, Gerber J. Recommendations for improving sexual health curricula in medical schools: results from a two-arm study collecting data from patients and medical students. J Sex Med 2009;6(2):362–8. [PubMed: 19215615]
111. Obedin-Maliver J, Goldsmith ES, Stewart L, et al. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. Jama 2011;306(9):971–7. [PubMed: 21900137]
112. Lee RS, Melhado TV, Chacko KM, et al. The dilemma of disclosure: patient perspectives on gay and lesbian providers. J Gen Intern Med 2008;23(2):142–7. [PubMed: 18043983]
113. Coleman E, Elders J, Satcher D, et al. Summit on medical school education in sexual health: report of an expert consultation. J Sex Med 2013;10(4):924–38. [PubMed: 23551542]
114. Albelda R, Badgett MVL, Schneebaum A, et al. Poverty in the lesbian, gay, and bisexual community. Los Angeles (CA): The Williams Institute; 2009.
115. Badgett MV, Durso LE, Schneebaum A. New patterns of poverty in the lesbian, gay, and bisexual community. Los Angeles (CA): The Williams Institute; 2013.
116. Redman LF. Outing the invisible poor: why economic justice and access to health care is an LGBT issue. Geo J Poverty L Pol'y 2010;17:451.
117. Halkitis PN, Cook SH, Ristuccia A, et al. Psychometric analysis of the Life Worries Scale for a new generation of sexual minority men: The P18 Cohort Study. Health Psychol 2018;37(1):89–101. [PubMed: 28967772]
118. Stall R, Friedman M, Catania JA. Interacting epidemics and gay men's health: a theory of syndemic production among urban gay men. In: Wolitski RJ, Stall R, Valdiserri RO, editors. Unequal opportunity: health disparities affecting gay and bisexual men in the United States. New York: Oxford University Press; 2008. p. 251–74.
119. Singer M AIDS and the health crisis of the US urban poor; the perspective of critical medical anthropology. Social Sci Med 1994;39(7):931–48.
120. Singer M, Bulled N, Ostrach B, et al. Syndemics and the biosocial conception of health. Lancet 2017;389(10072):941–50. [PubMed: 28271845]
121. Halkitis PN. Obama, marriage equality, and the health of gay men. Am J Public Health 2012;102(9):1628–9. [PubMed: 22813466]
122. Cook SH, Wood EP, Harris J, et al. Theoretical approaches and policy implications. In: Griffith DM, Bruce MA, Thorpe RJ Jr, editors. Men's health equity A Handbook. New York: Routledge; 2019. p. 343–59.
123. Halkitis PN, Kapadia F, Ompad DC, et al. Moving toward a holistic conceptual framework for understanding healthy aging among gay men. J Homosex 2015;62(5):571–87. [PubMed: 25492304]
124. Makadon HJ. Ending LGBT invisibility in health care: the first step in ensuring equitable care. Cleve Clin J Med 2011;78(4):220–4. [PubMed: 21460126]
125. Cahill S, Makadon H. Sexual orientation and gender identity data collection in clinical settings and in electronic health records: a key to ending LGBT health disparities. LGBT Health 2014;1(1):34–41. [PubMed: 26789508]
126. Halkitis PN. Coming out and the otherness of gay men across generations. QED A J GLBTQ Worldmaking 2019;6(2):109–20.
127. Commission J. Advancing effective communication, cultural competence, and patient-and family-centered care: a roadmap for hospitals. Oakbrook Terrace (IL): Joint Commission; 2010.
128. Gay and Lesbian Medical Association. Guidelines for care of lesbian, gay, bisexual, and transgender patients. San Francisco (CA): Gay and Lesbian Medical Association; 2006.
129. Makadon HJ, Potter J, Goldhammer H. The Fenway guide to lesbian, gay, bisexual, and transgender health. Philadelphia: ACP Press; 2008.
130. Thorpe RJ Jr, Halkitis PN. Biopsychosocial determinants of the health of boys and men across the lifespan. Behav Med 2016;42(3):129–31. [PubMed: 27337616]

131. Carnes N Gay men and men who have sex with men: intersectionality and syndemics. In: Wright ER, Carnes N, editors. Understanding the HIV/AIDS epidemic in the United States. Cham (Switzerland): Springer International; 2016. p. 43–69.

KEY POINTS

- Emerging adult gay men are disproportionally burdened by myriad health disparities, spanning multiple domains (eg, mental, physical, and sexual health).
- The health profile of emerging adult men is complicated further by barriers to accessing competent health care.
- Health care provider knowledge on the unique health and health care needs of emerging adult gay men is severely lacking.
- The utilization of a holistic health care paradigm, the addition of staff education and training sessions, and the creation of a welcoming clinical atmosphere and environment are necessary first steps in providing competent health care to populations of emerging adult gay men.