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Sexual health research with young Black men who have sex with men (YBMSM): experiences of benefits and harms

Renata Arrington-Sanders, MD, MPH, ScM,

Division of General Pediatrics & Adolescent Medicine, Johns Hopkins School of Medicine, 200 North Wolfe Street, 2063, Baltimore, MD 21287

Anthony Morgan,

Division of General Pediatrics & Adolescent Medicine, Johns Hopkins School of Medicine, 200 North Wolfe Street, 2063, Baltimore, MD 21287

Jessica Oidtman, ScM,

Division of General Pediatrics & Adolescent Medicine, Johns Hopkins School of Medicine, 200 North Wolfe Street, 2063, Baltimore, MD 21287

Thu (Ann) Dao,

Philadelphia College of Pharmacy, University of the Sciences

Margaret Moon, MD, MPH,

Division of General Pediatrics & Adolescent Medicine, Johns Hopkins School of Medicine, 200 North Wolfe Street, 2060, Baltimore, MD 21287

J. Dennis Fortenberry, MD, MS, and

Indiana University, 410 W. 10th St., Room 1001, Indianapolis IN 46202

Mary Ott, MD, MA

Indiana University, 410 W. 10th St., Room 1001, Indianapolis IN 46202

Abstract

Young Black men who have sex with men (YBMSM) are often underrepresented in sexual health research because of concerns about safety, privacy, and the potential for research harms. Empirical data is needed to understand YBMSM experience of participation in research, benefits and harms, to inform policy and regulatory decisions. Using qualitative methods, this paper examines 50 YBMSM, ages 15–19 years, experiences of benefits/discomforts, challenges of participating in sexual health research, and contextual factors impacting research experiences. Participants were asked about benefits and harms experienced in answering questions about sexual orientation, first same-sex attraction, and same-sex sexual experiences after completing an in-depth interview. Interviews were transcribed and coded. Inductive open coding was used to identify themes within and between interviews. Participants were able to describe perceived direct benefits resulting from research interview participation, including awareness of risky sexual behaviors, a safe space to share early coming out stories and same-sex sexual experiences, and a sense of empowerment and comfort with one's sexual orientation. Indirect benefits described by participants included

perceptions of helping others and larger gay community. Few participants described harms (discomfort recalling experiences). Our data suggest that participating in qualitative sexual health research focused on sexual orientation, sexual attraction, and early same-sex sexual experiences may result in minimal harms for YBMSM and multiple benefits, including feeling more comfortable than in a general medical visit.

Keywords

young Black men who have sex with men (YBMSM); sexual health research participation; institutional review boards (IRB); harms and benefits

Introduction

Young Black men who have sex with men (YBMSM) ages 13–24 have the highest rates of HIV acquisition among all young men who have sex with men (YMSM) in the US (Matthews et al., 2015). However, they are grossly underrepresented in sexual health prevention research (Wilson & Moore, 2009). Factors possibly contributing to this underrepresentation include YBMSM's awareness of unethical medical research targeting Black communities, social stigmas experienced by YBMSM due to sexual orientation, developmental vulnerabilities, study design and YBMSM community involvement (Santelli et al., 2003; Yancey, Ortega, & Kumanyika, 2006). This lack of participation may be further complicated by YBMSM's concerns about safety, privacy, and confidentiality due to stigmatized sexual behaviors (Catania et al., 1993; Diaz, Mainous, McCall, & Geesey, 2008).

Interventionists and behavioral researchers have emphasized the need for YBMSM's participation in sexual health research, and notably, the need for more empirical data to understand YBMSM's views on the potential benefits and/or harms (risks) as a result of participating in sexual health research studies (Mustanski, 2011). Sexual identity development, expectancies of discomfort discussing sexuality and perceptions of benefits and/or harms from participating in research may be uniquely influenced by both racial/ethnic group norms/expectations, as well as by racial-sexual oppression (Dube, Savin-Williams, & Diamond, 2001; Jamil, Harper, & Fernandez, 2009; Savin-Williams & Rodriguez, 1993). YBMSM often experience discrimination based on their perceived and/or actual sexual orientation and gender-role expression (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009), and as a result, are subjected to social isolation in their communities (Kraft, Beeker, Stokes, & Peterson, 2000). Such isolation may limit one's ability to openly discuss and explore sexuality, thereby limiting information to sexually explicit materials (Arrington-Sanders et al., 2015; Bontempo & d'Augelli, 2002), partners, and informal role models, such as gay families or social networks with older men (Arrington-Sanders, 2013; Bruce, D., Harper, G. W., & Adolescent Medicine Trials Network for HIV/AIDS Interventions, 2011). These experience may uniquely impact one's perceptions of and involvement in sexual health research as the opportunity to openly discuss sexuality has not been previously available.

The benefits and/or harms of research participation may be different in this group because of social forces and structures that reinforce certain social roles in YBMSM (Nash, 2008; Warner, 2008). Such factors reinforce gender expression like acting “masculine” in Black communities (Bowleg, 2013) and may impact participation in research and interpretation of whether research is viewed as harmful or beneficial. Gender expression may be closely related to outness, the degree to which a person is open about sexual orientation, and may also play a key role in YBMSMs view on research participation. Prior research in YMSM suggest that outness is tied to emotional response to and perceptions of potential benefits from answering sexual health research questions (Legate, Ryan, & Weinstein, 2012). This occurs possibly because perceived potential benefits occur in individuals who have greater well-being and mental health outcomes (Legate et al., 2012). Perception of benefits about sexual health may also be impacted by one’s first same- and opposite-sex sexual experience and the context (partner, event, timing, etc) of the experience (Arrington-Sanders et al., 2016). Yet, few studies have empirically examined how factors such as gender expression, context of the first experience, and outness are related to YBMSMs comfort level and perceptions of benefits and/or harms during research interviews.

In the absence of empirical data, there is little agreement about the risk of research with youth focused on sexual behavior, identity development and/or risk. Although these studies are generally considered less than minimal risk when conducted with adults, studies of YBMSM are often been classified as greater than minimal risk due to the assumption that asking youth about sexuality, gender identity and/or sexual risk behaviors may produce significant immediate psychosocial harms and/or by negatively influencing the sexual orientation, gender identity, and sexual risk taking trajectories of sexual and gender minority youth. For example, some institutional review boards (IRBs) classify sexual health research as minimal risk for participants while other IRBs strongly consider the psychological risks on youth due to participation in research and thus define it as more than minimal risk. Some researchers have suggested that by comparing participants’ reactions to research to other benchmarks in their life that may potentially cause distress (e.g., the well-child visit), we may be better equipped to understand adolescents’ experiences while participating in research studies (Ybarra, Langhinrichsen-Rohling, Friend, & Diener-West, 2009). Given that Black men who have sex with men disclose their sexuality less often and may be isolated more than their White peers, (Jamil et al., 2009) as a result of key contextual factors such as gender expression, level of outness, and context of first same-sex sexual experience, work is needed to examine whether such factors contribute to perceptions of risks and benefits.

In this study, we sought to understand how a sample of YBMSM describe perceived benefits and psychological harms of participating in a qualitative sexual health research study, and whether contextual factors like positive or negative first sexual experience, level of outness, and gender expression impacted experiences. We further sought to determine whether the perceived benefits and harms were impacted by sexual orientation of the interviewer and viewed as equivalent to a well-visit.

Methods

Fifty self-identified Black males aged 15–19 who reported prior oral or anal sex with a male partner were recruited to participate in a sexual health in-depth research interview about first few and most recent same-sex sexual experiences. Participants were recruited from local sexual and reproductive health establishments serving youth and young adults (i.e. adolescent STD and school-based health clinics). Youth <18 years were able to consent if they were seeking confidential health services covered under State Law. Additional recruitment occurred in social venues serving sexual minority youth, through snowball sampling (e.g. participant referrals), and in virtual social/sexual venues (e.g. Jack'd, 18 years). Participants were provided information about mandated reporting prior to the interview and referred to child protective services if child sexual abuse was reported. The study received approval from the local institutional IRB. Participants were provided a \$40 cash incentive, refreshments, and provided two bus tokens for transportation. Full details of the methods are published elsewhere (Arrington-Sanders et al., 2015).

The 10–15 minute brief ACASI survey queried participants on prior sexual behavior, history of a sexually transmitted disease (STD), and other psychosocial constructs, such as gender expression (self-identity or perceived identity identified by others in one of the following categories: butch, femme, androgynous, none of the above), level of outness based on the Outness Inventory (OI) (Mohr & Fassinger, 2000) and social support. The Outness Inventory is an 11-item measure designed to assess the degree to which individuals are open about their sexual orientation with various individuals (e.g., mothers, peers, coworkers, religious leaders, etc.) (Coefficient alpha=0.87). The Outness Inventory assesses outness across three subscales including: out to family, out to world, and out to religion. Respondents are asked to indicate how open they are to each individual listed, and responses are rated using a 7-point Likert scale ranging from 1 (person definitely does NOT know about your sexual orientation status) to 7 (person definitely knows about your sexual orientation status and it is OPENLY talked about), with higher scores representing higher degrees of outness. Scores of '0' reflect that the item is not applicable to the respondent.

Participants completed a brief audio-recorded computer assisted self-interview (ACASI) survey followed by a face-to-face in-depth interview at time of enrollment. The in-depth interview lasted 90–120 minutes and focused on first few and most recent consensual (same and opposite sex) sexual experiences, including satisfaction of, sexual risk experienced and the context of their lives during these experiences. The timeline follow-back (TLFB) technique was used to facilitate participant recall by identifying landmark events or activities occurring around the time of first few same-sex sexual experiences. TLFB has been effectively used to enhance recall to sexual events during follow up interviews in same-sex attracted adolescents (Weinhardt et al., 1988). One female and two male interviewers trained in qualitative research methods conducted research interviews in private office space located above an adolescent medicine clinic. All interviewers were of the same race/ethnicity of participants and two of the interviewers self-identified as gay.

Debriefing Interview

At the end of the in-depth interview, participants were asked to describe their experiences of participating in a sexual health research study. Participants were asked to separately rate, on a 4-point scale, how comfortable they felt answering questions about first attraction, first same-sex sexual experience, and sexual orientation. Participants were additionally asked whether or not answering any of the research questions made them more uncomfortable than a typical visit to their physician, psychologist, or counselor. Participants then qualitatively described their experiences in participating. Participants were assessed for psychological discomfort and depression as part of the interview and referred to services if necessary.

Qualitative Analysis

Interview audio files were sent to a professional transcription company where they were transcribed verbatim. The research team used qualitative analysis software (NVivo 10) to house and organize the data, as well as to facilitate data coding. Data analysis included using categorical and contextualizing analytic methods (Maxwell & Miller, 2008). The third author independently evaluated initial transcripts (N=10) to identify and collapse transcribed data into possible codes for the overall development of a coding schema; the coding schema was then presented and discussed with a second coder. The second coder then applied the coding schema to the same ten transcripts evaluated by the third author to validate codes and collapse and/or suggest new codes. Codes were then discussed with the first author and collapsed and/or re-named where needed. Once codes were agreed upon, codes were discussed with the entire research team, with coding disagreements discussed and recoded as needed. Two coders (2nd and 3rd author) then independently coded the transcribed data. To ensure agreement among codes and themes, 20% of all 50 transcripts were double-coded by the second author reaching high inter-rater reliability (Cohen's Kappa >0.80) (Hruschka et al., 2004).

Once quotes were identified, authors 1, 2, and 4 reviewed quotes and organized quotes into major thematic codes. Thematic codes were then organized into whether they could be classified as a description of a benefit or harm associated with participating in research. To understand how level of outness impacted perceived benefits and risk of participating in qualitative research, we then organized codes and themes into low versus high level of outness (where high level of outness was defined as $\geq$ mean (37.2) and low level of outness was defined as < mean) and to examine whether there were different themes described in the low versus high group. We also examined whether there were differences in number and type of themes by sexual orientation of the interviewer and first same-sex sexual experiences.

Results

Characteristics of the sample are presented in Table 1. At the time of the interview, participants had a mean age of 17.6 years ($SD=1.3$), and the majority (96%, $n=48$) self-identified as Black/African-American in the baseline ACASI. Two participants identified as other (mixed race that included Black and one other ethnicity). During the qualitative interview five participants described themselves as Black-Arab, Black-Caribbean, or Black-

Latino. Most participants (62%, $n=31$) self-identified as gay or homosexual, with 34% ($n=17$) identifying as bisexual, and 4% ($n=2$) self-identifying as other. One participant (2%) identified as transgender at the time of the interview. The mean score of overall outness as assessed by the OI was 37.2 ($SD=16.1$), which is considered in the middle range. Overall, the majority of participants described feeling very comfortable or comfortable discussing first attraction and first same-sex sexual experience (88%, $n=44$), and sexual orientation (92%, Table 1).

Benefits of Research Participation

Forty-four participants were able to describe benefits of research participation. Two major themes emerged around the benefits of participating in sexual health research (Table 2): 1) direct benefits of participating in research, defined by participants as experiencing an immediate effect from participating in the qualitative interviews; and 2) indirect benefits, defined as a perception that participation could help others. Most ($n=38$) described having experienced only direct benefits from participating. Three participants described both direct and indirect benefits from participating and four described only experiencing indirect benefits. The following direct themes describe what the interviews provided: a safe space to share early same-sex sexual experiences and personal stories; awareness of risky sexual behaviors; and a sense of empowerment and comfort with one's sexual orientation. Indirect subthemes included: sharing one's story can impart knowledge to researchers; and participation helps the larger gay community.

Direct Benefits of Participation—Participants ($n=18$) described that the interviews provided a safe space or an environment to openly recount and share stories of their early same-sex sexual experiences. For these participants, it was the first opportunity to talk about their experiences. While participants described wanting to share their experiences openly with others, they described never having a space that was supportive to do so. This participant's comment embodies this experience:

“I’ve been wanting to say this stuff. Like, I basically just told you my life story, and I always wanted to just sit down and talk to somebody about this. And I never had the chance to, because nobody really had—really wanted to have—they had the interest... but I felt uncomfortable telling them. I don’t understand how-- I don’t even know you, but I can feel comfortable telling you everything that went on.”
(16 year old gay male, OI =39)

Commonly participants described feeling isolated in their social environments so that having a space to share experiences provided them with a sense of being less isolated. One participant describes it in this manner:

“I feel like overall, like, just listening to all the questions, I feel like, I learned. I gained that everybody is not alone in a situation. That they are not the only one that’s feeling lonely or feeling left out about anything.” (18 year old, “other” sexual orientation, OI =48)

This participant's quote is an example of others who described that talking openly about their sexual development provided a sense that people cared for them. Participants

commonly described feeling that the interviews helped them to see that there are people who are interested in hearing their experiences and this made individuals feel less alone. It additionally provided them a sense of acceptance in the larger gay or transgender community.

Eighteen participants described that the interviews provided an opportunity to become aware of risky sexual behaviors by reflecting on previous same-sex sexual experiences and decisions. By reliving the past, participants described learning about mistakes that they had made in prior relationships. The following participant describes it in this way:

“I gained just a lot...bad decisions that I have done in my past, which I need to not do no more and start wearing more condoms.” (18 year old bisexual male, OI =35)

Self-reflection provided individuals with ideas about how to make better sexual health decisions in the future. The benefit of self-reflection was a common theme among participants, with most being able to identify either planning to avoid partners with characteristics participants had associated with sexual risk (i.e., someone who rushed to have sex) or using a behavioral change (i.e., use condoms more consistently) in the future.

Eight participants described that the interviews provided a sense of empowerment to come out and openly discuss their sexual orientation and attraction. These participants described that talking about one's sexual orientation in a research interview made them feel comfortable about their sexuality. This participant describes this important benefit of participation.

“The best part was talking’ about my coming out story because I been telling people, but no one has ever actually listened to me.” (18 year old gay male, OI =47)

By coming out in a research space that was viewed as supportive it was often described as fulfilling a personal void they had not experienced in their own community. It also helped others to feel empowered to share their personal experiences and information with others.

“It [the interview] actually made me feel like I was taking a step. It was actually good for me to talk about it, because it felt like if I can take a step in here and talk about it, then I can be able to talk about my situation to anybody.” (16 year old gay male, OI =15)

This sense of being empowered to talk about one's sexual orientation or sexuality in the future was closely tied to feeling that there was a larger community of support. These participants also described that participating in interviews made them feel encouraged to disclose their orientation and sexual behaviors to medical providers, family and friends.

Indirect Benefits of Participation—Fewer participants described only indirect benefits from participating. Indirect benefits from participating in the interviews included a sense that participating in interviews promoted one's ability to help research in general and the larger gay community. Participants described that sharing their personal stories provided researchers with knowledge about sexual development, sexual risk and behavior, which could help others in general. The other three participants described both direct and indirect benefits, specifically felt that the safe space of the interviews prompted disclosure of their

sexual orientation during the interview and such knowledge would have direct impact on the gay community. This sense of benefiting the broader society and gay community was tied to the perception that the interview team had good intentions to use the information collected to benefit others. This participant describes this as:

“Being able to talk to someone who actually seems like they want to better, like you seem like someone who wants to actually help and better the community by doing this and I really wanted to thank you for that.” (18 year old gay male, OI =41)

This quote suggests that participants viewed the researchers’ motives to conduct this qualitative research as positive and may be related to perceived indirect benefits to participating.

Harms from Research Participation

Few participants ($n=4$) described a direct harm or psychological discomfort from participating in the interview. Harm or psychological discomfort was defined as being visibly upset or describing emotional feelings of discomfort as a result of having to reflect on first sex experiences. One major theme emerged around direct harms: feeling emotional distress discussing negative events; and two themes emerged around indirect harms: 1) having a hard time recalling an event that was viewed as important; and 2) feeling embarrassed as a result of sharing information about first same-sex.

Direct Harms from Participation—Two of these participants described having to recall first same-sex sexual experiences that occurred at a very young age (age 7, or 8), of which one described the experience as not consensual. The participant had not shared the information with anyone else and sharing it was a very upsetting experience. Although, the second participant did not explicitly describe non-consensual sex during first same-sex, he described feeling conflicted because it occurred so early and other negative life events occurred around the time of the event. For example, he described:

“...when I had to go back and talk about when I was seven, that was kinda the worst part but I mean, it’s out of my system, I’m over it.” (17 year old gay male, OI =32)

Though participants were asked to describe only consensual first experiences, this participant still reflected on his first experience at seven years old, which was not enjoyable. Another participant described that his grandmother died around the time of his first sexual experience and recalling the experience evoked feelings related to his loss. The fourth participant described that recalling the first experience was upsetting because it occurred during a time when she was transitioning from male to female. All four participants were provided resources and support after the debriefing interview and linked to appropriate services. Two additional participants did not describe harms, but described feeling uncomfortable discussing their first experiences and could not specifically describe why. One additional participant disclosed sexual abuse as a teenager during the interview, but did not describe psychological harm during the interview. All participants who described discomfort or psychological harm were referred to local resources.

Indirect Harms from Participation—Other participants described indirect discomforts like having a hard time recalling ($n=4$) the event or feeling embarrassed ($n=5$) describing the first same-sex sexual experience, but no direct harms from participating. These were categorized as indirect because the discomfort occurred as a result of feeling embarrassed or having a hard time recalling the event, but not directly from describing the first sexual experience. The most common reason for participants' inability to recall was the length of time that had passed between their first same-sex sexual experience and the research interview. Participants that described an early sexual debut (around 11 years old) described difficulty in remembering first same-sex sexual experiences. Embarrassment was commonly described as being linked to awkward first experiences or not being able to quickly recall the event and feeling uncomfortable as a result of inability to recall.

Participants described having a hard time finding words to describe the experience, which also contributed to embarrassment. One participant describes the experience:

“The worst part I would say was just for me, because I’m just very private about what I do in my bedroom or in whatever. It was just a little uncomfortable not knowing which words to use and what not to say, yeah, but that’s it.” (18 year old gay male, OI =46)

Embarrassment also centered on describing number of sexual partners or explicitly having to describe the first experience. Despite this, all the participants who described initially feeling awkward, embarrassed or uncomfortable during the research interview described feeling more confident to talk about their experiences as the interview progressed. This ability to feel more comfortable discussing first attraction and same-sex sexual experiences as the interview progressed was due to interviewers who provided participants with a sense of trust and confidence. Participants described that having an interviewer who was ‘easy to talk to’ or conducting the interviews in a private setting rather than in a group setting were key in overcoming feelings of discomfort.

Comparison with Routine Care

Most ($n=38$, Table 2) participants qualitatively described that participating in the qualitative interview about first same-sex sexual experiences was equivalent to a ‘typical visit to your physician, psychologist, or counselor.’ Ten participants, however, felt more comfortable sharing sexual health information in the research interview than with a medical provider, and described, “*feeling better answering the questions here.*” This participant’s quote is representative of how participants described it:

“It was different because it was more of a relaxed time; and you wasn’t giving me that look like you got to answer it this way, you got to do it-- like it was just more of a relaxed environment.” (19 year old gay male, OI =28)

The view that providers were very forceful or too direct in their approach to obtain answers was a common theme among participants. Others described that the expectation of the interview, i.e., the space to talk openly about their sexual orientation, contributed to the view that the experience was more positive than a typical visit to a medical provider or psychologist. It should be noted, however, that two participants out of the fifty described that

the interviews made them feel more uncomfortable than a typical visit, mainly because it made them ‘think about the sex that’ they ‘weren’t having’ and due to saddening reflections on a ‘first love’.

Context of the Interview

We examined whether contextual factors like sexual orientation of the interviewer, level of outness of the participant and whether viewing first experience as negative or positive impacted research experience. Interviewers were described as key facilitators of creating a comfortable space and reassuring that the motives of the research were positive, by providing participants with a sense of trust and confidence. Participants were able to concretely describe that the interviewer’s demeanor and perceived same-race/ethnicity and involvement in the gay community; and the environment (close proximity to an adolescent clinic that served lesbian, gay, bisexual and transgender youth and presence of ‘safe space’ logo/pride flag) of the interview helped participants to quickly perceive trust and no mal-intent with the interviews. One participant commented that he was worried that by disclosing his sexual behavior and attraction in the interview he was going to feel judged, but this was not impacted by the sexual orientation of the interviewer (participant and the interviewer had the same sexual orientation).

Level of outness was not clearly associated with negative experiences in the interview. Most participants had an average level of outness and low levels of outness were not always associated with negative experiences. While most participants who described being uncomfortable or very uncomfortable discussing their sexual orientation had an average to low OI score, there were six participants with low to average OI scores who described direct benefits of disclosing their sexual orientation during the interview.

Fourteen participants described their first same-sex sexual experience as negative. Only two of the fourteen also described that the interview resulted in discomfort or harm. Two described it as embarrassing. The remaining described benefits from talking about the experience. We did not find that individuals who described a more outward female gender expression described more discomfort or harm as a result of the interview.

Discussion

These interviews represent an important first step in understanding the experiences of a sample of YBMSM that participated in qualitative sexual health research study. Our data suggest that participating in qualitative sexual health research that focuses on questions regarding sexual orientation, sexual attraction, and early same-sex sexual experiences may result in minimal harms for YBMSM and multiple benefits. One study has similarly shown that sexual minority youth overwhelmingly report feeling ‘very comfortable’ or ‘comfortable’ participating in research studies, and that few youth feel ‘very uncomfortable’ answering questions related to sexual behavior, substance use, and/or mental health (Mustanski, 2011). The 88% ($n=44$) of YBMSM in this sample who reported feeling ‘comfortable’ or ‘very comfortable’ answering questions regarding their first few and most recent same-sex sexual experiences parallels this previous work.

Participants described both direct and indirect benefits as a result of participating in this qualitative sexual health research study. This finding is in-line with the National Institutes of Health (NIH) *Intramural Protocol Review Standards* which term a research benefit as “something of health-related, psychosocial, or other value to an individual research subject [direct benefit], or something that will contribute to the acquisition of generalizable knowledge [social benefit].” We found that these research interviews allowed for self-reflection and self-awareness of risky sexual behaviors, including an intention to change their behavior in the future. Other research has demonstrated that activities that include self-reflection may decrease risk behaviors among gay and bisexual men (Goldhammer & Mayer, 2011). Interviews also served as a safe space for YBMSM to share coming out stories and early same-sex sexual experiences; was mechanism to become more comfortable with their sexuality; and create a space to connect to a broader gay/bisexual community. Similar direct benefits to research participation, including personal validation and support, have been shown in the literature examining heterosexual youth’s reactions to research participation (Ybarra et al., 2009). The lack of existing social structures aimed to help guide these young men through important stages of development has previously been demonstrated as an important risk factor for HIV in YMSM (Bruce, Harper, & Adolescent Medicine Trials Network for HIV/AIDS Interventions, 2011). The findings of this work suggest that participation in qualitative sexual health research can provide some YBMSM with a safe space to open up about sex, sexuality, and reflect on risk behaviors that is otherwise not present in their social networks and communities.

A small sample of youth described psychological discomfort as a result of participating in the qualitative research interview. Existing policy guidelines, including the Society of Adolescent Health and Medicine guidelines, acknowledge that the main risks to adolescent research participation are disclosure of sensitive information and negative psychological reactions to questions asked (Santelli et al., 2003). IRBs and behavioral researchers must simultaneously balance the principles laid out in the Belmont Report such as Beneficence, by ensuring that research risks are minimized and benefits are maximized; and Justice, through the requirement that all populations, including YBMSM, have the opportunity to share and possibly promote the potential benefits of high quality research to reduce health disparities.

We found that both individuals that experienced psychological discomfort and individuals who described that the space allowed for disclosure of their sexual orientation also described a middle or low level range of outness. It may be that the while some participants with high outness have had prior experience talking about their same-sex sexual experiences, individuals with middle range or low outness may experience the benefits of having a safe space to discuss early same-sex sexual experiences and disclose their sexual orientation. Participants more commonly described minor discomfort such as being embarrassed or having a difficult time recalling the first experience. There were no differences noted by sexual orientation of the interviewer or whether the first same-sex experience was viewed positively or negatively. Instead, participants commented that the research team and environment were key to their comfort level of participating in research. Although not specific to research among YBMSM, this is in-line with other studies that have shown that interviewers are important in impacting positive experiences by providing an empathetic,

supportive, and opening environment through which the interview can take place (Beskow, Runeson, & Åsgård, 1990; Dyregrov & Dyregrov, 1999; Dyregrov, 2004).

Mistrust in research has been an area identified as a reason for limited participation in African Americans (Murry et al., 2004). Participants described a perception of trust and emotional connection from the interviewers. It may be that the social isolation and lack of support experienced by some YBMSM during sexual development (Arrington-Sanders et al., 2015; Glick & Golden, 2014) may motivate some YBMSM to participate in qualitative research about sex and sexuality (Torres et al., 2013; Waldo, McFarland, Katz, MacKellar, & Valleroy, 2000), but limited awareness of studies or comfort with research results in limited participation. Future sexuality researchers who focus on this population should routinely undergo cultural humility training of interviewers, as this may be key in facilitating positive research experiences and creating safe spaces for young men.

In light of YBMSM experiencing the largest increase in HIV incidence between 2006 and 2010 (Prejean et al., 2011), and the disproportionate burden of HIV experienced by YBMSM (Koblin et al., 2013), current approaches to human subjects protections may conflict with the ethical duty to promote equitable access for vulnerable populations, such as YBMSM to participate in such research. The use of “well-child” adolescent and mental health visits has been used as a benchmark for determining whether research procedures are equivalent to routine examinations (Fisher, Kornetsky, & Prentice, 2007). The American Academy of Pediatrics recommend asking about sexual behavior and orientation as part of routine adolescent well visits, which can also be a source of psychological discomfort (Hagan, Shaw, & Duncan, 2008). Participants in this study also reported feeling more comfortable sharing sexual health information in the research interview than with a medical provider. Other studies examining the experiences of young gay and bisexual men in research have additionally shown that young men have more positive experiences in research settings as compared to a typical doctor’s visit (Mustanski, 2011). More empirical data is needed to understand the equivalency of participating in sexual health research. Stigma experienced in medical settings by YBMSM during disclosure of sexual orientation and same-sex sexual behavior (Bernstein et al., 2008; Malebranche, Peterson, Fullilove, & Stackhouse, 2004) may make a well-child or medical visit inequitable to an interview.

This work should be viewed in light of some potential limitations. YBMSM in this study were recruited using multiple recruitment approaches that mostly centered on care-seeking behavior (i.e., health clinics, social service community centers, venues with testing or outreach services). Such work may not generalize to other adolescents who are not seeking care or are physically isolated from others. Although the plurality recruitment approach used has been shown to be more representative than a single recruitment strategy alone (McCormack, 2014), the findings of this work may not be representative of all YBMSM living in other areas, especially since participants recruited through different methods may have different OI scores, which may serve as a facilitator of comfort in research interviews. We asked participants to rate their experience of their interview immediately after the interview and to recall on events that occurred in the past. While we used a timeline follow back procedure to enhance recall of the event, by allowing participants to reflect on other life events that occurred at that time, the inability to recall the event and other negative

experiences may have been limited by the duration from when the event occurred. Additionally, reflection on their experience participating in this qualitative study may have been different if collected 1 or 2 months after the interview versus immediately after. Longitudinal studies are needed that prospectively follow YBMSM to be able to ask participants about their experiences, explore developmental milestones in which YBMSM are most vulnerable, namely first same-sex sexual attraction and behavior, and examine how comfort levels change over time. Despite these limitations, the current study significantly adds to our understanding a sample of YBMSM's experiences participating in a qualitative behavioral research study.

The findings from this study provide empirical data for regulatory boards, including local IRBs, about the nature of the potential benefits and harms of participating in qualitative research focused on sexual health and may assist IRBs in evolving from subjective to an evidence-based risk and benefit assessment (Gunsalus et al., 2007; Mustanski, 2011; Wendler, Belsky, Thompson, & Emanuel, 2005). Findings from this study suggest that sexual health research can provide a safe space for YBMSM to share their experiences, express their sexuality, and assist with overall adolescent and sexual development. Future sexuality researchers must continue to employ questions that characterize participants' experiences, as well as assess how adolescents and YBMSM at greatest risk for disease benefit from research participation. Such empirical evidence, including the evidence described in this study, will better enable IRBs and ethicists to appropriately weigh the risks and benefits in proposed research studies, and allow review decisions to be made based on empirical and not subjective data. This may be crucial to conducting future sexual health research that includes adequate representation of YBMSM, and improves the health and HIV-related outcomes in this group.

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Sexual health research with young Black men who have sex with men (YBMSM): experiences of benefits and harms

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Table 1Characteristics of the study population ($n=50$)

Characteristic	Mean (<i>sd</i>), % (<i>n</i>)
Mean age of participants	17.6 (1.3)
Race/Ethnicity	
Black/African-American	96% (48)
Other	4% (2)
Sexual Orientation	
Homosexual/Gay	62% (31)
Bisexual	34% (17)
Other (not defined, heterosexual)	4% (2)
First same-sex experience	
Mean age at First Same-Sex Sexual Experience	13.9 (2.6)
Mean number of sexual partners	
Lifetime partners	13.3 (14.5)
Outness Inventory (OI)^y	
Overall	37.2 (16.1)
Outness to family	15.7 (6.1)
Outness to world	18.6 (9.8)
Outness to religion	2.88 (3.7)
Comfort Discussing First Attraction	
Very Comfortable	32% (16)
Comfortable	56% (28)
Uncomfortable	12% (6)
Very Uncomfortable	0% (0)
Comfort Discussing First Experience	
Very Comfortable	32% (16)
Comfortable	56% (28)
Uncomfortable	12% (6)
Very Uncomfortable	0% (0)
Comfort Discussing Sexual Orientation	
Very Comfortable	48% (24)
Comfortable	44% (22)
Uncomfortable	6% (3)
Very Uncomfortable	2% (1)

* OI: Range 2–75; 25th percentile: 27; 50th percentile: 36.5; 75th percentile: 47

Table 2

Themes

Classification	Definition	Thematic Code	# of times coded
Direct Benefits	Experiencing an immediate effect from participating in the qualitative interviews	1. Sense of and awareness of risky sexual behaviors	18
		2. Safe space to share early same-sex sexual experiences and personal stories	18
		3. Empowerment and comfort with one's sexual orientation	8
Indirect Benefits	Perception that participation could help others	1. Sharing one's story can impart knowledge to researchers	4
		2. Participation helps the larger gay community	3
Direct Harms	Harms that were experienced immediately during the interview without intervening factors	1. Being visibly upset or describing emotional feelings of discomfort as a result of having to reflect on first sex experiences	4
Indirect Discomfort	An uncomfortable feeling that was associated with participation, but did not result in direct discomfort		4
	Hard time recalling the event		4
	Feeling embarrassed		5