Published in final edited form as:

J HIV AIDS Soc Serv. 2013 ; 12(3-4): . doi:10.1080/15381501.2013.816211.

“What Could Have Been Different”: A Qualitative Study of Syndemic Theory and HIV Prevention among Young Men Who Have Sex with Men

Thomas Lyons, PhD,

HIV/AIDS Research and Policy Institute, Chicago State University, Chicago, IL, USA

Amy K. Johnson, MSW, and

Children’s Memorial Hospital, Chicago, IL, USA

Robert Garofalo, MD

Children’s Memorial Hospital and Northwestern University Feinberg School of Medicine, Chicago, IL, USA

Abstract

Young men who have sex with men (MSM) experience multiple health disparities, including alcohol and drug use, partner violence, victimization due to sexual orientation, and HIV infection. Syndemic theorists explain the clustering of these disparities among adult MSM as a result of cultural marginalization. To date, research on a similar emerging syndemic among young MSM has been limited to quantitative studies. This study seeks to better understand these disparities, and how they may cluster together, via qualitative interviews with 21 ethnically diverse, HIV infected young MSM aged 18–24 years old. These youth report a lack of gay-specific HIV prevention education, absence of role models, and lack of productive future goal-related activities as factors related to their acquisition of HIV, and downplay substance use as a factor. Although not necessarily the components traditionally cited by syndemic theorists, these findings support the notion that multiple factors of cultural marginalization cluster together in the lives of young MSM, and underscore the importance of community-level interventions, such as sexual health education, access to mentors, and assistance with future goal setting and planning.

Keywords

Young men who have sex with men; Syndemic; Marginalization; HIV/AIDS

Introduction: Syndemic Theory and Young Men who Have Sex with Men

The rate of growth of new HIV infections among youth aged 13 to 24 has been more than double that of the US population as a whole (Centers for Disease Control and Prevention, 2007). Male-to-male transmission accounts for almost 80% of HIV diagnoses among young men ages 16–19 (Rangel, Gavin, Reed, Fowler, & Lee, 2006; Wolitski, Valdiserri, Denning, & Levine, 2001). The HIV epidemic among young men who have sex with men (MSM) does not exist in a vacuum. Young MSM experience multiple biopsychosocial health disparities, including alcohol and drug use (Garofalo, Wolf, Kessel, Palfrey, & DuRant, 1998; Greenwood et al., 2001; Russell, Driscoll, & Truong, 2002; Thiede et al., 2003; Vermont Department of Health, 2000), suicide attempts (R. Garofalo, Wolf, Wissow,

Woods, & Goodman, 1999; McDaniel, Purcell, & D'Augelli, 2001; Savin-Williams, 2001), and victimization due to sexual orientation and/or gender non-conformity (Koblin et al., 2006; Russell, Franz, & Driscoll, 2001; Safren & Heimberg, 1999; Savin-Williams, 1994).

The term “syndemic” was first used to describe inextricable and mutually reinforcing connections among health disparities, such as substance abuse, violence, and HIV/AIDS among the urban poor (Singer, 1994). After exploring a similar pattern among adult MSM, Stall and colleagues concluded that urban gay male communities also suffer from the effects of a HIV-related syndemic, encompassing polydrug use, depression, childhood sexual abuse, and partner violence (Stall, Mills, & Williamson, 2003). Syndemic theorists explain the clustering of these epidemics in terms of cultural *marginalization*—exclusion from dominant norms and institutions (Cohen, 1999)—rather than sexual orientation or same-sex sexual behavior itself (Friedman, 2008). Stall and colleagues have recently expanded the etiology of the HIV syndemic to include childhood stressors such as homophobic culture and rejection by family, leading to internalized homophobia (Wolitski, Stall, & Valdiserri, 2008). Mustanski and colleagues provide quantitative evidence of a potential syndemic among young MSM of substance use, psychological distress, and partner violence (Mustanski, Garofalo, Herrick, & Donenberg, 2007).

Most young gay men do not become HIV positive, and navigate adolescence with limited negative health outcomes and minimum distress about their sexuality (Eccles, 2004). The minority of young gay men who do seroconvert may differ on multiple dimensions from their peers. It is, therefore, critical for HIV prevention efforts to attend to the unique stories of HIV positive young MSM, since these stories can elucidate how risks may cluster together, and in turn suggest innovative strategies that prevention programs might employ to address multiple dimensions of risk. To date, the best models of HIV prevention services for youth have centered around peer information and dissemination (Gurdin, Neigo, & Mince, 2008; Huba & Melchior, 1998) and youth health educators (Sieverding et al., 2005). Overall, research suggests that services for youth should include empowerment training (Grossman, 2001; Wright, Gonzalez, Werner, Laughner, & Wallace, 1998) within a comprehensive framework that addresses issues related to education, employment, and financial assistance (Wright et al., 1998). Moreover, HIV prevention programs should integrate school-based programs, multiservice youth agencies, and self-help groups (Cranston, 1991). However, few such programs have been designed for young MSM (Gurdin et al., 2008), perhaps because of the same forces of marginalization noted above.

In previous qualitative work, Seal and colleagues (Seal et al., 2000) solicited recommendations from young MSM concerning the kinds of HIV prevention programs that would best meet their needs. The respondents recommended holistic approaches such as access to mentors rather than strictly safer-sex approaches. Mutchler and colleagues found that young MSM knew the basics of safer sex techniques (i.e. using condoms) but lacked prevention education specific for MSM and access to safe, non-sexualized spaces for meeting other young MSM (Mutchler, 2000a, 2000b, 2002; Mutchler, Ayala, Herbert, & Fernandez, 2004).

Hence, both the growing syndemic literature and the literature on design of HIV prevention programs suggest that focusing on only one dimension of HIV risk will be less effective than an approach based on the multidimensional nature of vulnerability for HIV. To date, however, the literature on HIV and syndemic theory among young MSM has consisted of quantitative studies. In the current study, we conducted qualitative interviews of HIV positive MSM aged 18–24 years old as part of a larger project to develop a group based HIV prevention intervention for young MSM. Specifically, we asked the participants to reflect retrospectively on what could have been different in their lives that might have prevented

them from becoming HIV positive. In this report, we use a grounded theory approach (Glaser & Strauss, 1967) to elucidate the young men's narratives. Our research questions are, first, whether these young men identify the syndemic factors of substance use, violence, and internal homophobia/psychological distress as important factors in their becoming HIV positive. Second, we explore factors not central to syndemic theory, but which are emergent in the transcripts (Clarke, 1997). We seek to understand whether the latter factors also can be explained by cultural and social marginalization. Finally, we explore how an understanding of syndemic factors, as well as factors typically not included in syndemic models, can strengthen prevention programs for young MSM, including programs based on peer education and strengths-based programs.

Methods

All study procedures were approved by the Institutional Review Boards of the collaborators. The 21 participants were male; 18–24 years old; self-identified as gay or bisexual; and receiving health care and/or case management at a community health center with a primarily gay, lesbian, bisexual and transgender (GLBT) clientele and staff. We purposively recruited equal numbers of self-identified White, African American, and Latino participants with the expectation that their experiences related to HIV infection would vary. Participants were actively recruited by members of their health care team (e.g., case manager, physician), who described the study and provided contact information. Passive recruitment consisted of flyers posted in the clinic space, as well as emails to a blinded internal listserv (maintained by the health center case manager) of HIV positive youth who had consented to be contacted with information about research studies. Potential participants were screened in person or over the phone by study staff. Of the 23 youth who were eligible for the study, 21 agreed to participate. Due to the recruitment strategy, it is unknown how many young men were approached about the study.

Interviews lasted about an hour and were conducted by MSM interviewers experienced with interviewing this population. Because of the potentially upsetting nature of the questions, mental health professionals were on hand for counseling in case the participant became distressed; however, this intervention did not prove necessary. Participants were paid a small stipend for their time. As part of the informed consent process we obtained permission from each participant to audiorecord the sessions.

Interviews were semi-structured, eliciting information on broad domains relevant to HIV infection and prevention: (1) HIV and safer sex knowledge and attitudes; (2) by whom the participant believed he was infected, and in what circumstances; (3) patterns of sexual relationships, (4) drug and alcohol use; (5) sexual and racial minority stressors; and (6) mental and emotional health. In each domain the participant was asked to reflect upon how circumstances could have been different (i.e., so that he might not have become HIV positive). The participant was also invited to comment on how he might design an HIV prevention intervention for young MSM. The interviews concluded with debriefing questions about future goals, to shift attention away from the past.

Interview tapes were transcribed and then erased, and identifiers were deleted. The transcripts served two purposes: as data for qualitative analysis and as material for the curriculum under development. Each transcript was first summarized by members of the research team. The summaries briefly described the participant and his circumstances, recounted his narrative of becoming HIV positive, and excerpted numerous detailed quotations from the transcripts. These summaries were reviewed by a senior researcher against the transcripts to ensure adequacy of data summation. The quotations extracted in each summary were then coded by two members of the team using qualitative software

according to the constant comparative method (Taylor, 1998), in which each transcript informs the coding of further transcripts in a cumulative process.

These analyses were provided to the curriculum developers, as well as forming the basis for the current study. Second, to verify completeness and reliability of the coding taxonomy, a subset of eight interviews was coded line by line by two researchers, using the codes developed previously. Discrepancies between the two coders were discussed and resolved, and the coding of the entire corpus was updated based on the new set of codes. Additional (“axial”) codes indicated whether the factor was cited as part of “what could have been different” to avoid HIV infection. These procedures represented a compromise between complete line by line coding and the immediate need to use our qualitative data for development of our curriculum.

Results

Among the participants, 7 self-identified as white, 7 as black and 7 as Latino. Sixty-six percent of the 21 participants were employed at least part time. Ninety-five percent reported a high school diploma or GED (n=20), and 50 percent had attended at least some college. Twenty-nine percent were living with family members while 38 percent were living with roommates, and no participants reported being homeless at the time of the interview.

Table 1 shows the various factors mentioned by participants as leading to their becoming HIV positive. We include this table not to imply proportions in a population, but solely to show the wide range of factors identified using the two stage data analysis process described above. All participants identified more than one factor (mean = 5.2 factors, range 2–9 factors).

Polysubstance Use

In line with quantitative research showing correlations between unprotected sex and substance use among MSM, the most commonly mentioned factor in describing unprotected sex (13 of 21 interviews) was drug and alcohol use, specifically marijuana use. However, with the exception of one former crystal meth user (discussed below), the participants did not identify drug/alcohol use as the primary reason they became infected, and were vague about the role of substance use in bringing about HIV infection.

I: To what extent do you link drug and alcohol use to becoming HIV positive?

R: I would say 50–50. I would say that it most definitely, like, at some points I think it kind of...it was just another door that opened, putting myself in situations
....

[African American, 18]

Marijuana use was distinguished from other drugs by those interviewed:

R. ... I'm not gonna suck dick for weed. I'm not gonna have unprotected sex because I don't know what's going on because I'm stoned.

[White, 18]

R: Of course we know marijuana is going to relax your body, and I think the least you're going to be thinking of is having safer sex. But that age, it loosened me up. It relaxed me, and I didn't really care about anything else, but just the sexual activity and just the feeling of it. But it wasn't a daily activity that we were using marijuana every time that I would go over [to partner's house].

[Latino, 19]

Whatever the actual role of drug and alcohol use may have been, participants stressed other issues with their families, schools and communities, which we describe next, rather than substance use.

Lack of Familial and Peer Support

A factor cited in syndemic theory is lack of family and social support (Wolitski, Stall, & Valdiserri, 2008). Most participants (12 out of 21) reported that their parents or family did not accept their sexual orientation. In three cases, the parents forced their sons to leave their home, and/or the youth left because the living situation was intolerable. Five youth reported periods of homelessness. In other less severe cases participants described feeling rejected by their parents.

R: What could have been different? If I would have had somebody who actually gave a fuck about me. That's what could have been different. If somebody actually was there to understand me and not throw me out on the streets when they got tired of me. And all the different things that I faced with people in reality. I don't know. Reality will do a lot of things to you, man.

[African American, 23]

Even participants from non-abusive households had to cope with lack of acceptance of their sexual identity.

R: Well I think being openly gay in [a small town]...it caused me a lot of shit... And the school harassed me and my parents were fighting [the school] nonstop... and so you get this depression that you don't know is there and you start to act out.

[White, 24]

Participants identified sex as a way to escape mentally from feelings of depression.

R: It's kind of nice to, um, escape from reality for the ten minutes you're in the bedroom or the five hours you're in the bedroom. You're focused and your interest is on that person. [...] You know that you are not going to think about other things, so it's kind of easy to accept that as a "not think."

[White, 24]

Family rejection due to sexual orientation, as well as lack of support generally, was one of the most common themes in the transcripts, and was cited both as a reason for risky behavior and more globally as a reason why the participant believes he became HIV positive.

Power and Violence in Partner Relationships

Partner violence experienced by young MSM has been associated with drug use, unprotected sex, and HIV positive status (Mustanski et al., 2007). Five participants stated that the main reason they became infected with HIV was a relationship with an older infected partner, two of whom were abusive. In one case, the participant was initiated into a gang by his partner.

R: My ex-boyfriend was really--he didn't want anybody else to know that he was gay. That's why I never really knew what was an STD or what was an HIV.

I: He was your first and only guy?

R: Um huh.[...] When I first met him in Chicago, he really wasn't a gangbanger. And once we got over [to Los Angeles] he told me that him being gay...or that I could not show that I was gay; and I had to do a lot of bad things so his friends would think I'm cool. And that's it...I had to do stupid shit in order to get his attention.

[Latino, 20]

Partner violence, and homophobia among the youth's associates, are inextricable in the above quote. The link between both of these and family rejection is revealed when this participant goes on to say:

R: To begin with, all of that could have been avoided if my family wasn't really narrow minded [...] 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.

[Latino, 20]

While this participant's abusive partner is the proximal reason, he traces his seroconversion "to begin with" to a family that rejected him.

Other participants stated they became infected through sex in non-abusive primary partnerships. These participants said that they trusted their primary partners, and believed they were in mutually monogamous relationships.

Yeah, it was a monogamous relationship. We were together every day so I know that he didn't cheat; but um, unfortunately you got a six month or maybe even longer gaps where it doesn't show up even if you do get tested. [...] I feel like it's just a trust thing. [...] I think we both just kind of assumed that since we had tested negative before the relationship, then we would be fine through the whole thing. Neither of us really understood that that's not true.

[White, 24]

Other participants abandoned condoms because of their feelings for their partner:

R: Well, I always used condoms except for with the boyfriend who eventually was the one who infected me.

[White, 18]

R: Like a couple times at the beginning, like my first time and everything like that, false feelings came up, like, oh, wow, maybe I love this guy. You know, I gave him something, so he must feel something for me. Like, the first guy I bottomed for, like, that became a thing. [...] Like it kind of influenced that a little bit. Because I did have unprotected sex with him, too.

[Latino, 20]

The partners of these respondents were often older, in their 30s or 40s. In one case the participant reported that he is still in the relationship, and his partner, who he believes infected him with HIV, remains supportive of him. Being infected by a nonabusive partner may be a counterexample to the more common narrative of multiple vulnerabilities. Nonetheless the power dynamic within even a nonabusive relationship with an older partner came out in some interviews.

Yeah when I was younger, when I was 18, this guy basically said "ohhhh, if you like me you are going to have sex, you can have sex with me with no condom". And actually I kind of did it; because he didn't want to put a condom on and it was before my diagnosis.

I: And how old was he?

R: He was about 45.

[White, 24]

High Risk Lifestyles

The clustering of factors for HIV infection is most apparent in a few “extreme” cases of young men who fell into drug dealing, commercial sex or involvement in the pornography industry as means of obtaining income. A young man who had been a crystal meth dealer for two years, and was in recovery at the time of the interview, estimated that while dealing drugs he had had unprotected sex every night. Entering into the world of crystal meth dealing brought him

R: ...from a life where I was teased and made fun of as a kid [and] a middle child, to going to a place where I am accepted. Like you are going to do what you want to do and what makes you fit in.

[White, 22]

A second participant moved to Los Angeles as soon as he turned 18 to work in the porn industry.

R: I needed that money from the porn. But also, it was kind of like I wanted to be popular, I don't know. I was kind of lonely I guess [...] so that's kinda why I made the porn. It was my need to be out there, or whatever

[White, 24]

While the behaviors of these young men undoubtedly make them outliers from the standpoint of the young MSM population, in the interviews they linked their behavior to a sense of exclusion, of not fitting in, that was shared with many other participants.

The Role of Education & Mentorship

Exposure to HIV education varied greatly among the participants. Not all participants stated they had inadequate HIV education. However, some cited the lack of sex education in schools, in contrast to general reproductive health education.

R: What would have been different is that...the problem that I had at the time when I was being promiscuous with all of this, it was that I didn't have full information of anything. Not even of Chlamydia or syphilis. I didn't even know about those words until I ended up having HIV. That was one of the things.

[Latino, 23]

Participants focused on education that would acknowledge sexual minorities when asked how they would design HIV prevention programs for young men like themselves.

R: Maybe if it wasn't such a stigma to be gay, then I could have been more open about it in high school when I was learning about becoming sexually active. And if there had been more gay resources for me, then maybe I would have been more knowledgeable about HIV prevention or even just some gay sex issues. But since it really wasn't... "there's no gays here, so we don't need any gay resources", so it's like...I didn't really think about it.

[White, 22]

HIV prevention programs rarely included meeting openly HIV positive persons, particularly those their own age. One participant stated that if only older HIV positive people presented prevention messages,

I'd feel like oh, well, you probably got it back in the '80s when things were crazy. Like, people don't do that now. People don't get that way.

[White, 18]

Involvement of younger HIV positive persons as peer educators would address the invulnerability felt by young people and the misconception that HIV is a disease that only happens to others.

R: And I feel like what would have helped me is if I would have had somebody who had HIV talk to me in person, one-on-one. Because I had never met anyone. I couldn't put a face to HIV.

[White, 22]

Along with lack of HIV education, several participants stated that if they had been more goal oriented when they were younger, and involved in school or other constructive activities, they would not have become infected. They engaged in frequent high risk sexual activity because they lacked goals, specifically educational goals.

R: I would have liked to have, um, to have different things on my mind like excelling through high school. I made it through but barely. I wish guys and sex and the gay life wasn't on my mind so early.

[African American, 22]

R: I was too focused on meeting guys and trying to have those kind of relations. If I would have just dedicated that time and energy into bettering myself and going to school and things of that nature, then I guess it would have been more of a balance.

#x0005B;Latino, 24]

The participants' assessment that they became HIV positive in part because of a lack of direction in life, underscores the need for mentoring programs as an HIV prevention strategy (Seal et al., 2000) and safe, non-sexual spaces for socialization (Mutchler 2000a).

Discussion

Predictors of risky sexual behavior and HIV seroconversion among young MSM in recent studies have included substance use, history of childhood sexual abuse, lack of social and/or familial support, and marginalization due to sexual orientation and internalized homophobia (Mustanski et al., 2007; Rotheram-Borus et al., 1995). Our respondents' narratives include all of these factors. But they diverge from the survey-based literature in certain ways which may have implications for the design of effective prevention strategies. A factor that is consistently cited as a strong predictor in aggregate models, namely substance use, was not highlighted in these narratives. Instead, though a grounded theory analysis of the transcripts, a causal link emerges in the youth's narratives between HIV infection and (1) the lack of gay-specific HIV prevention education, (2) the absence of role models, and (3) the lack of productive future goal-related activities. What we believe these factors may have in common with those in the existing syndemic literature is marginalization. That is, lack of gay-specific HIV education and the lack of available role models reflect the fact that many young MSM are marginalized in school, in their communities of origin, as well as within their own families. "There's no gays here, so we don't need any gay resources"-- this participant's summing up of his school's attitude toward gays draws a link between a lack of gay specific education on the one hand, and homophobia at school that silences gay youth on the other. The lack of young HIV positive peer educators may also be due, in part, to this same homophobic climate, which may prevent HIV positive youth from engaging in prevention volunteering. In other words, these factors stem from the same underlying cultural marginalization as syndemic pathologies.

Although these young men believed that global factors contributed to their becoming HIV positive, and that other factors such as substance use were less important, we do not have

independent evidence that their beliefs are correct. More proximal behaviors, such as unprotected sex, multiple partners, or substance use with sex, are more logically linked to HIV infection. However, even the participants who discussed engaging in specific risky behaviors also mentioned global factors such as homophobia, and some explicitly drew links between broader marginalization and specific behaviors, for example between the desire to “fit in” and use of crystal meth. The relationship between the proximal behavior and the broader, underlying context was evoked by one participant:

And it's like you know what's going to happen. [...]I feel like what's lying underneath the surface for the reasons why I put myself out there, and why anybody else would put themselves out there. [...]I never think that [...]people are just going out there and having bareback sex for no reason at all whatsoever. It's something. It's something that they feel that they are getting out of it for the reasons why they're doing it.

[African American, 18]

Not only is there something “lying underneath the surface” of the behavior, but “it's like you know what's going to happen”—suggesting that the risky behavior, and perhaps the infection itself, is in some sense foreordained by the forces “lying underneath the surface.”

Of course, young MSM who do *not* become HIV positive also face silence around their sexuality, and/or outright homophobia in schools, in the community, and sometimes at home (Eccles, 2004). The vast majority of young MSM remain resilient to HIV risk. All of the youth in this study, perhaps unlike youth who do not become infected, cited multiple risk factors, and there was no single typical pathway by which the youth in this sample became infected. However, even for youth who are exceptional such as those involved in the porn industry or drug dealing, many of the risk factors mentioned were linked to the perception of marginal status.

There are several limitations to this study. First, as in any qualitative study we did not recruit a representative sample, nor did we intend to generalize to a population. As mentioned above, we did not attempt to characterize the typical pathway(s) by which the young men became infected nor to summarize all of the responses on a given theme, since in most cases each theme was mentioned by only a minority of respondents. In particular, further research is needed on the racial/ethnic and cultural contexts of the narratives; this analysis is beyond the scope of the current paper. Second, as noted above we do not have independent evidence of how these youth were actually infected, and in some cases recall bias may have distorted the memories of older respondents. Third, our data analysis ran parallel with the immediate need for material for an intervention, and thus we coded quotations extracted by the research team, and did not conduct complete coding, inter-rater reliability checks, and so on, on the entirety of each transcript. However, through this method we were able to obtain a diverse corpus of coded quotations that covered a wide range of topics, as shown in Table 1. These themes were verified through detailed coding of a subset of transcripts.

In summary, our findings lend support to syndemic theories that identify multiple factors of cultural marginalization which cluster together in the lives of young men at high risk for HIV. In addition, grounded theory analysis identified other factors, such as lack of appropriate HIV education, that may arise from similar forces of marginalization. Taken together, these findings lend strong support to an emerging consensus on best practices for effective HIV prevention with at-risk youth. Effective prevention programs should intervene on the multiple factors that young men themselves identify as fueling the HIV epidemic. They should strive to disentangle and address each of the multiple deleterious factors, such as lack of family support, homophobia in school, and substance use in the lives of individual youth. For example, youth who lack acceptance of their sexuality at home will benefit from

seeing a different perspective on their sexual identity in a school or community program. Despite more open attitudes among their peers in some schools in recent years, our participants confirm that “official” HIV prevention and sex education programs in schools, where they exist at all, are silent on the topic of sexual minorities. Similarly, fear and homophobia may be inhibiting HIV positive youth from volunteering in HIV prevention.

Although this study necessarily highlights deficits rather than strengths, strengths-based interventions may benefit from the insights of these HIV positive youth. For example, for youth who highlight lack of family support as the primary factor placing them at risk for HIV (“all of that could have been avoided if my family wasn’t so narrow minded...”), interventions should identify the strengths that counter these most critical areas of deficit, such as potential sources of support that might substitute for family support. Developing strengths in one area such as social support might in turn positively affect other intertwining risk factors such as substance use and vulnerability to partner violence. Finally, our findings suggest that the most effective programs should address not only behavior change and safer sex skills, but the underlying marginalization affecting young men at risk for HIV.

Acknowledgments

The authors would like to thank Marco Hidalgo, Chris Cotten, the research staff at Howard Brown Health Center, and the youth participants who were exceptionally open with us about their experiences. Source of support: National Institute of Mental Health grant, R34 MH079707, CFDA no. 93.242

References

- Centers for Disease Control and Prevention. Cases of HIV infection and AIDS in the United States and dependent areas. 2007; 2009 from <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2007report/default.htm>.
- Clarke, AE. A social worlds research adventure. In: Strauss, A.; Corbin, J., editors. *Grounded Theory in Practice*. Sage Publications; 1997.
- Cohen, C. *The Boundaries of Blackness: AIDS and the Breakdown of Black Politics*. University of Chicago Press; 1999.
- Cranston K. HIV education for gay, lesbian, and bisexual youth: Personal risk, personal power, and the community of conscience. *Journal of Homosexuality*. 1991; 22(3–4):247–259. [PubMed: 1573260]
- Eccles TA, Sayegh MA, Fortenberry JD, Zimet GD. More normal than not: A qualitative assessment of the development experiences of gay male youth. *The Journal of Adolescent Health*. 2004; 35(5): 425. [PubMed: 15488440]
- Friedman MS, Marshal MP, Stall R, Cheong J, Wright ER. Gay-related development, early abuse and adult health outcomes among gay males. *AIDS and Behavior*. 2008; 12(6):891–902. [PubMed: 17990094]
- Garofalo R, Mustanski B, Doenberg G. Parents know and parents matter: Is it time to develop family-based HIV prevention programs for young men who have sex with men? *Journal of Adolescent Health*. 2008; 43(2):201–204. [PubMed: 18639797]
- Garofalo R, Wolf CR, Kessel S, Palfrey J, DuRant RH. The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics*. 1998; 101:895–902. [PubMed: 9565422]
- Garofalo R, Wolf RC, Wissow LS, Woods ER, Goodman E. Sexual orientation and risk of suicide attempts among a representative sample of youth. *Arch Pediatr Adolesc Med*. 1999; 153(5):487–493. [PubMed: 10323629]
- Glaser, B.; Strauss, A. *The Discovery of Grounded Theory*. Chicago: Aldine Books; 1967.
- Greenwood GL, White EW, Page-Shafer K, Bein E, Osmond DH, Paul J, et al. Correlates of heavy substance use among young gay and bisexual men: The San Francisco Young Men’s Health Study. *Drug Alcohol Depend*. 2001; 61(2):105–112. [PubMed: 11137274]

- Grossman, AH., editor. Avoiding HIV/AIDS and the challenge of growing up gay, lesbian, and bisexual. New York: Oxford University Press; 2001.
- Gurdin, JB.; Neigo, S.; Mince, J. Youth and AIDS Project's HIV Prevention Program: An STI/HIV/AIDS prevention program for young gay men. In: Card, JJ.; Benner, TA., editors. Model programs for adolescent sexual health: Evidence-based HIV, STI and pregnancy prevention interventions. New York: Springer Publishing Company; 2008. p. 349-358.
- Huba GJ, Melchior LA. A model for adolescent targeted HIV/AIDS services: Conclusions from 10 adolescent-targeted projects funded by the Special Projects of National Significance Program of the Health Resources and Services Administration. *Journal of Adolescent Health*. 1998; 23(2)
- Koblin BA, Torian L, Xu G, Guilin V, Makki H, Mackellar D, et al. Violence and HIV-related risk among young men who have sex with men. *AIDS Care*. 2006; 18(8):961-967. [PubMed: 17012086]
- McDaniel JS, Purcell D, D'Augelli AR. The relationship between sexual orientation and risk for suicide: research findings and future directions for research and prevention. *Suicide Life Threat Behav*. 2001; 31(Suppl):84-105. [PubMed: 11326762]
- Mustanski B, Garofalo R, Herrick A, Donenberg G. Psychosocial health problems increase risk for HIV among urban young men who have sex with men: Preliminary evidence of a syndemic in need of attention. *Annals of Behavioral Medicine*. 2007; 34(1):37-45. [PubMed: 17688395]
- Mutchler MG. Making space for safer sex. *AIDS Education and Prevention*. 2000a; 12(1):1-14. [PubMed: 10749382]
- Mutchler, MG. Seeking sexual lives: Gay youth and masculinity tensions. In: Nardi, P., editor. *Gay Masculinities*. Vol. 12. Thousand Oaks: Sage Publications; 2000b.
- Mutchler MG. Will it be silence and violence or safety and prevention for the next generation of gay youth? *International Journal of Sexuality & Gender Studies*. 2002; 7(1):23-38.
- Mutchler, MG.; Ayala, G.; Herbert, P.; Fernandez, R. Gay-boy talk: Discourse for stopping HIV infections among young gay men. 2004.
- Rangel MC, Gavin L, Reed C, Fowler MG, Lee LM. Epidemiology of HIV and AIDS among adolescents and young adults in the United States. *J Adolesc Health*. 2006; 39(2):156-163. [PubMed: 16857526]
- Rotheram-Borus MJ, Reid H, Rosario M, Vanrossem R, Gillis R. Prevalence, course, and predictors of multiple problem behaviors among gay and bisexual male-adolescents. *Developmental Psychology*. 1995; 31:75-85.
- Russell ST, Driscoll AK, Truong N. Adolescent same-sex romantic attractions and relationships: Implications for substance use and abuse. *American Journal of Public Health*. 2002; 92(2):198-202. [PubMed: 11818291]
- Russell ST, Franz BT, Driscoll AK. Same-sex romantic attraction and experiences of violence in adolescence. *American Journal of Public Health*. 2001; 91(6):903-906. [PubMed: 11392932]
- Safren SA, Heimberg RG. Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents. *J Consult Clin Psychol*. 1999; 67(6):859-866. [PubMed: 10596508]
- Savin-Williams RC. Verbal and physical abuse as stressors in the lives of lesbian, gay male, and bisexual youths: associations with school problems, running away, substance abuse, prostitution, and suicide. *J Consult Clin Psychol*. 1994; 62(2):261-269. [PubMed: 8201062]
- Savin-Williams RC. Suicide attempts among sexual-minority youths: population and measurement issues. *J Consult Clin Psychol*. 2001; 69(6):983-991. [PubMed: 11777125]
- Seal DW, Kelly JA, Bloom FR, Stevenson LY, Coley BI, Broyles LA. Medical College of Wisconsin CITY Project Research Team, Milwaukee WI. HIV prevention with young men who have sex with men: What young men themselves say is needed. *AIDS Care*. 2000; 12(1):5-26. [PubMed: 10716014]
- Sieverding J, Boyer C, Siller J, Gallaread A, Krone M, Chang YJ. Youth United Through Health Education: Building Capacity Through a Community Collaborative Intervention to Prevent HIV/STD in Adolescents Residing in a High STD Prevalent Neighborhood. *AIDS Education and Prevention*. 2005; 17(4):375-385. [PubMed: 16178706]
- Singer M. AIDS and the health crisis of the U.S. urban poor; the perspective of critical medical anthropology. *Soc Sci Med*. 1994; 39(7):931-948. [PubMed: 7992126]

- Stall R, Mills TC, Williamson J. Association of cooccurring psychosocial health problems and increased vulnerability to HIV & AIDS among urban men who have sex with men. *American Journal of Public Health*. 2003; 93:939–942. [PubMed: 12773359]
- Taylor, S.; Bogdan, R. Introduction to qualitative research methods: A guidebook and resource. 3. Hoboken: John Wiley & Sons Inc; 1998.
- Thiede H, Valleroy LA, MacKellar DA, Celentano DD, Ford WL, Hagan H, et al. Regional patterns and correlates of substance use among young men who have sex with men in 7 US urban areas. *Am J Public Health*. 2003; 93(11):1915–1921. [PubMed: 14600066]
- Vermont Department of Health. The 1997 Vermont Youth Risk Behavior Survey. 2000; 2000 from www.state.vt.us/adap/yrbs97a.htm.
- Wolitski, R.; Stall, R.; Valdiserri, R., editors. Unequal Opportunity: Health disparities among gay and bisexual men in the United States. Oxford University Press; 2008.
- Wolitski RJ, Valdiserri RO, Denning PH, Levine WC. Are we headed for a resurgence of the HIV epidemic among men who have sex with men? *American Journal of Public Health*. 2001; 91:883–888. [PubMed: 11392927]
- Wright ER, Gonzalez C, Werner JN, Laughner ST, Wallace M. Youth Access Project: A model for responding to the HIV risk behaviors of gay, lesbian, and bisexual youth in the heartland. *Journal of Adolescent Health*. 1998; 23(2):83–95. [PubMed: 9712256]

Table 1

Themes Mentioned by Study Participants (n = 21) as Related to Their Becoming HIV Positive

Theme	Number of participants
Marijuana use with sex	13
Lack of HIV prevention education	13
Alcohol use with sex	12
Lack of family support	10
Internet partner hookups	9
Commercial sex work	7
Older partners	7
Party line *	6
Multiple partners	6
Homelessness	5
Childhood sexual abuse	5
Infected by main partner	5
Didn't like using condoms	4
Meth use with sex	3
Mental health problems	3
Condom breakage	2
Abusive/Coercive Partner	2
Sex at bathhouse	2
Incarcerated partners	2
Involved in porn industry	1
Thought he was positive/gave up	1
Infected through oral sex	1

Note: All participants mentioned more than one theme.

* Party Line: telephone lines where MSM chat and agree to meet for sex