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ABSTRACT

AN ASSESSMENT OF HIV STIGMA, RESILIENCE, AND QUEER-PERSON OF COLOR
IDENTITY AMONG YOUNG BLACK GAY, BISEXUAL, AND OTHER MEN WHO HAVE
SEX WITH MEN LIVING WITH HIV

By

MARCUS OSBY REED

July 17, 2023

Young Black-gay, bisexual, and other men who have sex with men (YB-GBMSM) are disproportionately impacted by HIV. For YB-GBMSM living with HIV, there is a weak understanding of how HIV stigma impacts their intersecting racial/ethnic and sexual minority identities. Existing literature suggests that the YB and GBMSM identities often act in opposition to another, denying prospects for an affirmed identity, which calls for engaging oneself in “the affective process of developing positive feelings and a strong sense of belonging to one’s social group” (Ghavami et al., 2011). Furthermore, there is a paucity of literature regarding YB-GBMSM holding a positive perspective that highlights the strengths of this community. To address these various gaps in the literature, a cross-sectional study of N=200 YB-GBMSM between the ages of 18-29 living with HIV and in Atlanta was conducted. It was hypothesized that HIV stigma diminishes efforts to maintain an affirmed identity, amongst YB-GBMSM

living with HIV, and further suggested that resilience might weaken this negative association. According to the measure employed in this study, resilience is defined as one's "ability to bounce back or recover from stress" (Smith et al., 2008). Based on the data provided by the summary correlations table, HIV stigma had a negative impact on Queer-Person of Color (QPOC) identity beliefs. Resilience, however, did not have a moderating effect on the relationship between HIV stigma and an affirmed QPOC identity, as hypothesized. Future research should be dedicated to establishing either a YB-GBMSM-specific measure of resilience or a more inclusive measure of resilience that highlights YB-GBMSM's unique experiences and their environmental context. Moreover, future interventions should identify practical ways to employ resilience, promote identity affirmation among YB-GBMSM, and continue pursuing strengths-based approaches that assist YB-GBMSM living with HIV with successfully navigating HIV stigma, and other pervasive forms of oppression/discrimination.

Key words: resilience, moderation analysis, HIV stigma, Queer-Person of Color identity, YB-GBMSM, identity affirmation, intersectional health

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MASTER OF PUBLIC HEALTH

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APPROVAL PAGE

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Completion of this project has arguably been one of the most challenging yet rewarding experiences of my academic career. It is because of the immense support provided by my family, partner, friends, thesis committee members, and colleagues on the EmPOWER Research Team that I stayed the course and persevered, despite the numerous obstacles I encountered along the way.

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To my colleagues on the EmPOWER Research Team, thank you all for helping me recognize my many gifts and talents and granting me the space to showcase them too.

Author's Statement Page

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A handwritten signature in black ink, appearing to read 'Marcus Reed', is centered on the page. The signature is fluid and cursive, with the first name 'Marcus' and the last name 'Reed' clearly distinguishable.

Marcus Reed

Signature of Author

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Chapter I - Introduction

1.1 Background

Although the body of research dedicated to queer (e.g., lesbian, gay, bisexual, transgender, and other sexual identities that are non-heteronormative) - people of color (QPOC) is growing, there is a scarcity of literature studying the positive aspects of this marginalized community's identity (Ghabrial & Andersen, 2021). This community includes (but is not limited to) young Black-gay, bisexual, and other men who have sex with men (YB-GBMSM). The bulk of existing literature centered around this subgroup primarily addresses sexual health risk while assuming a deficit-frame, in which this subgroup is characterized by its shortcomings (e.g., defining this subgroup in terms of its HIV and substance use risk) and thereby perceived through a negative lens (Wade & Harper, 2017). As for the limited research that is available discussing QPOC identity, evidence suggests that some scholars often regard this intersection (i.e., being Black and gay/same-gender loving) of their identity as being in conflict with another (Huang et al., 2010). Previous QPOC literature that has discussed this specific intersection often advanced this notion that bearing either marginalized identity could indirectly or directly attack the integrity of the other marginalized identity, thus fostering this sense of incompatibility that has been observed. For instance, QPOC experience racism from White queer communities and heterosexism from Black heterosexual communities (McConnell et al., 2018).

However, some scholars have expressed a clear demand for research examining YB-GBMSM's intersectional identity and health, given that it is important to "consider the needs and experiences of Black YGBMSM holistically, especially when this population continues to suffer disproportionate rates of negative health outcomes" (Wade & Harper, 2017). Furthermore, this research is warranted because it is impossible to divorce the intersections of one's identity, and

YB-GBMSM are no exception. Therefore, this particular intersection of this population's identity should be studied simultaneously. More specifically, efforts assisting YB-GBMSM with realizing an affirmed identity should be pursued, having recognized how achieving such will allow this population to realize optimal health and thrive. To clarify, an affirmed identity is the product of one engaging in "the affective process of developing positive feelings and a strong sense of belonging to one's social group" (Ghavami et al., 2011).

One adverse health outcome that disproportionately impacts this population is the human immunodeficiency virus (HIV). For YB-GBMSM living with HIV, maintaining an affirmed self-identity can be incredibly challenging. In addition to racism and heterosexism, YB-GBMSM living with HIV must battle another form of oppression/discrimination, HIV stigma. HIV stigma is a combination of , "the negative attitudes and beliefs about people with HIV," and "the prejudice that comes with labeling an individual as part of a group that is believed to be socially unacceptable" (Centers for Disease Control and Prevention, 2022). According to research, HIV stigma can have a profound negative impact on the lives of YB-GBMSM living with HIV via increased engagement in maladaptive behaviors and exposure to other adverse health outcomes (Babel et al., 2021; Hussen et al., 2015, 2022; Rueda et al., 2016).

One viable mechanism that could buffer the pervasive impact of HIV stigma for YB-GBMSM living with HIV is resilience (Harper et al., 2014). Resilience is a complex concept having numerous nuanced definitions (Southwick et al., 2014). In the context of this study, resilience refers to one's ability to "bounce back" or "recover from stress" (Smith et al., 2008). Additionally, engaging the resilience of YB-GBMSM aligns with efforts to adopt a strengths-based approach (Harper et al., 2014), through attempts to identify and call upon YB-GBMSM's

existing assets and resources to navigate adversity versus a deficit-frame that fixates on the weaknesses of this population.

To this author's knowledge, there is no documented research capturing: (1) how HIV stigma simultaneously affects both the racial/ethnic and sexual minority identities of YB-GBMSM living with HIV, particularly when this intersection of their identity is affirmed; and (2) whether resilience can moderate the relationship between HIV stigma and QPOC identity, potentially mitigating the burden of HIV stigma.

To advance knowledge of the relationships among HIV stigma and resilience and QPOC identity affirmation, a cross-sectional study of N=200 YB-GBMSM between the ages of 18-29 living with HIV in Atlanta was utilized to address these various gaps in the literature. It was hypothesized that: (1) HIV stigma diminishes efforts to maintain an affirmed QPOC identity, thus yielding a negative association and (2) resilience will moderate the relationship between HIV stigma and QPOC identity, demonstrating a protective effect as evidence suggests.

1.2 Research Questions

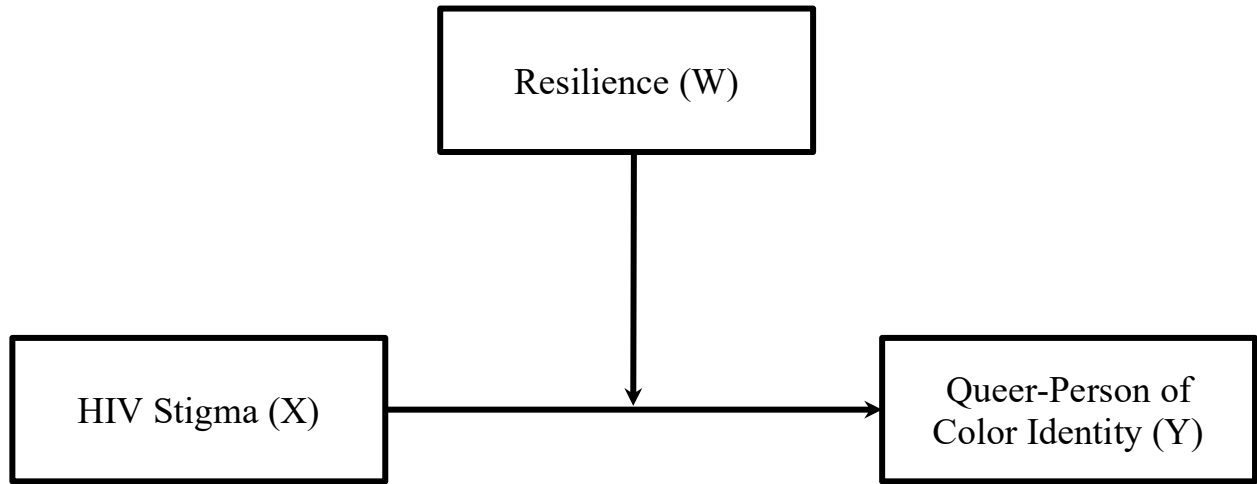
1. How does HIV stigma affect QPOC identity beliefs among YB-GBMSM living with HIV?
2. Does resilience influence the association between experiences of HIV stigma and YB-GBMSM's QPOC identity?

1.3 Study Purpose

The aims of this cross-sectional study are to evaluate: (1) whether there is a relationship between HIV stigma and QPOC identity, and (2) whether resilience moderates the relationship between HIV stigma and QPOC identity. A simple moderation analysis (see Figure 1) was conducted utilizing a previously collected dataset comprising 200 YB-GBMSM, all of whom

live with HIV in the metro-Atlanta area, which has been identified as a well-known HIV “hotspot” (Sullivan et al., 2021). This research helps fill an existing gap within the literature by examining how HIV stigma shapes the intersecting racial/ethnic and sexual minority identity of YB-GBMSM living with HIV while assuming a strengths-based approach (i.e., engaging the resilience of YB-GBMSM). A major goal of this study is to assist with advancing the ideas that YB-GBMSM can possess an affirmed, cohesive identity and that marginalized communities have existing assets and resources that should be operationalized to help address pervasive public health issues afflicting said communities.

Figure 1. Conceptual Diagram of a Moderation Analysis



Chapter II - Literature Review

2.1 YB-GBMSM (Living with HIV)

In the United States (U.S.), Black, gay, bisexual, and other men who have sex with men (MSM) are disproportionately affected by HIV. This marginalized subgroup represents the intersection of two high-risk populations: 1) Blacks/African Americans and 2) gay, bisexual, and other MSM. According to Center for Disease Control and Prevention (CDC) surveillance reports, in 2019, Blacks/African Americans represented 13% of the U.S. population but accounted for 40% of people living with HIV (Center for Disease Control and Prevention, 2021). Moreover, the same report also stated that gay, bisexual and other MSM accounted for 66% of new HIV infections from 2015-2019, despite only comprising 2% of the U.S. population (Center for Disease Control and Prevention, 2021). As such, Black MSM experience compounded risk, placing them in a particularly vulnerable position. Based on projections made by the CDC, if current infection rates persist, half of the Black MSM population in the U.S. face a lifetime risk of being diagnosed with HIV (Hess et al., 2017).

Behavioral risk factors (e.g., having unprotected anal intercourse, having undiagnosed or untreated sexually transmitted infections, and having multiple sexual partners) contribute greatly to this population's disproportionate HIV risk, but do not alone explain the gaping health disparities plaguing this marginalized group (Millet et al., 2007). Millet et al (2007) has recommended considering the broader contextual factors at play when seeking to gain a better understanding of Black MSM's plight. Compared to their MSM counterparts of other races/ethnicities, Black MSM encounter greater social and economic hardships (Millet et al., 2007). Black MSM experience, "two-fold greater odds of having any structural barriers that

increase HIV risk (e.g., unemployment, low income, previous incarceration, or low education)” (Millett et al., 2007).

Despite increasing HIV incidence rates, there is a paucity of research dedicated to acknowledging the experiences of Black, sexual minority men living with HIV (Han et al., 2010). As the population of YB-GBMSM living with HIV expands, there is an opportunity to learn more about the range of common experiences individuals within this community encounter, including developing a better understanding of what it looks like for YB-GBMSM to navigate HIV stigma and/or enlist the help of resources such as resilience to aid navigating said adversity (i.e., HIV stigma). Therefore, it would behoove public health practitioners and researchers alike to pursue this knowledge, recognizing the utility such information would have when assisting this community with navigating HIV stigma and/or similar adversities. As a result, it is dire that research efforts prioritize studying the aftermath of HIV.

2.2 Queer-Person of Color Identity; Identity Affirmation

Much of the existing literature studying YB-GBMSM tends to focus primarily on one aspect (i.e., race/ethnicity or sexual minority status) of their intersecting marginalized identities. More specifically, there is an absence of research discussing how this specific intersection of YB-GBMSM’s identity fare against pervasive, systemic forces, such as HIV stigma.

According to multiple population studies, sexual minorities fare worse than their heterosexual counterparts on a number of health outcomes, including “self-rated health (SRH), cardiovascular conditions, diabetes, functional limitations, and lifetime mood and anxiety disorders” (Hsieh & Ruther, 2016; Hatzenbuehler et al., 2013; Fredriksen-Goldsen et al., 2012; Bostwick et al., 2010; Conron et al., 2010; Diamant et al., 2000). Sexual minorities also perform poorer on several health measures compared with their heterosexual peers, such as increased risk

for suicide ideation, substance use, and limited healthcare access (Conron et al., 2010). Less studied, however, are the nuanced experiences of the various subpopulations within the broader sexual minority community (LGBTQIA+). More specifically, there is a dearth of literature discussing this particular intersection of a QPOC identity (i.e., race and sexual identity) and how this interaction ascribes unique meaning to the health and health risk exposures of sexual minorities of color (Hsieh & Ruther, 2016).

Even though there is extensive research discussing the identity development processes of racial/ethnic and sexual minority individuals independent of another, there is limited research focused on the co-identity development of YB-GBMSM's racial/ethnic and sexual minority identities (Jamil et al., 2009).

Although Corsbie-Massay et al (2017) have reported that YB-GBMSM experience identity conflict (i.e., when one or more aspects of one's identity threatens the salience of another aspect of one's identity), their study and others like it endorse the currently practiced deficit-frame, which is problematic when seeking to serve YB-GBMSM in an effective manner. In contrast to some scholars claiming that heterosexism delays Black MSM's experiences in forming their sexual minority identity, Jamil et al (2009) refute this idea by suggesting that both identities actually are cultivated simultaneously, and therefore should be studied together given the interdependent relationship. Crenshaw's (1989) transformative work addressing intersectionality provides additional justification for studying said relationship as recommended. Currently, the additive approach observed throughout the literature attempts to aggregate the experiences of both marginalized identities, suggesting that one's overarching identity is a collection of separate and distinct sub-identities. However, the reality is that truly disentangling an intersection of one's identities is impossible because individuals live an integrated experience

of their multiple identities; therefore, each of their multiple identities cannot be understood as a singular experience. Even when either identity is studied independent of another, the residual influence of the other identity remains present.

Due to the lack of an intersectional perspective in the literature, the experiences of YB-GBMSM can never be fully appreciated. In addition, advancing research that prioritizes identity affirmation is worthwhile, given evidence that suggests identity affirmation can translate to positive health outcomes such as greater medical appointment adherence (Harper et al., 2011). Hence, research examining the experiences of YB-GBMSM and the role of HIV stigma and resilience is justified. Because a poor self-concept can result in poor health outcomes (Harper et al., 2011) and that occupying this intersection poses heightened health risks (Hess et al., 2017), additional research uncovering the mechanisms that influence this connection is also warranted.

2.3 HIV Stigma

According to Goffman (1963), stigma can be experienced via, “an attribute that links a person to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one.” Even though Goffman examines stigma in a broad sense, this notion still holds true when discussing HIV-related stigma within the context of YB-GBMSM living with HIV.

HIV stigma is a major challenge for YB-GBMSM and other people living with HIV, with proven ill effects on mental and physical health (Jackson-Best & Edwards, 2018). Arnold et al (2014) provides supporting evidence illustrating how the devastating toll of HIV stigma can prompt engagement in maladaptive behaviors (e.g., reluctance to seek care, poor treatment medication adherence, and non-disclosure of HIV-positive serostatus). Amid navigating HIV stigma, bearing a QPOC identity while living with HIV poses challenges that interfere with co-

identity development and ultimately threatens prospects to realize optimal health among this population. Having recognized that HIV stigma has a profound, adverse impact on identity beliefs (Mahajan et al., 2008), it is worth pursuing efforts that mitigate this burden for YB-GBMSM living with HIV.

A few scholars have offered explanations as to why addressing HIV stigma is so challenging; Mahajan (2018) suggests that it is due to being relegated to a low-priority in the field of public health, and Valdiserri (2002) points to the deep ties that stigma has with other complex, controversial focus areas (e.g., gender, race, and culture).

As a result of the lack of research on YB-GBMSM living with HIV, there is also a lack of literature covering the toll HIV stigma has on this population. However, there is strong evidence illustrating how the impact of HIV stigma can translate to adverse health outcomes such as poor engagement in care (Babel et al., 2021).

To build evidence on the impact HIV stigma can have on YB-GBMSM's health (Babel et al., 2021), additional research exploring how HIV stigma influences QPOC identity formation and maintenance is desperately needed.

2.4 Resilience

Resilience research for sexual minorities is limited (Kwon, 2013), but some scholars believe that it offers positive benefits for men who sex with men (MSM) individuals by protecting this population from certain psychosocial outcomes despite experiencing stress (Wilson et al., 2016). The limited research on resilience pertaining to YB-GBMSM primarily focuses on adolescents. Studies that describe the experiences of MSM with resilience as they mature would expand knowledge of resilience throughout adulthood (Bruce et al., 2015).

Meyer (2015) asserts that resilience should be situated within the context of minority stress, recognizing how sexual minorities innately face continuous adversity. The minority stress framework posits that individuals bearing a marginalized identity experience increased exposures to stress (Meyer, 2003). Utilizing this framework helps afford a stronger understanding of resilience within the context of YB-GBMSM living with HIV. In fact, more recent work by McConnell et al (2018) embracing this framework points out that race can influence resilience levels among sexual minorities, providing evidence for White sexual minorities having greater community-resilience (i.e., connection to the LGBT community) than their Black sexual minority counterparts. Identity conflict partially explained this finding.

Additionally, some researchers that have adopted a strengths-based approach over a deficit-frame have shown that resilience can weaken the influence of HIV stigma (Earnshaw et al., 2013; Zimmerman, 2013). Despite YB-GBMSM often perceived in terms of what it lacks, resilience is believed to be a resource that abounds amongst YB-GBMSM. According to Meyer (2010), bearing multiple marginalized identities functions as an armor, supplying specifically sexual minorities of color with greater levels of resilience by virtue of having increased exposure and experience navigating multiple forms of discrimination/stress (i.e., heterosexism and homophobia).

Southwick et al (2014) noted that studying resilience can be tricky, given that it is a complex concept that has been defined in many ways to meet the needs of the various contexts in which it is being studied. Although this study embraces a simple definition of resilience (evaluating one's ability/tendency to "bounce back") (Smith et al., 2008), Bruce et al (2015) suggests that resilience should be viewed as a process, promoting the idea that resilience does not only exist within an individual as a trait but can also be engaged externally through supports and

resources furnished throughout one's community. Emerging evidence suggests that defining resilience should not be perceived as operating within a binary of individual traits versus external process. Rather, resilience should include both interpretations of the concept (Kuldas & Foody, 2022). Of course, this lack of consensus among scholars regarding how to define resilience makes it more difficult to measure and evaluate among YB-GBMSM, which can hinder efforts to serve this community effectively.

2.5 The Current Study

Based on prior literature, we observed the following: (a.) YB-GBMSM face high risk for adverse health outcomes, including HIV; (b.) YB-GBMSM identify as both a racial/ethnic and sexual-minority, which invites heightened health risks due to being multiply marginalized; (c.) for YB-GBMSM living with HIV, HIV stigma can undermine identity beliefs, which further complicates efforts to realize optimal health and thrive; and (d.) YB-GBMSM may have means (i.e., resilience) to alleviate the persistent toll of HIV stigma.

The current study was informed by synthesizing the previously discussed understanding of the circumstances facing YB-GBMSM living with HIV and assessing the knowledge gaps within the literature. Given that YB-GBMSM are often regarded as a "hard-to-reach" population, it seemed best to utilize available data collected through the OpenMind study (a study conducted by the EmPOWER research team at Emory University that investigated mental health service utilization among YB-GBMSM living with HIV) and opt for a cross-sectional study design with a quantitative approach to eliminate retention and response rate concerns. Although the author would like to have a richer understanding of the association among HIV stigma, resilience and QPOC identity, the cross-sectional study design coupled with self-report measures enabled a more immediate glimpse of the experiences and issues facing this marginalized community.

Because the study sample resides in a known HIV hotspot and all living with HIV, this study could afford novel insights specific to this community, which helps shed additional light on the unique experiences of a community that is often underrepresented in research.

CHAPTER III - Methods

3.1 Participants & Recruitment

Participants in the original study included 200 YB-GBMSM living with HIV. A few years ago, the EmPOWER research team, which is supported by Emory University, conducted the original data collection and analyses to inform related work and research concerning YB-GBMSM¹. Since collected, this primary data has been analyzed to address certain inquiries (i.e., inquiries are informed yet limited by the inherent constraints of the data) regarding YB-GBMSM, as is the case with the current study. The original study inclusion criteria involved (1) identifying as Black/African American; (2) male gender (inclusive of transgender men); (3) self-identifying as gay, bisexual, or another non-heterosexual orientation, and/or any history of consensual anal or oral sex with men; (4) bearing a HIV-positive serostatus; (5) being of or between the ages of 18-29 years old; and (6) living in the Atlanta Metropolitan Statistical Area. For the current study, the inclusion criteria remain unchanged. Participants were recruited from a range of settings including a large HIV care center as well as referrals from individual partners and community-based organizations. Participants were screened for eligibility using a self-administered REDCap survey; if eligible, a study team member reached out to schedule a survey session.

3.2 Procedure

Team members obtained verbal informed consent prior to beginning the survey. Generally, survey items were self-administered by the research participants using REDCap (a secure HIPAA-compliant online database) (Harris et al., 2009). For select cases, surveys were

¹ The original research articles that were produced as a direct result of the OpenMind study (i.e., the original study that informed the author's current study) are currently undergoing review and therefore have not been published.

conducted via Zoom videoconference technology and administered by trained study staff. Survey items were shared on a screen and read aloud by study staff as a strategy to maximize comprehension by the participant. Study staff entered responses, given verbally by participants, into REDCap. Each survey took approximately 45 minutes to complete. Participants received a \$50 electronic gift card upon completion of the interview. The Emory University IRB and Grady Research Oversight Committee approved the study protocol.

3.3 Measures

HIV Stigma. HIV stigma is assessed using the 10-item Brief Measure of Stigma for HIV+ Youth (Wright et al., 2007). Example items included “Having HIV makes me feel unclean” and “Most people think that a person with HIV is disgusting”. Participants were asked to indicate their level of agreement with each item, rating responses on a 4-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree). Items were summed to create a total HIV stigma score where higher scores indicated perceptions of experiencing greater HIV-related stigma. Cronbach's alpha was .87.

Resilience. Resilience was measured using the Brief Resilience Scale (BRS), a self-reported 6-item measure of individuals' resilience levels (Smith et al., 2008). Example items included “ I tend to bounce back quickly after hard times” and “I usually come through difficult times with little trouble”. This instrument utilized a 5-point Likert scale with response options ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). Items 1, 3, 5, were positively worded, and items 2, 4, 6 were negatively worded. Following data collection, negatively worded items were reversed so that they aligned with positively coded items. Items were then summed to create a total resilience score where higher scores reflected higher levels of resilience. Cronbach's alpha was .74.

Queer-Person of Color Identity (QPOC). The Queer Person of Color Identity Affirmation Scale (QPIAS) is a 12-item instrument that assesses individuals' attitudes toward their QPOC identity, i. e. identifying as both a sexual and racial/ethnic minority (Ghabrial & Andersen, 2021). Example items included "I think the difficulties I've faced as a person who is an LGBTQA+ ethnic/racial minority make me better at handling hard situations" and "I feel that my sexual identity and my ethnic/racial identity are at war with each other". Items were evaluated using a 7-point Likert scale; response options ranged from 1 (Strongly Disagree) to 7 (Strongly Agree). Items were summed to create a total QPOC identity score where higher scores indicated more positive QPOC identity beliefs. Cronbach's alpha was .87.

3.4 Covariates

Based on preliminary searches of the literature, the following covariates were selected to help study the relationship between HIV stigma, resilience, and QPOC identity with minimal outside interference to afford more reliable and accurate findings.

Perceived Social Support. The Multidimensional Scale of Perceived Social Support (MSPSS) is a 12-item questionnaire that assesses the adequacy of social support an individual receives (or may not) from 3 sources: family, friends, and significant others (Zimet et al., 1988). Example items included "There is a special person around when I am in need," "I get the emotional help and support I need from my family," and "I can count on my friends when things go wrong." This instrument used a 7-point Likert scale (1 = Very Strongly Disagree; 7 = Very Strongly Agree). Each source of social support represented a subscale and consisted of four items. Items were summed to create a total perceived social support score where higher scores indicated higher levels of social support. Cronbach's alpha was .94.

Depressive Symptoms. The Center for Epidemiologic Studies Depression Scale (CES-D) is a 20-item self-reported measure of depressive symptoms an individual may have experienced within a defined time frame (Radloff, 1977). Example items included “I felt that I could not shake off the blues even with help from my family or friends,” “I felt I was just as good as other people,” and “I felt hopeful about the future.” The total score was calculated by finding the sum of the 20 items. Response options ranged from 0 (Not at all or less than one day) to 3 (Nearly every day for 2 weeks). Items were summed to create a total depressive symptoms score where higher scores indicated greater depressive symptoms. Cronbach’s alpha was .97.

Educational Attainment. Participants self-reported their educational attainment on a 8-point scale ranging from 1 (eighth grade or less) to completing 8 (master’s degree or above).

Age. Participants self-reported their chronological age at the time of the study. The average age of the participants was 25.41 years old (SD = 3.96).

3.5 Data Analysis

For this current study, the author hypothesized the following: (1) there will be a strong, inverse relationship between HIV stigma and QPOC identity and (2) resilience will moderate the relationship between HIV stigma and QPOC identity.

Hypotheses were tested using IBM SPSS, 28.0. To test the first hypothesis, Pearson’s correlation coefficient was used to measure the directionality of relationships between all study variables, with an emphasis placed on the relationship between HIV stigma and QPOC identity. The strength of the correlations was categorized into one of three ranges. The ranges are arbitrary, so correlations should be interpreted based on this understanding. Correlations were defined as follows: weak (correlation coefficients inclusive of and between 0.01 and 0.39), moderate (correlation coefficients inclusive of and between 0.4 and 0.59), and strong (correlation

coefficients inclusive of and between 0.6 and 0.99). The same measurement system applied to negative correlations. Correlation coefficients of +1, 0, and -1 indicate a perfect positive correlation, no correlation, and a perfect inverse correlation, respectively.

To test the second hypothesis, a moderation analysis was conducted, which assesses whether a third (i.e., extraneous) variable has an impact on the relationship between the predictor and outcome variables. To determine whether resilience moderates the association between HIV stigma and QPOC identity, two linear regression models were conducted: (1) to assess the direct influence of HIV stigma on QPOC identity and (2) to assess the *interaction* between HIV stigma and resilience on QPOC identity. The information gleaned from both regression models helps tease apart “when” resilience would moderate the relationship between HIV stigma and QPOC identity. The first linear regression model provided an understanding of the association between HIV stigma and QPOC identity. The second linear regression model then assessed the *multiplicative* effect of resilience on the association between HIV stigma and QPOC identity. The findings of this model were then utilized to determine presence of a moderating effect, which is achieved when the interaction term (i.e., the product of HIV stigma and resilience) yields statistically significant results. Both regression models were bootstrapped with a conservative 5,000 resamples to provide more reliable estimates, understanding that this dataset has missing values and some of it fails to adhere to a normal distribution. All significance levels were set to the commonly practiced .05.

Chapter IV - Results

4.1 Sociodemographic Profile of Study Participants

Table 1 provides an overview of select sociodemographic characteristics of the study participants (e.g., educational attainment, annual household income, and employment status). Most participants identified as a cisgender male (96.0%), gay/homosexual/same gender loving (85%), having a high school diploma or equivalent (41.5%), being employed full time (46%), and being actively engaged in HIV care (98%). A majority of the participants reported having an annual household income of less than \$10,000 (32%) or earning between \$10,000 – and \$19,999 annually (20.5%).

Table 1. *Sociodemographic Characteristics of Study Participants*

Sociodemographic Variables	n = 200	%
Gender Identity		
Male	192	96.00
Trans masculine	2	1.00
Genderqueer/gender non-conforming	5	2.50
Missing	1	0.50
Sexual Identity		
Gay/homosexual	170	85.00
Bisexual	25	12.50
None of the above	5	2.50
Receiving HIV Care		
No	4	2.00
Yes	196	98.00
Highest Grade Level Completed		
9 th to 11 th grade	14	7.00
High school diploma or GED	83	41.50
Some college, technical school, or vocational school	59	29.50
Technical school or vocational school graduate	7	3.50
Two-year college graduate	8	4.00
Bachelor's degree	25	12.50
Master's degree or above	4	2.00
Current Employment Status		
Employed, full time	92	46.00
Employed, part time	42	21.00
Unemployed	55	27.50
Other	11	5.50
Estimated Annual Household Income		
Less than \$10,000	64	32.00
\$10,000 - \$19,999	41	20.50
\$20,000 - \$29,999	39	19.50
\$30,000 - \$49,999	38	19.00
\$50,000 - \$99,999	13	6.50
Greater than \$100,000	4	2.00
Missing	1	0.50

4.2 Data Analysis Results

Table 2 provides a summary of correlations of the study variables. Positive correlations indicate that both variables being studied move in tandem, as one variable increases, the other variable does the same. Alternatively, negative correlations indicate the opposite, as one variable increases, the other variable then decreases.

There is a negative association between HIV stigma and QPOC identity, meaning that as HIV stigma increases, QPOC identity decreases. In addition, there is a weak, positive association between HIV stigma and resilience, meaning that as HIV stigma increases, resilience increases as well. Except for depressive symptoms, HIV stigma is negatively correlated with all remaining covariates (age, educational attainment, and perceived social support). As it relates to depressive symptoms, HIV stigma shares the strongest positive correlation with this variable, withstanding the association being deemed weak. Conversely, QPOC identity was positively correlated with all covariates, despite all associations still being weak. There is also a weak, inverse association between resilience and QPOC identity.

Table 3 and Table 4 provide the results of the two bootstrapped linear regression models (i.e., the moderation analysis) used to determine whether resilience moderates the relationship between HIV stigma and QPOC identity. The first linear regression (i.e., see Table 3) demonstrates the direct effect of HIV stigma and resilience on QPOC identity, before introducing the interaction term (i.e., the product of HIV stigma and resilience) to the model. The second linear regression (i.e., see Table 4) model ascertains whether resilience is a moderator, based on the observed interaction effect. This model illustrates the effect of HIV stigma on QPOC identity at varying levels of resilience. Based on our findings, regardless of intensity, resilience does not

moderate the relationship between HIV stigma and QPOC identity ($p = .85$, 95% CI [-2.21, 2.55]). With this being the case, we failed to reject the null hypothesis.

Table 2. *Summary Correlations Matrix of Study Variables*

	1	2	3	4	5	6	7
1 HIV Stigma	--						
2 Age	-.03	--					
3 Depressive Symptoms	.38**	.03	--				
4 Perceived Social Support	-.14	.02	-.23**	--			
5 Educational Attainment	-.09	.22**	-.06	.08	--		
6 Resilience	.14*	-.02	.27**	0.1	-.12	--	
7 Queer-POC Identity	-.22**	.14	.01	.26**	.15*	-.13	--

Note.

** *Correlation is significant at the 0.01 level (2-tailed).*

* *Correlation is significant at the 0.05 level (2-tailed).*

Table 3. *Linear Regression Model Showing Main Effects*

Model	B	Bootstrap ^a			95% Confidence Interval	
		Bias	Std. Error	Sig. (2-tailed)	Lower	Upper
1 (Constant)	55.56	-.35	9.42	<.001	36.88	73.54
HIV Stigma	-.52	.01	.15	<.001	-.80	-.22
Age	.34	.01	.23	.14	-.09	.82
Depressive Symptoms	.17	.00	.05	.00	.07	.28
Perceived Social Support	.21	.00	.07	.00	.06	.35
Educational Attainment	.64	-.03	.61	.29	-.62	1.77
Resilience	-.67	.01	.32	.04	-1.28	-.04

Note.

a. Unless otherwise noted, bootstrap results are based on 5000 bootstrap samples

Table 4. *Linear Regression Model Showing Interaction Effects*

Model	B	Bootstrap ^a			95% Confidence Interval	
		Bias	Std. Error	Sig. (2-tailed)	Lower	Upper
1 (Constant)	45.36	-.60	9.64	<.001	25.03	63.08
HIV Stigma	-.54	.01	.15	<.001	-.82	-.24
Age	.34	.02	.25	.16	-.09	.87
Depressive Symptoms	.13	.00	.05	.01	.03	.23
Perceived Social Support	.18	.00	.08	.02	.03	.34
Educational Attainment	.81	-.04	.62	.20	-.45	1.94
Interaction Term ^b	.24	-.04	1.21	.85	-2.21	2.55

Note.

a. Unless otherwise noted, bootstrap results are based on 5000 bootstrap samples

b. Interaction Term = The product of HIV stigma and resilience

Chapter V - Discussion/Conclusion

5.1 Discussion of Research Questions

In this study, the author examined how HIV stigma influences QPOC identity and whether resilience moderated the relationship between HIV stigma and QPOC identity.

For the first research question, the author found a strong negative association between HIV stigma and QPOC identity, which serves as evidence supporting the hypothesis made. HIV stigma is a pervasive and formidable force that can manifest as profound stress in the lives of YB-GBMSM living with HIV. Considering the magnitude of this stress, it can easily undermine the integrity of and efforts to maintain an affirmed QPOC identity.

For the second research question, the hypothesis was not supported. In the context of this study, resilience failed to demonstrate the protective (moderator) effect observed in previous studies. It is possible that the resilience measure, which was not developed in this specific population, does not adequately capture the facets of resilience among YB-GBMSM. In particular, this instrument perceives resilience as a trait, not a process, underscoring the need to revisit how resilience is defined and employed in research. In the context of this study, the resilience measure utilized seems more fitting for events or circumstances that are more proximal, solvable (i.e., capable of being resolved at the individual-level) and transient, not HIV stigma, which, oppositely, is distal, elusive, and systemic (i.e., long-term and enduring). As opposed to being perceived as an individual-level attribute that one may arbitrarily possess, resilience as a process likely includes external factors, which would grant YB-GBMSM a greater sense of agency over their circumstances by having the ability to build and engage their coping skills and network of resources. Based on this understanding of resilience, a more effective

measure should be developed, ideally specifically for YB-GBMSM or a more inclusive measure capturing this population's lived experiences.

Though the second hypothesis was not supported, it is important to consider how this particular finding fits within the existing narrative regarding YB-GBMSM, along with providing learning opportunities. A potential inference is that, unlike racism and heterosexism, no one or nothing prepares YB-GBMSM living with HIV to deal with HIV stigma, and that includes one's previous experience with navigating more familiar forms of discrimination/oppression (e.g., racism and heterosexism). From a public health perspective, addressing factors beyond a personality trait (i.e., the individual-level) presents a better approach to help individuals navigate a pervasive, societal force such as HIV stigma. Plus, defining resilience as a social process would denote an inherent iterative nature that affords learning how to practice action-taking (e.g., summoning resources and implementing coping skills) that makes navigating HIV stigma easier.

5.2 Study Strengths and Limitations

The key strength of this study is the insight afforded regarding YB-GBMSM living with HIV in the metro Atlanta area. Given the various holes identified in the literature, this novel study marks a step in the right direction. Withstanding the existing knowledge of YB-GBMSM, there is still much to learn from this subset of individuals, especially about the unique experiences of those individuals living with HIV. A major advantage of the current study is the value it adds to the current knowledge base regarding YB-GBMSM: this marginalized population has access to an underutilized resource that could be harnessed to help this community navigate another layer of oppression/discrimination (i.e., HIV stigma).

The limitations of this study are its study design, reliance on self-report measures, and measurement of resilience. First, the study features a cross-sectional study design, which limits

an in-depth understanding of potential longitudinal forces at work. While this study design affords a “snapshot” of a commonly hard-to-reach population, a longitudinal observation of the dynamics at play could have produced richer findings and insights about the roles of stigma and resilience within the target population. Second, all the measures included in this study were self-report, thus there was the potential for social desirability bias. A potential concern is participants overestimating or underestimating their experiences to appear more favorable to the researchers (despite efforts taken to ensure confidentiality), considering the sensitive topics covered (e.g., substance use, sexual behavior, and mental health symptomatology). Lastly, the limited definition of resilience could have adversely influenced the observed findings. Given that resilience was measured only as an individual trait, other dimensions of resilience related to external factors may have added to the explanatory value of this variable in the moderation analyses.

5.3 Implications of Findings

This study supports pursuing an asset-frame approach to YB-GBMSM studies, that recognizes the needs of this population, such as struggles with HIV stigma, while appreciating positive attributes and unique perspectives experiences within this population. Even though this population encounters an array of hardships, the experience of stigma should not automatically eliminate the possibility that this population may hold the tools and skills (i.e., resilience) necessary to maneuver said hardships. Adopting an asset-frame helps researchers avoid making this mistake by shifting the focus from this population’s shortcomings to its strengths. Too often, solutions intended to serve marginalized communities are believed to exist exclusively beyond the population affected and/or the harsh environment they inhabit. Contrary to the deficit-frame research portraying YB-GBMSM as a helpless community struggling to navigate adversity, this

population has access to resources and supports (present among them/within their environment) that could potentially facilitate efforts to realize optimal health.

A crucial takeaway from emerging literature that this study attempted to address is that tackling systemic issues require a multifaceted response. Effectively targeting a pervasive, complex issue such as HIV stigma requires public health practitioners to engage in a concerted cross-sector effort with others who share a similar mission (DeSalvo et al., 2017). Although in this study, resilience did not significantly moderate the relationship between HIV stigma and QPOC identity, future studies could use resilience measures that operate beyond the individual-level within the broader socio-ecological levels. Understanding that HIV stigma is a structural issue, addressing this issue requires soliciting the aid of community partners, political figures, among other leaders existing beyond the individual-level. As mentioned earlier, for populations such as YB-GBMSM, combating systemic issues such as HIV stigma demands also paying attention to the underlying contextual (e.g., social, political, and economic) factors that ascribe meaning to their lived experiences (i.e., social determinants of health), serving as one of many avenues to mitigate the burden of HIV stigma, and other forms of oppression/discrimination. Unfortunately, realizing upstream solutions are time-intensive and expensive, which requires long-term commitments from partners.

Another key implication of this study is that it highlights the importance of appreciating YB-GBMSM's experiences through an intersectional lens. As mentioned previously, there is a scarcity of literature reflecting the unique experiences of YB-GBMSM. Despite some scholars' criticisms that having intersecting, marginalized identities yield tension, studying both aspects of YB-GBMSM's identity independent of another is also problematic. Because it is impossible for YB-GBMSM to separate their identities future research should address the intersectionality of

identities. Furthermore, conflating the experiences of Black, heterosexual men and non-Black sexual minority men as an attempt to ascertain the experiences of YB-GBMSM continuously discounts both the experiences and existence of this population. The sum of experiences as a YB-GBMSM will never equal the sum of experiences as a Black, heterosexual male and the sum of experiences as a non-Black (e.g., Caucasian) sexual minority male, which underscores the notion that sexual minorities are not a monolith and the diversity embedded within this community should be both appreciated and recognized.

5.4 Future Directions for Research

Future research should consider conducting a longitudinal study with a larger sample size to afford greater insight about the population, building upon the limited knowledge available. A longitudinal study could help provide a complete picture of the issue, helping fill in the rough outline created by this current cross-sectional study. Additionally, future research seeking to gain a better understanding of resilience should develop and adopt a streamlined definition that can be applied in a variety of contexts, in an effort to enhance the quality, quantity and consistency of research findings. Accurately capturing the nuances of resilience and how it may be defined within the context of this population also demands the development of a population-specific measure.

Given that this study used a quantitative approach only, which does not fully represent the lived experiences of participants future studies could include qualitative methods in a mixed-methods approach. For example, conducting in-depth qualitative interviews with study participants offers another way (besides modifying the study design) to help contextualize and inform this study's underwhelming yet valuable findings. Considering that White, Eurocentric, cisgender, heteronormative measures are often utilized to report the experiences of YB-

GBMSM, a qualitative approach helps minimize whitewashing the unique experiences of this marginalized community along with supplying a voice to this disenfranchised population, that usually goes unheard (both within public health research and beyond this realm) and is naturally denied in quantitative research. Essentially, adopting a qualitative approach helps restore the human element of research that is often missing in quantitative research, which offers explanatory value to the study that can double as damage control against the standing, misleading narrative about YB-GBMSM (thanks to having a better understanding of the forces involved).

Lastly, future interventions should identify practical ways to employ resilience, promote identity affirmation among YB-GBMSM, and continue pursuing strengths-based approaches that assist YB-GBMSM living with HIV with successfully navigating HIV stigma, and other pervasive forms of oppression/discrimination.

5.5 Conclusion

Most of the current literature discussing YB-GBMSM living with HIV speaks of this population in a disparaging way, insinuating it is in a constant state of need (i.e., appealing to the deficit-frame). With this in mind, there is a dire need for research discussing YB-GBMSM living with HIV in a positive manner that acknowledges the other holistic-health needs of this population, such as those concerning intersectional health and identity.

Absent from the literature from the literature is a study that assumes a strengths-based approach while examining how HIV stigma affects the intersectional identity beliefs of YB-GBMSM living with HIV, and also assessing whether resilience (i.e., an existing asset among YB-GBMSM) moderates said relationship. After noticing this gap in the literature, we attempted to fill it by conducting a cross-sectional study.

Based on the results of the moderation analysis, it was observed that HIV stigma is negatively associated with a QPOC identity, and that the current measure of resilience, though a promising response to buffer HIV stigma, is not necessarily a sufficient response. In the context of this study, resilience alone is insufficient to help YB-GBMSM living with HIV deal with HIV stigma. Although the current hypothesis was not supported, future research on resilience within YB-GBMSM is warranted. Amidst navigating HIV stigma, this population also battles with racism, homophobia, and other existing challenges, creating this whirlwind of hardships and oppression that can be downright debilitating and paralyzing for YB-GBMSM. Therefore, it is imperative that the deficit-frame is abandoned, having noticed that defining this population by its plight is a disservice to them, by restricting efforts to support YB-GBMSM in a meaningful way. Having a narrow-minded perception of this population yields narrow-minded solutions. Researchers and public health practitioners could instead adopt a strengths-based approach, inviting greater opportunities to realize more sustainable solutions that can help this population lead healthier and more stable lives. Ultimately, effectively assisting this population begins with recognizing that, regardless of both the adversities and shortcomings facing this population, YB-GBMSM have strengths that can be harnessed as well. Given what is at stake for this population, additional research efforts committed to taking inventory of YB-GBMSM's assets is desperately warranted.

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