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Psychosocial Challenges and Protective Factors Among MSM Living with HIV: An Integrative Review of the Literature Using an Intersectional Framework

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Abstract

Objective: Given the emerging data on intersecting identities involving men who have sex with men (MSM) with respect to various factors, there lies a need to include one's human immunodeficiency virus (HIV) status in this intersection, given the experience of stigmatization and inequalities. This integrative review covers psychosocial risk and protective factors experienced by MSM of HIV-positive status, while also considering other intersecting identities (e.g., ethnicity, older age). Method: Following a standardized search inquiry, 2139 records were identified and narrowed down to 24 peer reviewed articles. Results: Psychological and social protective factors such as positive mental health outcomes; lessened or resolved internalized homophobia; social networks in younger and older MSM, with a discussion on the contextually relevant impact that religion has among Black MSM. Some risk factors such as co-occurring stigmas, psychological distress, exposure to violence, and trauma are explained. Implications: These immediate findings highlight factors that contribute to resilient pathways among ethnic minorities, and of other intersections among sexual minority men. In order to mitigate risks, developing tailored interventions with a focus on co-occurring and syndemic stigmas is crucial, to help ensure the psychological and social well-being of diverse HIV-positive MSM. An adapted version to the minority stress model is thus presented.

Keywords: MSM, HIV, mental health, psychosocial, intersectionality, minority stress model.

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Men who have sex with men, or MSM, is a term that bundles all men that partake in any sexual encounter with another self-identifying man regardless of said man's gender identity, or if they identity on the sexuality continuum (i.e., gay, bisexual, bi-curious, pansexual). As per the literature on MSM, this minority group faces an abundance of mental health, social, economic, and physical health disparities, compared to the general population (see Buttram & Kurtz, 2015; Charlton et al., 2018).

Studies claim the importance of accounting for intersectionality in the impact that health status (i.e., seropositive, or seronegative for the human immunodeficiency virus; HIV), and internalized homophobia have on mental health and resilience (see Herrick et al., 2013). These disparities tend to be exacerbated for HIV-positive MSM (Pellowski et al., 2013), or those with acquired immunodeficiency syndrome (AIDS), if developed. Discrimination, stigma, and mental health stressors tend to become apparent as a function of these complex pathways in HIV-positive MSM (Bogart et al., 2011). What may further complicate this is when intersecting minority statuses are in play, such as ethnicity or age. For instance, Black HIV-positive MSM tend to experience greater psychosocial risk factors such as depressive symptomology, internalized homophobia, and stigma, compared to white men of a same cohort (Graham et al., 2011). These other identities shape a different reality for some MSM, which can indeed lead to further stressors.

Despite such visible disparities among these minorities, MSM groups have also expressed resilient narratives, despite the addition of stigma and perceived stressors. Resilient pathways are indeed possible, which have been positively associated with social support (Hussen et al., 2018), better mental health (McGowan et al., 2018), among others. Given the interconnectedness between risk and resilient factors, it is important to not only look at one facet of the coin, and to examine both in depth. Thus, this paper will examine a review of both, in the context of MSM who have tested seropositive for HIV, while highlighting and placing focus on various self-reported identities in these complex pathways.

Theoretical Models

Minority Stress. As this theory suggests, groups of sexual minorities status tend to experience greater amounts of mental distress. Meyer (2003) suggests that various facets exist that contribute to stressful environments, such as expectations of prejudice, expectations of rejection, concealment of one's sexual orientation, and internalized homophobia. Coping mechanisms are also discussed (see Figure 1). As the author explains, these facets contribute to poorer psychophysical health outcomes (i.e., mental health challenges, in addition to physical

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conditions such as heart disease and elevated blood pressure). With focus on the psychological aspect, these factors are quite apparent among gay and bisexual men, and other MSM (Meyer, 2003), whereby greater risk for depression and drug use has been previously reported (Javanbakht et al., 2020). Various stigmas, discrimination, and social disparities can also explain why MSM tend to experience worsened outcomes (Wohl et al., 2013), as such groups may not feel supported and continue to experience inequalities in their everyday lives. Taken together, such psychosocial variables impact the well-being of minority MSM. Hence, it is of importance to further various research methods to achieve resilient outcomes in minorities, mitigating the negative effects previously mentioned.

Intersectionality. The major drawback to the minority stress theory is that it neither examines the effect of various sources of inequalities faced by minority groups, nor does it highlight individuals' layers of social/cultural identities. Hence, such a simplistic view may not demonstrate enough variations of what occurs in the real world. This is where intersectionality comes in. As Crenshaw (1989) explains, the intersectionality framework focuses on oppression stemming from various inequalities. Originally used to express how Black lesbian women faced various forms of oppression, it is now widely used to highlight various structural and social inequalities faced by various minority groups. Examples of such inequalities can be due to sexual orientation (i.e., gay, bisexual, pansexual), gender (i.e., male, female, transgender), lower socioeconomic status (SES), education, ethnicity (i.e., Black, Latinx, Indigenous), age, etc. Such factors intersect, and as such, allow researchers to examine the additive effect of social inequalities on minority groups.

Although these inequalities can be additive (i.e., black + gay + HIV-positive), it is important to note such identities are equally constructed alongside one another, can indeed be interdependent (i.e., not mutually exclusive; Bowleg, 2008; Purdie-Vaughns & Eibach, 2008), and can even result in a greater impact than the sum of measured oppressions. In the case of MSM, sexual orientation, ethnicity, age, and lower SES are examples of social inequalities most prevalent in research. Another facet that is lacking from the minority stress theory is the influence of HIV status on MSM groups given its higher prevalence. Instead, this intersectional framework would indeed encompass HIV status as a social inequality given stigmas and oppressive behaviours experienced by these *vulnerabilized* individuals.

Gap in the Literature

Given the importance of intersectionality theory relative to minority stress, there has been a trend to follow this practice when research involves lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and

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others (LGBTQIA+), or MSM more generally. Data among Two-spirited (2S) people from Native or Indigenous communities were sparse or such identities were not explicit in research results. Despite this absence in the recent literature composing this corpus, 2S and HIV-infections are a reality for these communities (Roscoe, 1998), and relevant studies need to become widely available. What is further lacking is the impact that psychosocial variables have on MSM groups, when taking an intersectionality approach. Only one review focused on young Black MSM, some being HIV seropositive, and elaborated on such variables. However, it did not include any other intersecting identities such as other ethnicities, age, etc. Broadening the review to other intersecting identities would allow a more comprehensive overview of the lived experiences and realities of diverse HIV-positive MSM, in addition to having a better understanding of risk and resilient factors that has emerged in this subpopulation.

Method

Search Strategy and Eligibility Criteria

For this review of the literature, Pubmed, PsychInfo, and Ebscohost databases were used to identify potential articles. Articles had to initially mention a psychological/social risk or protective factor among HIV-positive MSM and/or Transgender individuals. Note that in this review, transgender-specific articles were not included in the final article count, given considerable differences in lived experiences when compared to MSM (Poteat et al., 2016). It was equally relevant to exclude articles prior to 1996, given this was the year that tritherapy (i.e., triple antiretroviral therapy), which combines various transcriptase and protein inhibitors against HIV, was released. The assumption here is that the introduction of tritherapy ultimately reshaped and influenced psychosocial outcomes for MSM with a HIV-positive status and greatly influenced the life expectation of people living with HIV. Lastly, with a focus on both qualitative and quantitative studies written in English and from *Western* countries, the search included peer-reviewed journals and dissertations. Boolean operators and variations of search terms were used while database searching.

To determine eligibility for this specific review, inclusion criteria included **1)** studies from 1996 to May 2020, **2)** qualitative or quantitative study design, **3)** psychological and/or social factor, in the context of risk or resilience, **4)** written in English and from a *Western* country, **5)** published in a peer reviewed journal or as a dissertation, **6)** aspects of intersectionality, and **7)** MSM with a HIV-positive diagnosis. Exclusion criteria included, **1)** articles written in another language than English, **2)** case studies or chapters **3)** studies with a sole focus on

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interventions, and 4) a sample with sole focus on transgender individuals. Articles were extracted and uploaded to Rayyan (Ofman et al., 2003), where inclusion and exclusion criteria were systematically applied.

A three-step approach was used in the identification of relevant articles, as described by Meade and Richardson (1997). Reading the title of the peer-reviewed paper, followed by the abstract, and the article in its entirety. Inclusion and exclusion criteria were employed in each step. Articles were discarded accordingly, each affixed with appropriate reasoning.

Our initial search sparked 2139 records. Upon removing duplicates, 1202 records remained. 572 remained after filtering through each article title for relevance, 157 after reading abstracts and screening for the central aspects of each article's focus, and 24 articles after reading them in full (see Online Resource 1).

Quality of Data

Although the ideal theoretical approach for determining the quality of data in qualitative research hereby would have been applying the National Institute for Health and Care Excellence guidelines (NICE, 2012), the quality of research for this integrative review was assessed using a different standardized approach. The following approach was to ensure the same guidelines could be applied uniformly throughout qualitative and quantitative studies. Articles were first ensured to have been peer reviewed; published in a peer review journal or a doctoral dissertation that was peer reviewed by their respective thesis committee. Next, vigor of their methodology and results was assessed critically, sample size considered. Their methodological approach and results were then compared to the article's conclusions, to ensure findings were expressed cautiously and not over-interpreted beyond the scope of associations (for quantitative data). Lastly, biases and conflict of interests were explored (e.g., comparing consistently positive mentions of religion seemed apparent, with one's source of funding).

Results

Resilient Factors Among HIV-Positive MSM

Psychological Variables. Internalized homophobia (IH), or homonegativity, is one facet of minority stress and is a psychological variable that some HIV-positive individuals experience. In a study involving 427 black MSM, some with a HIV-positive status, those who had resolved their IH, were more likely to report greater resilience (Quinn et al., 2015). Many of these individuals were financially disadvantaged and had less education (i.e., most only completed high school). This demonstrates that individuals experiencing a facet of minority stress and who are more vulnerable to social inequalities, are likely to remain less resilient if they do not have access to proper

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interventions. Although the results shed light on variability of IH in this sample, one cannot simply group all black men homogenously (see Wilson et al., 2016), given biopsychosocial individual differences. However, once any internalization of such stigma is dealt with, resilient pathways are likely to emerge. Herrick and colleagues (2013) sampled 1541 gay and bisexual MSM, with slightly less than half of the participants identifying as HIV-positive and one third of the sample consisting of ethnic minorities. Through logistic regression, participants with less psychological distress, less stress, or no intimate partner violence, were more likely to experience less IH, or have resolved it. This implies that with less psychological strain, one is more likely to reduce IH, allowing them to foster resilience, despite intersecting identities. Although significant results, associations were not stratified by ethnic background (where roughly 20% of the sample identified as Black, and another 10% identified as Hispanic) to account for group differences. Interestingly, results did not differ by HIV status, suggesting that in this sample of MSM, participants reported similar levels of IH across predictor variables. Another predictor of IH was greater gay community acculturation (Quinn et al., 2015). The black MSM in this study demonstrated that embracing and adapting to the cultural sphere surrounding the gay community was positively associated with experiencing less IH. Despite this, the bidirectionality of these variables was not tested and remains unclear in this study; is it that lower levels of IH leads to greater community acculturation and socialization, and conversely, that socialization and being in gay venues leads to a reduction of IH? Future research is needed to disentangle the bidirectionality of the association or lack thereof.

Experiencing better mental health was a consistent outcome variable across the literature. Better psychological well-being was positively associated to greater self-efficacy and social support in an elderly sample of MSM (Emlet et al., 2013; see also Brown et al., 2019) and social support in young black MSM (Vincent et al., 2020). Being supported by social or community structures were both associated with less psychological distress in groups with intersecting identities. However, the major methodological flaw in their designs were with respect to having control groups, such that differences in mental health outcome were not contrasted with potentially less stigmatized groups (i.e., white younger MSM). Another predictor of better mental health was experiencing little to no HIV internalized stigma. HIV internalized stigma, in its association with psychological distress, was partially mediated by having access to positive psychological resources (i.e., related to self-efficacy; Fritz, 2017). Through positive psychological resources, despite internalization of such stigma, one can experience better mental health outcomes. In this mediation model, income was one variable controlled for (as many participants were economically

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disadvantaged), although education was not. Assuming that there was substantial power in the study, including both variables aforementioned as moderators could have been more valuable to observe if these intersecting identities attenuated or exacerbated mental health outcomes in this sample of MSM.

Substance use before/during, sex, or PNP, was the outcome of one study. Experiencing one facet of minority stress was negatively associated with PNP or substance use before or during sexual activity (Dentato, 2011; cf. Bonne, 2014). Although this demonstrated that experiencing a facet of minority stress is associated with a decrease in drug use, before or during sex, the methodological concern with this study is that no control group was used to compare a less stigmatized group (i.e., heterosexual men on PNP) with this sample. Interestingly, despite social exclusion and stigma experienced by PNP users, these diverse men nonetheless experienced resilient pathways (Souleymanov, 2018). This qualitative study construes that resilience emerged due to “social bonds, friendships, and relations of care in their PNP networks” (p. 33), all facets of positive social interactions.

Social Variables. Considering social and interpersonal variables is especially important when studying individuals with intersecting identities. Expectedly, having supportive social networks was positively associated with resilient outcomes (Harper et al., 2014), as has been found across the literature for promoting resilience in various contexts. In a Canadian context, having supportive networks is a determinant of health and well-being (Mikkonen & Raphael, 2010).

Discrimination is quite important, given that many minorities experience this, either overtly or covertly. Thus, resisting forms of discrimination is one pathway to resilience. With the goal of achieving this, Handlovsky and colleagues (2018) conducted semi-structured interviews with 25 older gay men highlighting various intersecting identities. They identified three avenues in resisting discrimination: i) Building and sustaining support networks, ii) advocating for health needs, and iii) addressing mental health. Despite these men facing oppressive experiences related to their HIV status, age, and sexual orientation, this sample was nonetheless composed of White educated men; as such, replicating these results with various other intersecting identities and social positions are necessary (i.e., Black or Latino, bisexuals or other MSM identities, and less educated men).

Derived from a qualitative study, having greater partner or social support can help reduce the impact of stigma in Black MSM (where $N = 12$ couples), thereby easing access to HIV services (Tan et al., 2018). This was especially true when their partner was of HIV-positive status as well. This is coherent, given the dyadic nature of couples, and the interdependency that exists. Although meaningful results, replicability among a larger sample is

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warranted to ensure generalizability. Similar results from a qualitative study were reported where access to HIV service due to stigma was buffered with the presence of family, friends, and peers (Remien et al., 2015), more so when the presence of social support was from individuals “living in similar circumstances” (p. 20). Interestingly, in terms of time between HIV care visits, resilience’s effect on Black MSM was more pronounced than that of their white counterparts, suggesting that resilience in Black men mitigated effects of stigma, possibly, and encouraged them to access care services more frequently (Brewer et al., 2020) than white peers.

Using a qualitative design, Bower and colleagues (2019) interviewed several LGBT older individuals, whereby one facet of the interview dove into stigma and religion. Older people, as the researchers describe, felt stigmatized by religion due to their sexual orientation or HIV status. To counter this felt stigma, some individuals mentioned reconceptualizing or creating distance from religion to gain this peace of mind, and to better cope or eradicate this stigma from their lives. Others, however, partook in religion and used it as a coping mechanism (Bower et al., 2019). Although the sample did include HIV-positive MSM, it is difficult to dissect which information directly applied to this subgroup given this qualitative study including LGBT aging individuals. As such, cautious interpretation of such findings was instilled. For Black MSM, some results seemed to overlap with the previous finding. In a sample of 21 MSM, with African American ethnicities and roughly half the sample reporting a HIV-positive status, resilient narratives emerged in light of religion and spirituality. Participants expressed that the latter had contributed to an increase in inner strength (Buttram, 2015). It is important to note that the role of Church in the lives of Black MSM is both complex and polarizing. As Wilson and colleagues (2016) explain, although this place of worship carries a great degree of stigma towards the sexual identity of BMSM, with disregard of one’s HIV status, there exists a support between BMSM in this setting which helps mitigate external racism and succor Black minority men into a path of self-acceptance.

Aging, reflecting on your life, and sharing personal experiences with the goal of empowering other MSM, can be deemed a biopsychosocial element that is associated with resilience. As Boyer and colleagues (2019) further explain, allowing aging MSM to share stories related to the HIV/AIDS pandemic to the next generation, is one way to increase resilient outcomes by overcoming various stigma related to both homo/bisexuality (in the context of some participants) and HIV. Not only does it allow for MSM of different generations to have important conversations, but it similarly creates a sense of community and allows the presence of positive role models to emerge for younger generations. One narrative, as described by the authors, was a lack of positive role models

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reported in the life of aging MSM. Thus, empowering and generativity are ways that aging MSM can pass the torch, helping create resilient outcomes for both themselves, and other MSM with a HIV diagnosis.

Risk Factors among HIV-Positive MSM

Psychological Variables. Resilience, in the context of MSM (including both HIV-positive and negative men), has been associated with various psychological constructs. More specifically, aging and less resilient men reported greater psychological distress (including depression and suicidality); greater IH was reported too (King & Orel, 2012). A discussion on various psychological variables associated with HIV-positive MSM and their intersecting identities is presented below.

As previously mentioned, there exists an extensive literature on psychopathology in the context of MSM, compared to non MSM populations. However, what is less researched is psychological distress in ethnic and diverse HIV-seropositive MSM groups. To address this, one research team examined depressive symptomology longitudinally in a largely Black sample of HIV-positive and negative MSM (Mukerji et al., 2017). These authors denoted that, independent of age and education level, among others, cocaine use from HIV-positive MSM predicted an eightfold increased odd pertaining to the group experiencing greater depressive symptomology. Although findings need replication with various ethnic minorities, this data from Mukerji and colleagues highlight the psychological distress experienced by MSM at various intersections (2017). Given that drug use and mental health may indeed be contextually situated among Black MSM (Wilson et al., 2016), it is imperative to disentangle these risk factors that exacerbate the risk for poor psychological health.

Greater IH has been positively associated with depressive symptoms (see Bonne, 2014). Given this, a study conducted by Vincent and colleagues (2020) examined various direct and indirect predictors of depressive symptomology in a large sample of roughly 1800 young Black MSM, where one out of every seventh individual was seropositive for HIV. In univariate analyses, experienced racism, SES distress (i.e., an index of low socioeconomic status or distress) and HIV status were each independently associated with depressive symptoms. After controlling for city location, it was denoted that two variables, experienced racism and experienced heterosexism, were independently and indirectly associated with depressive symptoms through IH. These researchers also demonstrated that experienced heterosexism and having a HIV-positive status were independently and indirectly associated with depressive symptomology through anticipated HIV-related stigma (see also Chambers et al., 2015). What this research suggests is that the experiences of Black MSM, regardless of status, is complex and distinct from ethnic

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majorities, and that to further our knowledge on *vulnerabilized* groups, examining such intersections are critical.

Although their methodological approach was rigid in its use of bootstrapping for mediation analyses, considering serial-mediation and moderation effects in their model is warranted, in hopes of increasing the representative nature of the complex proximate and distal interactions of which are present around us (see Bioecological model; Bronfenbrenner & Morris, 2007). A similar study ran moderated-mediations in a sample of HIV-positive diverse MSM. It was found that lower self-compassion moderated the indirect association between HIV-stigma and negative affect, through IH (Skinta et al., 2019). Specifically, the interactions between low self-compassion, HIV-stigma and IH were associated with greater negative affect; however, this was not the case for individuals reporting average or greater self-compassion.

Coupled with or without negative affect, other psychopathologies can emerge too. However, when examining at one's global mental well-being in the context of HIV-positive older MSM, a picture emerges. Findings from Emlet and colleagues (2013) suggest that barriers in activities, comorbid conditions (i.e., cardiovascular, respiratory) and victimization (verbal, physical or sexual) are risk factors associated with reduced physical and psychological well-being. Taken together, this suggests that certain risk factors may exacerbate one's psychological health and highlights the need for intervention, specifically designed and tailored for elderly, both sexually and ethnically diverse, populations.

As mentioned in the resilience section of this review, resolved IH seems to be the ideal scenario with promising outcomes. However, resolving IH is not an easy or quick process, and can be contextually situated. For example, in the study previously mentioned by Quinn and colleagues (2015), among the 427 Black MSM, individuals who reported greater participation or involvement in religion tended to experience greater IH. This indirectly went in contrast with the findings from Bower and colleagues (2019), whereby some participants experienced reduced stigma through religion.

Given the various descriptions of trauma, it is hereby defined as any of the following, without precision for one's age: a) physical, sexual, or emotional abuse; and/or b) physical or emotional neglect (see Bernstein et al., 2003 about trauma classification for children and adolescence). This construct is quite important in MSM research, given its high prevalence in gay and bisexual men, and a risk factor for HIV transmission (Mimiaga et al., 2009). In this review, Phillips and colleagues (2014) demonstrated that in a sample of young HIV-positive Black MSM ($M_{age} = 20.40$), being emotionally or physically abused by a caregiver was statistically significant in its association with

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worsened mental health outcomes (i.e., depressive symptomology and suicidal attempts). Being sexually abused was not statistically associated with the outcome variable. Although the prevalence of sexual abuse was rather low in this sample of young men, previous research has shown that MSM groups have a higher rate of childhood sexual abuse than the general population, and an even greater rate, averaging 35.5% for clinical populations in the MSM community (Schafer et al., 2013). It is important to note that the items of abuse used by Phillips and colleagues (2014) have neither been standardized, nor were their psychometric properties assessed.

Exposure to violence was a prominent theme in this research, more so among Black MSM. Among a sample of HIV-positive ethnic MSM across the United States, exposure to violence with a deadly weapon was significantly associated with substance use (alcohol and drugs), but not with higher risk sexual behaviors (i.e., condomless sex; Phillips et al., 2014). These researchers also noted that the fear of violence in one's community was also associated with worse mental health outcomes, when stratified by city.

Intimate partner violence was also more prevalent in MSM groups (Chen et al., 2019; Wang et al., 2018) compared to the general population (Messinger, 2011). In a Canadian sample among HIV-positive MSM, Indigenous individuals were more likely to report incidents of intimate partner violence, than White or Black men (Siemieniuk et al., 2013). Looking at the entire sample, these authors reported that intimate partner violence was associated with higher odds of being diagnosed with AIDS, an increased risk of being hospitalized due to HIV complications, in addition to having experienced traumatic events. Perhaps with a larger Black subsample in this study, assuming feasibility in terms of methodological design and subpopulations available in areas of recruitment, it would have permitted for statistically significant sensitivity analyses for this subgroup, as was the case with Indigenous (who possibly identify as 2S) HIV-positive MSM.

When controlling for the effects of HIV status in 228 Black MSM, higher levels of IH was associated with the use of alcohol before or during a sexual encounter, with a 63% increase in likelihood of consuming alcohol per one standard deviation increase in IH (Bonne, 2014). This association was moderated by peer support, whereby alcohol use was exacerbated when coupled with a less supportive network.

Social Variables. Two of the most common risk factors for mental health difficulties, and is associated with resilience, are stigma and access to care (King & Orel, 2012). Whereas greater stigma tends to be conducive to less resilient individuals, while less access to care services (in the context of HIV) tends to be positively associated with resilient outcomes.

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Various stigmas are experienced by MSM. Multiple and layered stigma exists, especially among Black HIV-positive MSM. HIV stigma is compounded with injustices such as sexism, homophobia, and racism (Chambers et al., 2015). This synergy created by intersectional identities explains how marginalization occurs within this minority group. One important facet of this synergetic connection is that addressing one source of stigma may negatively impact another (Wilson et al., 2016). Tackling one form of stigmatization may exacerbate internalized stigma of another; for instance, when tackling stigma created due to homophobia, it may enhance internalized stigmatization that occurs from simply identifying as a Black man (Wilson et al., 2016). This does not only concern BMSM, but also other ethnic MSM such as Latinx identifying individuals. HIV-positive MSM from the latter group tend to face layered stigma due to homosexuality, their HIV status, in addition to their Latino identity, thus creating co-occurring stigmas that impact their psychosocial and physical functioning (see Henkel et al., 2008). One other aspect to consider is the individual magnitude of these co-occurring stigmas. In one study sample, it was demonstrated that Latino HIV-positive men experienced more HIV-related stigma than their Black counterparts, but the reverse was true for stigma related to homosexuality (see Wohl et al., 2013 for details). Co-occurring stigmas are experienced differently, and to different degrees, from one ethnic minority and HIV context to the next. As such, it is imperative to find means to mitigate the impact of these co-occurring stigmas in *vulnerabilized* MSM minorities, and its variations.

Reduced access or barriers to acquiring HIV services, at the individual level, is a prominent social theme that negatively affects MSM. In young MSM, their sexual identity as gay, bisexual, or other can create barriers to seeking HIV services due to stigma and IH (Remien et al., 2015). As these authors state, the sexual identities of MSM are “powerful deterrents to entering and staying in HIV care” (p. S20). Although sexual identity is one facet that influences the use of HIV services, among Black MSM, the portrait is exacerbated, a pattern that is similar to what was described in the previous section. Tied to notions of co-occurring stigma around homosexuality, ethnicity, and femininity, in addition to HIV-stigma within their communities, a lack of acceptance still exists. As in the review by Wilson and colleagues (2015) explains, Black communities tend to hold onto the idea that HIV or AIDS is a gay disease of white men, and as such, this denial is generating social barriers in allowing Black MSM to access HIV services.

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Discussion

In this review, psychosocial themes faced by HIV-positive MSM were described. From facing multiple layers of oppression to internalized homophobia, vs. surrounding oneself with social networks and reduced substance use, examples of such psychosocial outcomes varied by study and MSM sample. Despite worsening mental health conditions such as depressive symptomology and IH experienced by sexual minority men living with HIV, what was made evident was that, due to societal factors, intersecting identities play an important role in the emergence of co-occurring stigmas. Conversely, when social factors act in unison and one has such capacities, it can contribute to resilient outcomes. We will discuss resilience a little later. Not only is the attempt to resolve one stigma challenging, but it can exacerbate the perception of another stigma that one is experiencing, creating barriers when designing interventions to mitigate such risks. These co-occurring stigmas have been described in the literature (e.g., Chambers et al., 2015; Wilson et al., 2016) and more research is needed on how to effectively reduce these synergetic stigmatizations to improve psychological health outcomes and to reduce social disparities among HIV-positive sexual and gender minority MSM. This highlighted the relevance and need of social support and resisting discrimination in these men.

Other risk factors experienced by HIV+ MSM that became apparent in this review were trauma, intimate partner violence, and exposure to violence. These themes were consistent across the literature. Compared to the general population, such risk factors hold a greater prevalence in minority groups (e.g., Field & Caetano, 2004; Merrick et al., 2018). As such, it is imperative for research to address interventions mitigating these negative experiences among HIV+ MSM, in addition to behavioural interventions targeting socio-cultural attitudes among heteronormative and HIV-seronegative populations.

Another prominent theme was the contextual role that religion plays in the lives of MSM. As expressed through narratives from MSM and other identities, some found religion and church stigmatizing, others gravitated to religion for support and hope, whereas others re-defined it. However, in the lives of Black MSM, religion was contextual. Despite co-occurring stigmatizations, some Black men continued to lean on the church for support from other Black minority men, as a benchmark for self-acceptance. This highlights the pervasive nature and importance of social/community support, despite evident stigmatizing perceptions from religion or church, on a structural level.

One interesting finding is the outcome of reduced risk-taking behaviours with or without the use of substances in MSM who experienced feelings related to expectations of rejections, one facet of minority stress

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(Dentato, 2011). This finding has not been replicated, as the consensus in the literature has been that increased minority stress is positively associated with increased risk-taking behavior, such as substance use before or during sexual intercourse in Black MSM (see Wilson et al., 2016). However, further research is required to validate the directionality of this finding, detangling whether expectation of rejections could potentially be seen as a resilient factor among some MSM.

Many of these psychosocial risk and protective factors experienced by HIV-positive MSM have been well studied, however more research is needed to examine the contextual nature of these variables and co-occurring stigmas in other ethnic backgrounds, with samples of men from both western and non-western countries alike. It is also important to make note that the concept of resilience exists in *grey* areas, so to speak; it is not defined whether a person experiences resilience or not. Resilience in the face of adversity is seen on a continuum, can be molded, attenuated, or strengthened; it is equally contextual, where resilient outcomes in one context may not extend to others (Southwick et al., 2014).

Adaptations to the Minority Stress Model

Given the data presented in this review, regarding HIV-positive MSM, and using the article from Poteat and colleagues (2016) as a reference point for the experiences of transgender women, the authors of this review suggest adaptations to the Minority Stress model (see figure 2) considering the plethora of identities encapsulated within the human experience. Such additions are in respect to intersecting identities and co-occurring stigmas that would allow for a comprehensive overview of gender and sexual minority experiences moving forward, instead of the sole focus placed on cisgender Gay or Bisexual men. These two alternatives are not enough to view and include sexual orientations, gender, and ethnicity as minority status when a body of research supports the notion that other factors such as HIV-status, age, SES, other genders such as non-binary and 2S persons play a role in systematic oppressive experiences among minorities. Although the original minority stress model paved way for research on sexual minority, and has helped our understanding on experiences faced by MSM in particular, a theoretical foundation is needed to explain intersecting identities respective to psychosocial outcomes in all sexual and gender minority persons. Herein, the rationale for the proposed adaptations in Meyer's (2003) original model is presented.

These adaptations provide a more accurate worldview of the lived experienced faced not only by cisgender MSM, but of all sexual and gender minorities alike including queer, 2S, nonbinary and transgender individuals. It is made clear in the proposed adaptations that various added processes work together (i.e., stigma, discrimination,

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racism, and sexism) to explain why both minority groups including individuals with intersecting identities (i.e., HIV status, ethnic identity, age) tend to experience exacerbated health outcomes. It is crucial to remark that not all members with minority status' will experience worsened mental health outcomes when in-group comparisons with white MSM are made, however therein remain important health inequities for the former group (Hickson et al., 2020). However, between-group analyses have constantly shown psychosocial disparities among sexual and gender minorities when compared to their cisgender and heterosexual counterparts (Alvy et al., 2011; Mills et al., 2004).

Limitations

As this integrative method review dealt with both qualitative and quantitative data, its strength is also its limitation. Given that in quantitative analyses comparisons between associations can be made, in qualitative analyses, one cannot translate narratives and experiences into a dependent variable, per se. As such, cautious utility of qualitative studies was warranted in this review, when comparisons were made across methods. Regarding this study's methodology, solely psychosocial variables were examined. Other variables such as structural factors could have been added to further our knowledge of the interconnectedness that occurs in the world we live in, as the bioecological model stipulates (Bronfenbrenner & Morris, 2007).

Additionally, the sample for this review consisted of mainly MSM, with a portion of participants being of HIV-positive status in each study. However, it is limiting to only address needs and issues of MSM, without the inclusion of gender identity (i.e., transgender, nonbinary) given the possibility of overlap. Intersectionality here, would have offered utility to shed light on the human experiences and explain the complexities of transgender individuals. However, in this review, transgender and nonbinary individuals' experiences were not included due to the sole fact that their needs, compared to intersectional MSM, were vastly different (Poteat et al., 2016). Lastly, the exclusion of non-western countries is a limitation in this study's generalizability. However, it was needed to maintain some homogeneity of experiences, regarding legal treatment of MSM, accessibility to HIV services, a similarity in human rights application, etc. The regard and rights of MSM in Canada are not comparable to that in Russia or India, for instance. Decriminalization of homosexuality in India only transpired as of 2018, and despite such decriminalization in Russia, gay men continue to experience torture and senseless murder. Thus, it was important to maintain some homogeneity across samples to examine trends in the literature using a Western lens. Another limitation is the absence of studies implicating Two-spirited and Indigenous or Native MSM; we did not perform searches in indigenous databases specifically (e.g., see the indigenous studies portal research tool;

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University of Saskatchewan Library, 2019), which may explain the absence of respective academic articles in mainstream databanks used at screening.

Future Directions

Given the importance of disseminating information to be used when tailoring interventions, it is critical that further research be conducted beyond Caucasian identities. Research on Black, Latinx, Indigenous, Asian-Pacific populations, to name a few, are primordial to better understand intersecting identities, while ensuring the use of a control sample. With this, novel interventions can be conceived to reduce co-occurring stigmas in minority MSM. Despite the need to increase external validity and representativeness of ethnic identities, the inclusion of other gender identities in research is paramount to better recognize their diverse lived experiences.

Another important aspect to consider is resilience. More research is needed that delves into what makes one ethnic minority more or less resilient, compared to another. Are these differences explained by various co-occurring stigmas, in addition to community or familial acceptance and support, or lack thereof? For instance, resilience had a greater effect on Black MSM than on White MSM, when it came to examining time between one's last use of HIV services (Brewer et al., 2020). Would the same trend be found for other ethnic identities, and if so, what biological and social mechanisms are contributing to this? Stringent evidence-based research is needed to understand these associations and their utility in the lives of MSM, both of HIV-positive status and with various intersecting identities.

Conclusion

Given the various risk and protective factors described throughout this review, what is made apparent is that factors are not independent of each other; there are multiple components to consider in the larger model that describe MSM conditions. Using the proposed adapted model would equip researchers and public health officials to further analyze, intervene and support minority groups by understanding diverse lived experiences of MSM and other sexual and gender minorities, respective to various minority status and interconnecting factors. Promoting resilience is not an impossible task, but it indeed can be fragile for some. Understanding the minority identities, their fragilities and their risk/protective factors are ways to explore what in their *forest of "cons" could be a sign of "pros"*. As the solution for racialized minorities is not to be of another identity or of another culture, a way to service diverse HIV seropositive sexual and gender minorities is to expand our understanding of endless shades of colour that promote strength in a world filled with adversity.

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Fig. 1 Illustration of the Minority Stress Model

Note. Various internal and external influences that interact to account for positive or negative mental health outcomes. Reprinted from “Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence”, by I. H. Meyer, 2003, *Psychological Bulletin*, 129, 674–697. Copyright 2003 by American Psychological Association.

Fig. 2 Illustration of the adapted Minority Stress Model using an intersectional framework.

Various internal and external influences that interact to account for positive or negative mental health outcomes, when taking into account intersecting minority identities. In box (d), stigma, racism and sexism have been added as distal processes.

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Psychosocial Challenges and Protective Factors Among MSM Living with HIV: An Integrative Review of the Literature Using an Intersectional Framework Sexuality & Culture

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Online Resource 1

PRISMA Flow Diagram

Adapted from Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement*. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097