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'YES, I AM MORE THAN JUST THAT': GAY/BISEXUAL YOUNG MEN RESIDING IN THE UNITED STATES DISCUSS THE INFLUENCE OF MINORITY STRESS ON THEIR SEXUAL RISK BEHAVIOR PRIOR TO HIV INFECTION

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Abstract

Rates of HIV infection in the United States are markedly over-represented among gay/bisexual young men (GBYM), especially those who are African American and Latino. The degree to which minority stress may explain racial disparities in HIV incidence is understudied in GBYM. This qualitative study examined racial/ethnic-minority and sexual-minority stress and their perceived influence on HIV infection in a sample of GBYM living with HIV. Findings indicated that racial/ethnic-minority stress more often emerged during sexual interactions, while sexual-minority stress was often family-based. Our discussion offers recommendations for primary HIV prevention efforts for GBYM.

Keywords

HIV prevention; adolescent sexuality; qualitative studies; HIV-positive youth; racism; minority stress

Each year, more than 25% of new HIV infections in the United States (12,200 cases) are among young people between the ages of 13 and 24 years old. The majority of these infections (72%) are acquired by young men who have sex with men (MSM), including gay/bisexual young men (GBYM) who are African American, European American, and Latino. African American and Latino GBYM are particularly encumbered by a disproportionately high incidence rate (Centers for Disease Control and Prevention [CDC], 2012a, 2012b, 2012c). African Americans and Latinos comprise only 16% and 19%, respectively, of the overall U.S. adolescent population (compared with 77% European American), yet they

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account for 63% (African American) and 16% (Latino) of annual new HIV infections in young MSM (compared with 18% among European Americans). The disparate rates at which HIV is affecting GBYM can be linked to experiences of stigma and social discrimination rooted in homophobia and racism (Diaz, Ayala, & Bein, 2004; Meyer, 1995).

Social Discrimination and Health Outcomes

Minority stress postulates that sexual minorities (e.g., lesbian, gay, and bisexual [LGB] people) may be especially susceptible to negative mental, physical, and behavioral health outcomes resulting from direct and institutional forms of social discrimination (Meyer, 1995). These forms of discrimination operate through four interrelated processes including, from external to intrapsychic, (1) the occurrence of objectively stressful events, (2) one's expectation and vigilance regarding subsequent events, (3) one's internalization of negative societal attitudes regarding sexual minorities, and (4) a concealment of one's sexual-minority identity (Meyer, 2003). Research examining sexual minorities who are also racial/ethnic minorities suggests that minority stress can encapsulate both sexual identity- and racial/ethnic identity-related discrimination as both aspects of identity are tied to stigmatization and negative health outcomes (Chung & Katayama, 1998; Jamil, Harper, Fernandez, & Adolescent Trials Network for HIV/AIDS Interventions, 2009; Manalansan, 1996; Savin-Williams & Cohen, 1996).

The relationship between racism and negative health outcomes in adolescents is understudied. However, perceived racism in adults has been associated with negative psychological symptoms, including negative affect (Brondolo, Brady ver Halen, Pencille, Beatty, & Contrada, 2009), clinically significant depressive symptoms (Steffen & Bowden, 2006), anxiety (Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003), and negative health behavior (Pascoe & Smart Richman, 2009). Perceived racism may also negatively influence certain health behaviors of racial/ethnic minorities including their participation in routine detection behaviors (e.g., cancer screening), health promotion behaviors (e.g., medication adherence), and preventive behaviors (e.g., condom use; McSwan, 2000; Ryan, Gee, & LaFlamme, 2006; Yoshikawa, Wilson, Chae, & Cheng, 2004).

Sexual-minority stress has been associated with depression and suicidal ideation, while experiences of combined racism and homophobia have also been linked to sexual risk behavior (e.g., unprotected anal intercourse) in racial/ethnic-minority MSM (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Hatzenbuehler, 2011). Most notably, negative psychosocial outcomes (e.g., low self-esteem, loneliness, and social isolation) are theorized to mediate the influence of racism and homophobia on unprotected anal intercourse in adult African American and Latino gay/bisexual men (Diaz et al., 2004). There is reason to postulate that GBYM could be at least as susceptible to the effects of social oppression as are adults. The basis of this speculation is that GBYM may experience sexual-minority stress not only from members of the dominant culture (Cochran & Mays, 1987; Greene, 2003; Harper, Jernewall, & Zea, 2004), but also from members of their families and cultural communities (Diaz, 1998; Harper et al., 2004).

Several studies have documented that GBYM experience verbal and physical victimization and ridicule from family members as well as peers (Grossman, 2001; Harper & Schneider, 2003; Hershberger & D'Augelli, 1995; Meyer, 1995). Other studies demonstrate that family acceptance and support regarding sexual identity and behavior can influence the overall well-being of GBYM, above and beyond discriminatory experiences tied to minority stress (D'Augelli, Hershberger, & Pilkington, 1998; Ryan, Huebner, Diaz, & Sanchez, 2009). It is, therefore, especially important to consider how sexual-minority stress may be enacted within the family system and how, in turn, it may influence HIV risk behavior in GBYM.

Sexual-Minority Stress in the Family System

GBYM are reaching important sexual milestones at earlier ages (CDC, 2011; Grov, Bimbi, Nanin, & Parsons, 2006). In one study, participants first admitted to themselves that they were attracted to the same sex at age 15, engaged in their first sexual encounter with another male at age 16, and typically disclosed their same-sex attraction to someone else at age 17 (Grov et al., 2006). This pattern supports the notion that sexual activity may serve as a developmental marker of sexual identity formation in GBYM and that these activities occur during an age span when, presumably, many are residing with their families of origin (Rotheram-Borus, Reid, Rosario, Vanrossem, & Gillis, 1995). Unfortunately, the emerging sexual identities of young people are not always accepted, much less affirmed, by members of their families. One study of sexual identity disclosure in MSM revealed that those who disclosed their sexual orientation at younger ages were more likely to have experienced homophobic harassment before reaching adulthood, compared with those who disclosed at older ages (Friedman, Marshal, Stall, Cheong, & Wright, 2008).

More recently, a study of European American and Latino LGB young adults (aged 21–25 years old) found that those who experienced sexual identity-related family rejection during adolescence had increased odds for developing psychological symptoms and engaging in sexual risk behavior in early adulthood (Ryan et al., 2009). In nonsupportive family systems, GBYM may displace their sexual activities to the homes of their sexual partners or into more public arenas, such as parks or public restrooms (Savin-Williams & Cohen, 2004). In an attempt to secure financial support, as many as one in four GBYM increases his susceptibility to HIV infection by engaging in sex in exchange for pay or other resources (Garofalo, Herrick, Mustanski, & Donenberg, 2007).

For GBYM, including those who are racial/ethnic minorities, the opportunity to connect with each other face to face (e.g., in bars, clubs, organizations, LGB-friendly neighborhoods) and in virtual settings (e.g., Internet chat rooms or message boards) has been identified as salient to sexual orientation identity development (Jamil et al., 2009). Yet GBYM, particularly those younger than age 21, are limited in terms of their ability to enter spaces legally (such as bars or dance clubs) where older gay/bisexual men typically congregate. With a limited number of LGB-affirming youth spaces available to young people, GBYM are found to seek social connection in sexually charged settings (e.g., sex clubs, bathhouses, cruising parks) that are frequented by older and more experienced MSM, thereby increasing their susceptibility for HIV infection (Garofalo & Harper, 2003; Garofalo et al., 2007).

Stressors related to minority stress may contribute to HIV risk behaviors in gay/bisexual males (Meyer, 2003); however, overlooked in scientific and practice literature is the examination of these stressors and their connection to HIV infection among GBYM aged 13 to 24 years old—the fastest-growing HIV-infected group in the United States (CDC, 2012b, 2012c). To our knowledge, qualitative examinations of this phenomenon are also absent from the literature.

Current Study

The current study examined how experiences of racial/ethnic and sexual identity-related discrimination influenced HIV infection through male–male sexual contact in a sample of GBYM living with HIV. This article is based on a larger study that aimed to develop and determine the feasibility of a culturally specific, HIV primary prevention intervention for GBYM aged 16 to 20 years old. We focused our primary prevention efforts on this age group given the national epidemiological evidence indicating that HIV incidence is increasing in African American, European American, and Latino GBYM (CDC, 2012a). To ensure our responsiveness in intervening to address the health-risk needs of this population, our study team gathered these data from a purposive sample of HIV-positive GBYM (aged 18–24 years old), each of whom acquired HIV through male–male sexual behavior sometime between the ages of 16 and 21 years old.

METHOD

Study Context

We conducted qualitative interviews within a community-based health clinic in which the programs and services are designed for lesbian, gay, bisexual, and transgender (LGBT) individuals residing in a major metropolitan area in the Midwestern United States. Interviews were conducted between November 2007 and May 2008. At the time of data collection, this site was also the only known health center within this geographic area offering medical and social services tailored to young MSM (including GBYM) living with HIV.

Participants and Eligibility

A total of 30 individuals volunteered to be screened for study participation after gleaning study contact information from promotional materials distributed around the health center. To be considered eligible for study participation, volunteers were required to be cisgender male (i.e., a biological male who currently identifies as male); be at least 18 years old and no older than 24 years of age; have an HIV-positive serostatus (or meet diagnostic criteria for AIDS); have acquired HIV through male–male sexual contact between the ages of 16 and 21 years old; identify as Black/African American, Hispanic/Latino, or White/European American; and live within the metropolitan area in which our study was conducted. In addition, given the psychosocial challenges associated with a recent HIV/AIDS diagnosis (Brown, Lourie, & Pao, 2003), we did not enroll in this study volunteers who had been diagnosed with HIV/AIDS less than 60 days before screening. Of those screened, 21 volunteers met eligibility criteria, agreed to participate, and completed the study.

Procedure

Eligible and interested volunteers were scheduled for their one-time study visit, which consisted of three elements: a process of informed consent and study enrollment, an individual indepth interview, and a debriefing protocol. The average length of a study visit was 120 min and participants were paid $25 for their time. Our multidisciplinary and multiethnic study staff consisted of master's-level and doctoral-level men from backgrounds in psychology, social work, and medicine; all identified as gay or bisexual. Staff members were well trained on ethical considerations pertaining to youth living with HIV/AIDS, informed consent, participant risk assessment, and qualitative research and data collection. All interviews were digitally recorded and transcribed verbatim. Institutional review board approvals were granted by the prime awardee and the LGBT health center at which data collection took place.

Interview guide—Our semistructured interview guide consisted of open-ended items and related probes pertaining to eight content areas. Content areas of particular relevance to this study included participants' experiences of racial/ethnic-minority stress (e.g., "How, if at all, is coming out as (or being) gay/bisexual/questioning different for a guy of your racial/ethnic background than compared to guys of other racial/ethnic backgrounds?") and their experiences of sexual-minority stress (e.g., "How, if at all, did feelings about your sexual orientation—or your sexual orientation itself—cause problems in your life?").

Within each content area, the interviewer instructed participants to respond to items while considering their life circumstances between the ages of 16 and 21 years old (e.g., "For the remainder of the interview, I want you to answer the following questions as if I were interviewing you when you were between the ages of 16 to 21 years old"). We encouraged participants younger than age 21 to refer to an age range spanning from 16 years to the age at which they learned of their HIV/AIDS diagnosis.

Qualitative Data Analysis

Six staff members participated in the qualitative data analysis, which was informed by a directed approach to content analysis (Hsieh & Shannon, 2005). The goal of directed content analysis is to validate or expand a theory—in our case, the influence of minority stress on HIV risk behavior—by allowing for newly identified categories to offer either a contradictory view of this theory or to further validate, refine, and extend the theory.

We relied on existing research regarding minority stress (both race/ethnic minority- and sexual minority-related) and HIV risk behavior in GBYM to determine our qualitative coding framework. To establish the reliability of the coding framework, we used a multiphasic, interrater coding process combining pair-level and group-level analysis (Miles & Huberman, 1994). Within each phase of analysis, an analyst was first responsible for coding an interview transcript independently, guided by the predetermined coding framework. Once completed, to reduce independent rater bias, analysts met in pairs to establish consensus and resolve discrepancies between their respective codes. Once interrater consensus was established, and as an additional method of reducing bias, all three coding pairs met and established theoretical consistency by repeating the consensus-

building process as a larger group. In cases where paired analysts identified data on which they were unable to reach consensus, the larger group analyzed the data to determine if they represented either a subcategory of a preexisting code or an altogether new code/phenomenon that was unique to our sample.

We documented the establishment of theoretically predetermined and emergent codes within a metamatrix, and we relied on this chart to conduct comparative (i.e., cross-case) analyses across racial/ethnic and sexual identity subgroups (Miles & Huberman, 1994). True to the iterative nature of qualitative inquiry, we repeated our analytic phases until all available interviews were coded at least once and until novel codes no longer emerged from our data analysis (i.e., saturation). Atlas.ti software assisted us in the management and organization of codes and qualitative data.

RESULTS

Sample

As indicated in Table 1, participants were 21 African American ($n = 7$), Latino ($n = 7$), and European American ($n = 7$) GBYM ranging in age from 18 to 24 years old ($M = 21.8$ years, $SD = 1.61$). At the time of data collection, participants identified as gay ($n = 19$) and bisexual ($n = 2$), although 8 participants recalled identifying as bisexual, “questioning,” “straight,” or “no label” during the ages of 16 to 20 years old. Their mean ages by race/ethnicity were relatively homogeneous (African American, $M_{age} = 21.7$ years, $SD = 2.06$; Latino, $M_{age} = 21.7$ years, $SD = 1.7$; European American, $M_{age} = 21.9$ years, $SD = 1.21$). On average, African American respondents were the youngest at the point of HIV diagnosis ($M = 18.4$ years, $SD = 2.07$), followed by Latinos ($M = 20$ years, $SD = 1.53$) and European Americans ($M = 20.7$ years, $SD = 1.11$).

Qualitative Findings

We have organized the qualitative findings according to participants’ experiences with two primary forms of minority stress—(1) racial/ethnic-minority stress and (2) sexual-minority stress—as well as how these experiences may have contributed to acquisition of HIV. Accompanying the presentation of each theme are quotes and a demographic profile of the quoted participant. We begin by highlighting findings pertaining to racial/ethnic-minority stress.

Experiences of racial/ethnic-minority stress—All European American GBYM in the sample denied experiencing racial/ethnic-related stress, resulting in data collected exclusively from African American and Latino respondents. These respondents reported experiences of racial/ethnic-minority stress in the context of interracial sexual situations. Such situations involved past male partners communicating a strong desire to have sex with participants on account of their racial/ethnic backgrounds. Findings were mixed regarding the participants’ attributions of these behaviors as racist or discriminatory in nature. For example, some participants with sexual partners who strongly favored them on account of their racial/ethnic backgrounds often did not connect this treatment to anything beyond a partner’s sexual preference.

> **Interviewer (I)** Even though it's a little bit younger, I think you were 13 or 14 to 15 prior to 16 and you were with some people in terms of surviving, did you experience racism [from sexual partners] then?
>
> **Participant (P)** No. Actually they really liked the whole idea that I was Cuban or Mexican. I don't know why.–(Carlos, 20, Latino, bisexual)

Other participants perceived sexual partners' race/ethnicity-related desire and attention as degrading. They reported the great emphasis placed on their racial/ethnic backgrounds as dehumanizing and objectifying, and reported that such an emphasis on their racial/ethnic background overshadowed other important personal characteristics. One participant noted, "If someone is fetishizing or is just generally taking a sense of … eroticism because of the fact that I'm African American, I am offended by that because I am more than just a skin color. Yes, I am more than just that" (Carl, 24, African American, gay).

Both groups of participants—those who perceived "preference" and those who perceived "objectification" in their sexual part ners—testified to being expected to fit within a "cultural stereotype" consistent with their race/ethnicity. This stereotype often involved possessing characteristics or behavior such as mannerisms, intellectual capacity, or sexual behavior specific to particular races or ethnicities. For example, Latino participants often reported being regarded as sexually insatiable by partners of non-Latino backgrounds: " … It's like, the fact that I was Puerto Rican, and it was, like, we're just gonna have sex. So it was like, you know, I was not … like, just a piece of sack cloth, you know?" (Mario, 24, Latino, gay). African American GBYM described interacting with male sexual partners who compared participants to a "thuggish" masculine ideal and who treated them as intellectual and social inferiors.

> I slightly feel like the White guys that specifically are, like … I wouldn't necessarily say attracted to you, but are geared towards ethnic races, they still kind of look down to them. And especially more so if you actually fit within your cultural stereotype … I've talked to White guys that, like, have this thought pattern that they like the thuggish, I-look-like-I-just-got-out-of-County[-jail] type of guys because, essentially, it's like, of course they can go anywhere with this person and look better than them and be taken seriously. And they, themselves, will be with someone like this because that person, in particular, is used to getting this type of reaction from people, and so they won't necessarily stand up for themselves and, like, say 'this is not how it is' and 'I won't tolerate this type of treatment from you or anybody else.' (Andre, 18, African American, gay)

In some cases, racial-minority GBYM's perceived expectancy to fit within a cultural stereotype consistent with their race/ethnicity influenced their sexual behavior. Most notable were a small number of testimonies in which participants articulated engaging in certain sexual behaviors because they perceived it as being expected of them by their sexual partners.

> A part of me was flattered that some of the guys are feeling that way towards me and feel like I'm what they want. … If I didn't want to get down with them

> [before], then it made me want to … because it's like I wanted to fulfill their need. So I guess if the objectification wasn't there, and I would have had a clear mind, I probably would have not made that choice to have sex with those people at that time. (Mario, 24, Latino, gay)

An unexpected emergent theme was related to African American GBYM who expressed anger and indignation at the racialized sexual objectification they received from their partners. The proceeding quote demonstrates this participant's willingness to end a sexual relationship due to the contention caused by racial objectification.

> And because of that, that would automatically cause friction. That's the sort of thing that can end a sexual relationship just like that. (Carl, 24, African American, gay)

Other participants expressed indignation regarding this treatment from sexual partners. For example, "Andre" went on to highlight how being treated unfairly by European American male partners decreased his likelihood to engage in sexual activity with them.

> … There have been a few guys that were so sadly mistaken in thinking that I was anything of the sort, and thinking that they'd have the opportunity to treat me like some stupid little Black boy, and usually they'd never really last long. (Andre, 18, African American, gay)

For African American and Latino GBYM, racialized sexual objectification was a form of racial/ethnic-minority stress experienced in interactions with European American male partners. Our findings suggest that this form of stress might influence both sexual risk and protective behavior in our sample.

Experiences of sexual-minority stress—The majority of the sample, irrespective of race/ethnicity, discussed experiences of sexual-minority stress and beliefs regarding its influence on acquisition of HIV. Experiences of sexual-minority stress from family were most commonly reflected in testimonies from GBYM of color. Participants described a range of family responses to their identities as GBYM, including family members vocalizing their intolerant stance of being "really against it" (Chris, 22, African American, gay). Several Latino GBYM described their parents reacting negatively by associating homosexuality with a failed attempt to develop a masculine identity and/or by questioning participants about their possible childhood sexual abuse histories.

> I've had some friends that have gone through the same thing. It also depends. I mean, if [a GBYM is in] a single-parent home, then maybe not so much. But if it's a dual-parent home where you have a father and a mother, one of them is gonna react, and that's what the case is usually sometimes. I guess it's mainly because when you're a single parent, you feel like you have no other choice. You're missing some figure in [the GBYM's] life that's probably making them this way. That's what I think. If you have both parents, they're both like, 'OK. You have the mother. You have the father. You have the girl's side. You have the man's side. What the hell's your problem?' You know, like, 'how are you gay?' Because that's how my

> parents made it seem. Either that or you got abused. That's the only reasons why you're gay. (Art, 20, Latino, gay)

One participant shared that his family disagreed with the gay "lifestyle" and, consequently, attempted to discredit his sexual identity on the basis of his age and perceived "confusion":

> People can make it stressful because they make you think that your judgment is wrong. If you make the judgment and then call that you are gay, a lot of people, especially your mother, or whoever, somebody that is close to you, they may not agree with the lifestyle; they turn and try to make you feel that you are confused now and say, 'You're not gay. If you can't make up your mind if you are gay or bisexual or curious, then maybe you need … someone to understand you. … Get some more knowledge on it. Just wait.' I knew that I was gay a long time ago! (Edward, 22, African American, gay)

Several participants also described how family intolerance and rejection regarding their sexual identities presented a barrier to participants receiving relevant sexual health education from their family:

> … Being straight and having sex is a whole different thing of [sic] being gay and having sex, at least in my parents' sight. It would have been … easier for them to be speaking in terms of me having sex with a woman than with a man, because [with a man] they wouldn't know what to say or what to do. (Vicente, 23, Latino, gay)

In response to interactions with nonsupportive family, participants spoke of seeking sexual identity support and knowledge from outside their family systems. For these participants, when it came to their sexual identities and family, "I couldn't go to them and talk to them about it, so that's why I would always talk to other guys who I would meet who were in the lifestyle" (Chris, 22, African American, bisexual).

Participants reported frequently meeting peers and adult gay/bisexual males online. Findings concerning the specific types of sexual identity support that participants sought or received from these men were sparse. However, it was clear that participants often sought sexual experience and safer-sex knowledge from other gay/bisexual males—some of whom were (or became) sexual partners. These sexual partners were often older and more sexually experienced, and they were inclined to have sex with little interest in providing nonsexual social support to participants.

> And being at that same age (17 years old) of not having the knowledge of HIV, those behaviors I was doing, possibly they were higher (i.e., greater) than if I had the social support. And maybe I wouldn't be seeking [it], chatting [online] about having sex with strangers or with people usually older than me that have many years' experience with just having sex. (Vicente, 23, Latino, gay)

Forming nonsexual support systems with other gay/bisexual men proved to be difficult for some participants. One participant noted how he reconciled both negative initial impressions of gay/bisexual men and perceived sexual-minority stress (e.g., gay bashing) to satisfy his

need for social connection and community. This is the only case wherein a participant attributed his acquiring HIV to the men in his social network.

> Is that all I have to look forward to? You know, the partying and the hard drinking and the unprotected sex and the disease and the gay bashing [targeted at me] and the inconsistency of monogamy. There's a lot of bad role-modeling going on. So, I kind of followed suit and, of course, it did lead me right to where I didn't think I was going to go: dealing with HIV. I just jumped right into the pool with everybody else. (Edward, 22, African American, gay)

Participants who experienced family-based sexual-minority stress described attempts at seeking connection with gay/bisexual male communities, and several were also forced to leave their families and subsequently became homeless. The proceeding quotes characterize how some participants linked their experience of family-based sexual-minority stress with homelessness and HIV infection.

> I felt like because I was dealing with men and because my family didn't approve of that, I felt like I had to go to the streets to get love, or to get answers, or someone to listen to me, which, you know, now I realize was not a good thing because I realize now that … doing that throughout the years that followed … caused me to get the STD that I do have [now]. (Chris, 22, African American, gay)

> **I** And that time period between 13 and 14 when you [left home and became homeless and traded sex for resources], how was that linked—or is any of that linked—to you becoming HIV-positive?

> **P** To begin with, all of that could have been avoided if my family wasn't really narrow-minded, so …

> **I** And in terms of what could be different, what could be different?

> **P** They could have been open-minded. I mean, that's kind of it. 'Cause, I mean, for one mistake that my parents did, I went through so much. (Carlos, 20, Latino, bisexual)

In contrast, only one testimony in our entire sample reflected what we identified to be a unique case where family members and peers alike were reportedly supportive of the participant's sexuality.

> … I feel like the artful environment I grew as a part of, like, my dad owns a graphic design company, so lots of his employees are gay. My mom's a professor at a university in [a liberal U.S. region], so she's very non-judging; she has lots of students. And my friends growing up, we were sitting around talking about the same type of things, like, ooh, I wonder if I—like, 'Ooh, I'd like to try doing this,' or 'That boy's cute,' and see how they react to what you're saying, and it just becomes fine. I never was picked on, had a fight, felt scared. I feel lucky in that way that I grew up having lots of friends, being really popular, even at a Baptist school, the times that I was there. (Joe, 22, European American, gay)

Our findings highlight the predominance of sexual-minority stress reported primarily by African American and Latino GBYM within the family system. These findings also illustrate how experiences of family-based sexual-minority stress often contributed to participants' subsequent involvement in sexual risk behavior while in the pursuit of sexual identity-related social support.

DISCUSSION

We are unaware of any other study examining the pre-exposure experiences of racial/ethnic- and sexual-minority stress in a multiethnic sample of GBYM living with HIV/AIDS. Our sample is diverse in terms of race/ethnicity and sexual identity, and its overall narrative body reflects a young multiethnic sample not often documented in HIV prevention literature. We employed rigorous qualitative methodology to examine the phenomena of minority stress and HIV risk in our sample, and we believe our findings contribute meaningfully to the public health literature concerning HIV primary prevention with young MSM.

Overall, members of our sample more frequently reported experiences of sexual-minority stress than they reported experiences of racial/ethnic-minority stress. This trend may have emerged in part because stress related to race/ethnicity was not reported by European American GBYM. In addition, participants may have been more primed to discuss aspects of their sexual identities in greater depth (compared with their racial/ethnic identities) given that interview prompts related to their acquisition of HIV through same-sex sexual behavior.

Experiences of racial/ethnic discrimination emerged in interpersonal sexual situations between racial/ethnic-minority GBYM involved in interracial sexual dyads. In these experiences, racial/ethnic-minority stress appeared to have the most definitive influence on sexual health. Participants indicated being treated as sexual objects by their sex partners on account of their race/ethnicity, which is consistent with a phenomenon previously identified only in adult gay/bisexual men (Diaz, 1999).

Unique in our findings are cases in which racial/ethnic-minority GBYM reported not engaging in sexual risk behavior (or any sexual behavior) after being racially objectified by a sexual suitor. These cases composed a small minority; however, their presence highlights how racial/ethnic identity salience and knowledge regarding race/ethnicity-based discrimination may serve as a protective factor in interracial sexual situations involving GBYM. Such cases also appear consistent with a resilience perspective of minority identity development (Moradi, DeBlaere, & Huang, 2010). This perspective posits that LGB people of color are better equipped to manage minority stress than are LGB European Americans because their "experiences with racism prior to coming out … inoculated [them] against the effects of stress related to homophobia" (Meyer, 2010, p. 447).

Participants from all three racial/ethnic groups reported experiencing discrimination from family members on account of their sexual behavior and/or identities, although African American and Latino participants most commonly reported these experiences. Experiences of family rejection and nonsupport were intertwined with compromised self-worth and increased sexual risk. These findings are consistent with previous research regarding poor

family support and its contribution to increased odds for GBYM to engage in unprotected anal intercourse (Ryan et al., 2009).

The GBYM in our sample, prior to becoming infected with HIV, reported several ways that sexual risk behavior occurred in the context of their seeking greater social support related to their stigmatized sexual identities. A subsample of participants who experienced family rejection chose to seek support through social connections made with older gay/bisexual males. In these cases, participants appeared to seek sexual partners in the hopes of identifying meaningful and supportive relationships, but they often encountered social networks of men interested in, as participant Vicente stated, “just having sex.” In the absence of knowledge or skills to negotiate sexual health behavior in these sexual situations, GBYM may have placed themselves at greater risk for acquiring HIV.

Aside from difficulties within their family systems, our findings also highlighted participants’ challenges locating and forming social ties with peers. GBYM’s reported challenges forging social connections with MSM communities are not unique to our sample and were reported in another multiethnic sample of GBYM (Jamil et al., 2009). In our sample, barriers to forging social connections included participants’ negative perceptions and perceived dysfunction in gay/bisexual males’ social networks. Other barriers were externally influenced and included difficulty accessing community spaces catering primarily to adult MSM (e.g., bars).

Implications for HIV Prevention

From our findings emerged several implications for HIV primary and secondary prevention. First, considering that our sample consisted of GBYM who acquired HIV between the ages of 16 and 21 years old, it is clear that prevention intervention efforts must be aimed at same-sex-attracted adolescents who are as young as 16. No existing evidence-based HIV prevention interventions comprehensively address the developmental challenges faced by GBYM—namely, managing the dynamic of racial and sexual identity stress from family and peers and its confluence on sexual risk in the context of emerging adulthood.

Second, GBYM would benefit from family-based services that are psychosocial, risk reduct ion-focused, and sexual health-promoting in nature. Developmental literature on both racial/ethnic identity formation and sexual identity formation highlights the role of family members in identity-related socialization and identity salience (Cass, 1979; Helms, 1990; Hughes, 2003; Troiden, 1989), both of which are suggested moderators of minority stress in GBYM (Jamil et al., 2009).

Lastly, our findings underscore the importance of socialization with peer groups, and particularly gay/bisexual male communities, in GBYM’s sexual identity formation. In many cases, a sexual relationship was the most viable pathway through which participants connected with other gay/bisexual males. In some cases, participants were ill-equipped to negotiate their sexual health vis-à-vis more experienced sexual partners who may not have been interested in providing social support. Participants also spoke of several internal and external barriers that prevented them from forming supportive relationships with other gay/bisexual males.

Behavioral intervention efforts to reduce HIV infection must therefore be intentional in providing opportunities for GBYM to interface with each other and with older gay/bisexual male role models who, for example, promote safer sex or provide social support. One recent qualitative study of informal mentor relationships between gay males highlighted the importance of gay mentorship in providing to mentees supportive gay identity role models, access to health resources, and adaptive enculturation to gay male culture (Sheran & Arnold, 2012). This intergenerational approach may be especially important for African American GBYM, as evidence suggests the social networks of African American MSM may explain racial disparities in their HIV infection and transmission rates (Millett, Flores, Peterson, & Bakeman, 2007; Millett, Peterson, Wolitski, & Stall, 2006). Through mentorship-like relationships, negative internalized messages regarding gay/bisexual male communities like those that emerged from our sample may be actively dispelled in exchange for messages promoting community, brotherhood, and sexual health.

Also from our findings emerged the importance of addressing racial/ethnic- and sexual-minority stress in HIV prevention efforts geared toward GBYM. Such efforts could be informed by group-level work already documented among African American heterosexual young men (Watts, Abdul-Adil, & Pratt, 2002), as both African American and Latino GBYM may benefit from a group-based approach to developing consciousness about racial/ethnic discrimination and homophobia, their influence on sexual health, and how to manage these forms of stigma. Targeted interventions would do well to include material aimed at empowering African American and Latino GBYM to recognize and repel objectification and exoticization by potential partners. European American young men could also benefit from a similar model wherein they may learn more about ethnic diversity within European American culture, as well as racism, stereotyping, and objectification within the gay and bisexual communities.

Study Strengths and Limitations

In addition to its intervention implications, this study had several notable strengths. Most notable was its reliance on a multiethnic sample that is, on average, younger than any known qualitative sample of HIV-positive GBYM. Another important strength of our study involved its phenomenological approach to exploring the retrospective accounts of HIV-positive GBYM who are not often the focus of HIV prevention-focused inquiry. Their pre-exposure insights regarding sexual risk are especially valuable in developing primary and secondary HIV prevention with GBYM.

One notable limitation of this study concerns its limited external validity. Given our study's phenomenological focus on 21 narratives, and nonprobabilistic sampling method, our study findings are not generalizable to all African American, European American, or Latino GBYM who acquire HIV through unprotected sex before age 21. It is important to note, however, that random sampling has been argued against as a method of establishing external validity in qualitative research (Marshall, 1996). A further limitation was our lack of targeted inquiry regarding *ethnic* identity in European American participants. Although beyond the scope of the larger investigation from which these data are based, a deeper exploration of ethnic identity in this racial group (e.g., Irish American, Italian American,

Polish American) may have revealed heretofore neglected experiences of ethnic-minority stress among European American GBYM and its effects on their sexual risk and protective behavior.

CONCLUSION

The findings contained in this article can directly translate into HIV prevention efforts, both universal and indicated, for sexually active HIV-negative GBYM. Our findings highlight forms of minority stress that may be especially present in GBYM most at risk for acquiring HIV and explain how these stressful experiences surface in family settings and with sexual partners. The findings from our study make a strong argument for primary HIV prevention services aimed at GBYM as young as 16 years old that openly address stigma management related to racial/ethnic identity and sexual identity in peer- and family-based group modalities.

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TABLE 1.

Sample Characteristics by Race/Ethnicity

Race/Ethnicity (*n* = 7 each)	Pseudonym	Sexual Identity at Interview	Age at Interview	Age at HIV/AIDS Diagnosis	Predominant Sexual Identity From Ages 16–20 Years
African American	Anthony	gay	20	16	gay
	Carl	gay	23	19	bisexual
	Edward	gay	22	20	gay
	Frank	gay	24	21	gay
	Cornelius	gay	23	16	gay
	Chris	bisexual	22	20	bisexual
	Andre	gay	18	17	gay
		Mean age (years)	21.7	18.4	
		(*SD*)	(2.06)	(2.07)	
European American					
	Adam	gay	22	19	gay
	Ben	gay	24	22	gay
	Nate	gay	20	20	gay
	Ryan	gay	21	21	gay
	Nick	gay	22	22	questioning
	Joe	gay	22	21	straight
	Peter	gay	22	20	questioning
		Mean age (years)	21.9	20.7	
		(*SD*)	(1.21)	(1.11)	
Latino					
	Vicente	gay	23	18	questioning
	Carlos	bisexual	20	20	bisexual
	Abel	gay	20	20	bisexual
	Emilio	gay	23	21	questioning
	Ricky	gay	22	21	gay
	Art	gay	20	18	gay
	Mario	gay	24	22	no label
		Mean age (years)	21.7	20	

Race/Ethnicity (n = 7 each)	Pseudonym	Sexual Identity at Interview	Age at Interview	Age at HIV/AIDS Diagnosis	Predominant Sexual Identity From Ages 16–20 Years
		(*SD*)	(1.7)	(1.53)	
		Mean total age (years)	21.8	19.7	
		(*SD*)	(1.61)	(1.18)	