

6-3-2014

Syndemic Health Disparities and Resilience Processes Related to HIV Transmission Risk among African American/Black Men in South Florida

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DOI: 10.25148/etd.FI14071107

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FLORIDA INTERNATIONAL UNIVERSITY

Miami, Florida

SYNDEMIC HEALTH DISPARITIES AND RESILIENCE PROCESSES
RELATED TO HIV TRANSMISSION RISK AMONG AFRICAN
AMERICAN/BLACK MEN IN SOUTH FLORIDA

A dissertation submitted in partial fulfillment of

the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

GLOBAL AND SOCIOCULTURAL STUDIES

by

Mance E. Buttram

2014

To: Interim Dean Michael R. Heithaus
College of Arts and Sciences

This dissertation, written by Mance E. Buttram, and entitled Syndemic Health Disparities and Resilience Processes Related to HIV Transmission Risk among African American/Black Men in South Florida, having been approved in respect to style and intellectual content, is referred to you for judgment.

We have read this dissertation and recommend that it be approved.

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ACKNOWLEDGMENTS

I would like to acknowledge people who have helped make this work possible. I am grateful to all of my committee members for agreeing to serve, consult, guide, and encourage all parts of the research process. I have been pushed to create a dissertation that is better than what I thought I could have achieved on my own and I thank you. I would like to thank Dr. Maria Aysa-Lastra for all of her hard work and dedication in helping me succeed at Florida International University. Dr. Steven Kurtz deserves a special acknowledgement for encouragement, opportunities, and assistance along the way. I appreciate all of these things very much. My friends and family also deserve special thanks for supporting me along this journey. Without them this work would not have been possible. Lastly, I would like to acknowledge the men who participated in this study and shared part of their lives with me.

This dissertation research was funded by an Early Career Investigator Award from the Center for Applied Research on Substance Use and Health Disparities (ARSH) at Nova Southeastern University.

ABSTRACT OF THE DISSERTATION
SYNDEMIC HEALTH DISPARITIES AND RESILIENCE PROCESSES
RELATED TO HIV TRANSMISSION RISK AMONG AFRICAN
AMERICAN/BLACK MEN IN SOUTH FLORIDA

by

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Florida International University, 2014

Miami, Florida

Professors Dennis Wiedman and Mark Padilla, Co-Major Professors

Rates of HIV infection continue to climb among minority populations and men who have sex with men (MSM), with African American/Black MSM being especially impacted. Numerous studies have found HIV transmission risk to be associated with many health and social disparities resulting from larger environmental and structural forces. Using anthropological and social environment-based theories of resilience that focus on individual agency and larger social and environmental structures, this dissertation employed a mixed methods design to investigate resilience processes among African American/Black MSM.

Quantitative analyses compared African American/Black (N=108) and Caucasian/White (N=250) MSM who participated in a previously conducted randomized controlled trial (RCT) of sexual and substance use risk reduction interventions. At RCT study entry, using past 90 day recall periods, there were

no differences in unprotected sex frequency, however African American/Black MSM reported higher frequencies of days high ($P<0.000$), and drugs and sex used in combination ($P<0.000$), and substance dependence ($P<0.000$) and lower levels of social support ($P<0.024$) compared to Caucasian/White MSM. At 12-month follow-up, multi-level statistical models found that African American/Black MSM reduced their frequencies of days high and unprotected sex at greater rates than Caucasian/White MSM ($P<0.001$).

Qualitative data collected among a sub-sample of African American/Black MSM from the RCT ($N=21$) described the men's experiences of living with multiple health and social disparities and the importance of RCT study assessments in facilitating reductions in risk behaviors. A cross-case analysis showed different resilience processes undertaken by men who experienced low socioeconomic status, little family support, and homophobia ($N=16$) compared to those who did not ($N=5$).

The dissertation concludes that resilience processes to HIV transmission risk and related health and social disparities among African American/Black MSM varies and are dependent on specific social environmental factors, including social relationships, structural homophobia, and access to social, economic, and cultural capital. Men define for themselves what it means to be resilient within their social environment. These conclusions suggest that both individual and structural-level resilience-based HIV prevention interventions are needed.

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CHAPTER 1

INTRODUCTION

*Most Black guys, we want better. It's that drive that's
in us that we always want better.*

-36 year old African American from Miami

The desire for a better life, for better things, for better situations speaks to the vulnerable nature of many African American/Black men who have sex with men (MSM) in the Miami-Ft. Lauderdale, Florida metropolitan area. While not indicative of the whole population, many of these men experience a range of risks on daily basis, including discrimination determined by race, class, or sexual behavior, and high levels of substance use, violence, and poverty. Moreover, metropolitan Miami reports the highest HIV and AIDS incidence rates in the U.S. (Centers for Disease Control and Prevention 2009) and almost half (45%) of HIV-positive MSM in a recent Miami study were unaware of their infection (Centers for Disease Control and Prevention 2010a).

The desire for something better is one that is not always achievable given the realities of structural inequality, health disparities, and lack of access to necessary resources. However, many African American/Black MSM are coping with these risks and overcoming the barriers they face. In a word, these men are resilient. The research presented here illustrates the need to address these barriers in order to assist African American/Black MSM in achieving better

outcomes. However, as MSM, they are particularly at increased risk for HIV infection, thus this challenge is great.

Over 30 years after the first case of HIV was identified in the United States, the numbers of infected individuals continues to grow. According to the Centers for Disease Control and Prevention, men who have sex with men MSM comprise the majority of all new HIV infections in the United States (Centers for Disease Control and Prevention 2012). In addition, MSM are much more likely to experience additional health disparities not faced by men who only have sex with women, including high rates of depression, victimization, and greater rates of substance use (Stall, Friedman, and Catania 2008). Further, these disparities are often syndemic, or interconnected, acting synergistically, contributing to an excess burden of disease (Millstein 2002; Singer 2009).

The syndemic paradigm has been used for nearly 10 years to frame research on HIV and related health and social disparities; however recent literature has called for the application of resilience theory to guide such investigations of HIV transmission risk and related syndemic health and social disparities among MSM (Herrick et al. 2011). Despite syndemic health disparities, most MSM exhibit resilience (Stall et al. 2008). This is evidenced in the areas of smoking cessation and recovery (Greenwood et al. 2005), avoiding recreational drug use or addiction despite its prevalence in urban MSM communities (Mills et al. 2004; Stall et al. 2001), and participation in the gay rights movement over the past 40 years (Herrick et al. 2011). Taken together,

this research would appear to indicate an inclination for behavioral resilience among MSM with regard to health, yet, no apparent studies in the field of public health have examined the processes by which MSM are able to enact resilience to health disparities, especially HIV transmission risk (Stall et al. 2008).

The current study will examine syndemic and structural inequalities experienced by African American/Black MSM, changes in syndemic risk over time, and resilience processes used by African American/Black MSM to cope with and overcome health and social disparities. Research from the public health literature examining MSM and syndemic health disparities associated with HIV transmission risk using resilience theory is not apparent, though it has been theorized (Herrick et al. 2014). A resilience framework seeks to understand the assets and resources individuals use to cope with and manage their histories of syndemic problems (Stall et al. 2008). Thus the proposed research will advance the understanding of syndemic and social/behavioral resilience processes, while also informing public health policy and practice. Further, this research responds to the field's interest in understanding resilience processes among MSM from an applied perspective as critical to reducing health disparities in this population (Herrick et al. 2011).

Specifically, I will ask: (1) What structural and syndemic health disparities and/or protective factors were present among African American/Black MSM upon entry into the Project ROOM study intervention trial?, (2) How did the presence or magnitude of syndemic health disparities change during the 12 month follow-up period following the Project ROOM study intervention participation, and what

resilience processes occurred during that time to effect change?, and (3) How did the presence or absence of individual agency and social environment resources affect the resilience processes for African American MSM in overcoming HIV transmission risk and related syndemic health disparities? A mixed methods approach will be used to explore these questions.

Using a large survey data set of 515 substance-using MSM living in South Florida, the present dissertation will investigate the presence of syndemic health disparities, including substance use, HIV transmission risk, mental distress and victimization, structural inequality, and social environment. These findings will compare African American/Black MSM to White MSM to understand the extent to which Black men experience greater or different risks. Next, longitudinal survey data will be paired with in-depth qualitative interviews with a sub-sample of African American/Black MSM study participants in order to acquire an understanding of what resilience processes are expressed by these men.

The data presented will illustrate the ways in which MSM with elevated syndemic health disparities undertake resilience processes as a means of mitigating or overcoming syndemic risk and associated health and social problems. These analyses will highlight similarities and differences in the specific techniques adopted by these men. Importantly, research on resilience will be expanded by incorporating minority voices, in this case African American/Black MSM, into the prevailing literature's focus on white, middle-class populations, which will lead to the identification of new approaches to intervention. (Liebenberg and Ungar 2009).

Organization of Chapters

The organization of the chapters is as follows. Chapter 2 describes the theoretical overview of the dissertation, which includes a full discussion of resilience theory and the development of the syndemic concept within the field of critical medical anthropology. This chapter concludes with a discussion of the application of these theoretical frameworks to the present study.

Chapter 3 presents a full discussion of the research methods and analytic processes. Data from the intervention trial, Project ROOM study, from which the quantitative data were obtained, are described here. Further, this chapter describes the development of the qualitative portion of this study including the sample design, analyses, and human subjects protections.

The presentation of main findings from this dissertation is found in Chapters 4, 5, and 6. In order to facilitate dissemination and publication of the key findings, each of these chapters are formatted similar to those used by peer-reviewed journals. Thus, Chapters 4, 5, and 6 begin with a review of literature pertinent to the data presented, a brief recap of the methods and analytic procedures, the presentation of the results, and a discussion of the key findings.

Chapter 4 begins the description of syndemic health disparities, structural inequality and the social environment among African American MSM. This chapter highlights ways in which all of these concepts are related. Next, Chapter 4 presents the results of the quantitative data, followed by the results of the

qualitative data. Based on the quantitative and qualitative findings, Chapter 4 ends with a discussion of the lived experiences of men to address research question number one.

Chapter 5 builds on the discussion from Chapter 4 and addresses research question number two. First, the survey data will be used to examine behavioral changes that took place over a 12 month period for these men. Next, Chapter 5 presents findings from the qualitative data to explain why these changes occurred.

The final research question is addressed in Chapter 6. This chapter uses only qualitative data to examine what and how resilience processes are used by African American MSM and the ways in which resilience is related to agency and structure. Finally, this chapter describes the strengths of this present study, compared to previous research.

Chapter 7 is the final chapter. It summarizes the results of the dissertation, study limitations, and contributions. In addition, this chapter presents recommendations for future research and developing interventions to reduce HIV transmission risk among African American MSM.

CHAPTER 2

THEORETICAL FRAMEWORKS: RESILIENCE, SYNDEMICS, AND MEN WHO HAVE SEX WITH MEN

Introduction

In recent years, the concept of resilience has received much attention with regard to health and well-being, especially among researchers studying HIV transmission risk among highly vulnerable populations such as MSM (Herrick, et al. 2011; Herrick, et al. 2014; Kubicek, et al. 2013; Kurtz, et al. 2012). With its roots in the field of psychology, resilience theory and research have grown and evolved over the past 40 years. Though much current literature continues to use individual-level, psychological-based conceptions of resilience, a small, but growing body of literature has begun to incorporate an anthropological perspective into investigations of resilience and health. This chapter presents a brief background of the growth of resilience theory from psychology to its recent fusion with anthropology. Particular attention will be given to the concepts of navigation, negotiation, and hidden resilience developed by Ungar and colleagues (Harvey 2012; Liebenberg and Ungar 2009; Ungar 2008; Ungar 2011). Next, a brief overview of medical anthropology and the contributions of critical medical anthropology in particular will be described. Important concepts of structural violence and the syndemic framework are explored in detail. The chapter ends with a discussion of syndemic health disparities among MSM in

South Florida and the contribution resilience theory makes in investigating causes of syndemic health disparities and solutions for addressing them.

Evolution of Resilience Theory

Since resilience research and theory were developed by Norman Garmezy during the early 1970s the definition of resilience has evolved with continued study. Through his work with children and adolescents, Garmezy came to understand resilience as the capacity to recover and maintain adaptive behaviors after insult (Ahern 2006). This was a direct move away from research that, up until that time, had focused on the vulnerability, or the pathology of risk, poverty, and traumatic stress (Condly 2006). This new research focused on young people who demonstrated positive outcomes despite the presence of poverty or parental mental illness (Garmezy 1973; Garmezy and Streitman 1974).

First Wave of Research

This early work belongs to the first wave of research, which employed a positivist realism approach and understood that resilience may not be knowable via sensory experience, but it can be approximated through indirect measurement (Alcoff 2010; Kolar 2011). Thus research was focused on the assessment of measurable factors associated with resilience (Kolar, 2011) such as competence (Garmezy et al. 1984) and temperament (Anthony 1987). The ultimate objective was to identify the relationships and markers of positive

adaptation among young people who would otherwise be expected to struggle because of genetic or environmental risk (Masten and Obradovic 2006).

Garnezy's concept of resilience came to be refined by his colleagues, who state that "resilience refers to patterns of positive adaptation in the context of significant risk or adversity" (Masten and Powell 2003:4). A key point underlying this definition is that resilience is not a trait of an individual; rather individuals manifest resilience through behaviors or life patterns (Masten and Powell 2003). Such manifestations are part of what Masten (2001) calls *ordinary magic*, or the idea that individuals are capable of astonishing resistance, recovery, coping, and success when faced with adversity, yet equipped with only the usual human adaptational capabilities and resources.

This understanding of resilience is based on two fundamental judgments: 1) there is a current or previous significant risk or adversity to overcome and 2) a person is "doing okay" (Masten and Coatsworth 1998). This second judgment has proved problematic. Though some researchers continue to use this theoretical model of resilience, the criteria by which "doing okay" is measured have varied widely (Masten and Powell 2003). In the initial studies conducted by Garnezy and his colleagues, "doing okay" was assessed as competence in developmental tasks (Garnezy et al. 1984), but it has also been understood to mean the absence of mental health problems (Masten 2001).

Recently, debate has emerged about how to measure good adaptation or adjustment, who should determine these criteria, or how to aggregate findings when different criteria are used (Luthar et al. 2000; Masten 2001; Rutter 2000).

Kolar (2011) states that published research often does not include discussions on the reasoning behind specific approaches to resilience, and that the various benchmarks of positive adaptation, exceptional adaptation, or even negative adaptation appear to be arbitrary or vague. Judgments about what constitutes positive or negative outcomes lead to a conceptualization of resilience that is full of subjective assumptions (Glantz and Sloboda 1999). Moreover it has been proposed that positive adaptation is frequently constructed from White, middle-class values (Ungar, 2004). This leads some researchers to call for broadening the study of resilience from children and adolescents to diverse populations, including adults and minorities outside of the mainstream (Liebenberg and Ungar 2009).

Second Wave of Research

Such concern has led to a re-thinking of resilience using a constructivist-interpretivist approach in which the concept of resilience is dependent upon individual contexts of meanings, beliefs, values, practices, and so forth (Kolar 2011; Schwandt 2000). This second wave of research focuses on uncovering the mechanisms and processes that account for the various assets or protective factors that individuals possess (Kolar 2011). A process-based approach is seen as an improvement over measuring personal characteristics as outcomes because it avoids the implication that individuals should be blamed for their lack of resilient characteristics (Teram and Ungar 2009).

The process based approach in resilience literature has been accompanied by a gradual shifting of the focus toward individual agency.

Anthropologists Obrist (2006) and Obrist et al. (2010) employ this analytic strategy. They continue the move away from the study of vulnerability by incorporating concepts of agency and resilience. Obrist (2006), whose research focuses on women's health in an urban environment in Tanzania, examines the ways that individual agency is utilized to sustain and restore health. Taken a step further, Obrist et al. (2010) offer a theoretical framework for studying the mitigation of health risks. Connected to the practice theory of Bourdieu (1977; 1990) and Ortner (1984; 1996), the authors suggest that social scientists should investigate individuals' capacities to react to and cope with adverse conditions and be proactive in creating options that increase competence and overcome adversity. Put simply, Obrist et al. (2010) are advocating the anthropological study of resilience.

More recent literature proposes advancing the idea that resilience is a quality of an individual's social environment (Liebenberg and Ungar 2009).

Ungar (2008:225) offers this social ecological definition of resilience:

In the context of exposure to significant adversity, resilience is both the capacity of individuals to *navigate* their way to the psychological, social, cultural, and physical resources that sustain their well-being and their capacity individually and collectively to *negotiate* for these resources to be provided and experienced in culturally meaningful ways.

Resilience as a Combination of Process and Outcomes

In his definition, Ungar (2008; 2010; 2011; Liebenberg and Ungar 2009) has sought to intentionally link resilience to culture by theorizing that resilience is not a universal state or a trait of individuals. Instead it is dependent on the

culture in which the individual is embedded and the capacity of that culture, and associated structures, to make resources not only available and accessible, but to do so in culturally meaningful ways. This definition blends early theoretical notions of resilience that focused on outcomes of individual agency along with assets, and resources (navigation), with the second wave of research focused on context and meaning individuals and groups ascribe to the resources that are available and accessible (negotiation). This approach is equivalent to the one advocated by Obrist et al.'s (2010) focus on the relationship between individual agency and its relationship with the social environment. Further, Ungar's concepts of navigation and negotiation are analogous to the role of strategy, individual intention, and action that were the focus of much of the processual and practice theories that came before. As individual agency has come to play a larger role in the resilience literature, researchers like Ungar have moved the concept of resilience past Masten's (2001) notion of "ordinary magic" in order to incorporate an understanding of outcomes with a broader focus on processes in complex environments and culturally diverse communities (Liebenberg and Ungar, 2009).

Understanding resilience in this way, Ungar and colleagues advocate a combination of process- and outcome-based approaches (Glantz and Sloboda 1999; Liebenberg and Ungar 2009; Ungar 2008). Research using an outcome-based approach may identify markers of resilience that can be used to recognize the processes involved in generating resilience. At the same time, interactive understandings produced by process-based approaches can be used to inform

and guide outcome based approaches (Kolar 2011). This is best done using back-and-forth movement between qualitative and quantitative methods within the same study (Este et al. 2009; Mertens 2009).

Resilience Factors

The utilization of multiple methods allows researchers to identify and understand resilience across three layers of interaction: individual-level factors (e.g., personality characteristics, talents, skills) social-level factors (e.g., relationships and social support), and societal-level factors (e.g., community and culture) (Condly 2006; Olsson et al. 2003). Researchers have noted that resilience is not a fixed individual trait (Zimmerman and Arunkumar 1994), nor can it be measured simply with dichotomous variables (Condly 2006). Thus, looking across several levels and employing a social ecological approach, researchers are able to see the diverse influences that impact resilience processes (Liebenberg and Ungar 2009).

The influences that impact resilience processes are known as protective factors and risk factors. The concept was first developed by Rutter (1985), who believed that protective factors interacted with risk so as to provide beneficial effects. Garmezy et al. (1984) categorized protective factors into individual attributes, family qualities, and supportive systems outside of the family in order to easily identify resilient attributes of individuals and their contexts. Put simply, a protective factor is a quality or characteristic that relates to positive adaptability (Rutter 2000). Protective factors include assets, or internal individual characteristics such as competence, coping skills, or self-efficacy; they also

include resources that are external to the individual such as social support or community organizations (Fergus and Zimmerman 2005) and the ability of these supports and organizations to adequately supply the necessary resources (Ungar 2010).

While protective factors refer to positive outcomes in the face of adverse circumstances, risk factors are defined as characteristics of an individual or group that predict negative outcomes (Kolar 2011; Wright and Masten 2006). A basic tenet of resilience is that individuals have experienced some risk and have adapted positively by utilizing protective factors in order to mitigate risk (Kolar 2011; Liebenberg and Ungar 2009). While some researchers understand risk factors and protective factors as being opposite ends of the same spectrum (Fergusson and Horwood 2003), this may not always be the case. Low and high levels of risk are not always correlated with positive or negative outcomes (Fergus and Zimmerman 2005). In addition, risk factors are variable and may not be present in all settings, at all times, or in all contexts. External factors and ecological contexts of an individual's experiences all contribute to how they experience risk because individuals may be exposed to multiple risks, may have multiple assets, or multiple resources (Fergus and Zimmerman 2005).

Risk factors do not operate independently. They mutually influence each other and have interactive effects with the environment in which they occur (Fergus and Zimmerman 2005; Kolar 2011). Further, it has been noted that risk factors, often co-occurring with other risk factors, are usually part of a string of

stressful experiences rather than one event, and can often accumulate over time (Garmezy et al. 1984; Olsson et al. 2003).

Critical Medical Anthropology and Health

Medical anthropology is an appropriate discipline from which to study resilience because it is based on the idea that culture affects health and does so through protective and risk factors (Lock and Nichter 2002; Winkelman 2009). This sub-discipline also examines the larger ecological, physical, and social environment to help explain the many factors affecting health. Medical anthropologists incorporating a critical perspective into their work – sometimes referred to as Critical Medical Anthropology (CMA) – investigate how the larger social relations and economic resources affect vulnerability to disease (Winkelman 2009). Thus, critical medical anthropologists study the local social production of illness and poverty as they are located within larger regional, national, or global dynamics of class, colonialism, and capitalism (McElroy and Townsend 2009; Singer 2004).

With the emergence of CMA, came the reconceptualization of several key terms used by medical anthropologists. Singer (2004) notes that health, seen as the possession of complete physical, mental, and social well-being, must be evaluated within a larger socio-cultural context. Further, he states that disease is just as much social in origin as it is biological (Baer et al. 1997). Viewing disease separately from social contexts minimizes the underlying social processes and relationships that also affect health (Baer et al. 1997; Singer 2004).

One key concept of CMA that incorporates social context and health is structural violence. This concept was developed within the liberation theology movement in the 1960s and 1970s in Latin America (Scheper-Hughes 2004). It refers to violence that is permitted or encouraged within a given society and is systematically exerted by individuals in one certain social order toward other groups (Farmer 2004; Scheper-Hughes 2004). Marginalization, exclusion and oppression are reproduced in social relations through dominate discourse, stigma, and ideology (Farmer 2004; Scheper-Hughes 2004). As a result, social inequalities, such as poverty, sickness, hunger, or premature death, are naturalized and seen as part of the natural order of society, separated from larger social or political origins. Thus the blame for such conditions is placed on the most poor or vulnerable (Scheper-Hughes 2004).

Two leading anthropologists that examine structural violence are Nancy Scheper-Hughes and Paul Farmer. Scheper-Hughes' first book, *Saints, Scholars and Schizophrenics: Mental Illness in Rural Ireland* (1979), described mental illness in rural Ireland. Her later work focused on class relations, poverty and inequality during Brazil's economic miracle and the resulting structural violence directed toward children and youth (1984; 1993). Paul Farmer's (1990; 2004) research on social inequality, poverty, and HIV in Haiti also uses a structural violence framework. The HIV and tuberculosis epidemics in Haiti, according to Farmer (2004) are rooted in the nation's experience with colonialism and slavery, and the enduring racism that followed. Regarding structural violence more generally, Farmer states that susceptibility to HIV infection is aggravated by

social factors, including poverty and racism, and a better understanding of these social phenomenon are urgently needed in clinical medicine (Farmer et al. 2006).

One of the primary contributions of the critical approach in medical anthropology is that it confronts power structures, health ideas and practices, and social inequality (Leatherman and Goodman 2011; Sobo 2011). The key mechanism to understand this emerged in the mid-1990s. The concept of “syndemic” is an attempt by critical medical anthropologists understand the “big picture,” of health which includes social, political, and economic conditions that are determinants of poor health (Singer 2004:27).

Origins of the Syndemic Framework

The presence of two or more risk factors in an individual, interacting synergistically, and contributing to an excess burden of disease, is called a syndemic by medical anthropologists and public health practitioners (Millstein 2002). The term syndemic was developed in the 1990s by Merrill Singer in order to call attention to the synergistic nature of health and social problems of the poor and underserved (Singer and Snipes 1992). In addition, he sought to move beyond older conceptions of disease that did not effectively grasp the relationships between epidemic diseases and the socio-environmental context that promotes their interaction (Singer 2009).

The syndemic theoretical perspective, which implies a focus on health disparities and the social conditions that perpetuate them (Mustanski et al. 2007),

is a response to the rise of germ theory in the 1800s. Though controversial at the time, germ theory, which proposes each disease has its own pathogenic cause, is today the cornerstone of modern biomedicine (Singer 2009). The biomedical approach is one that privileges biology over social origins of disease and hinders a larger ecological conception of human illness (Singer 1986). It separates a person with an illness from his or her immediate social context and community and leaves no room for the social, psychological, and behavioral dimensions of illness (Engel 1977). In response, Engel (1977) proposed the biosocial model of disease to address these concerns by incorporating them into investigations of human illness. This approach is still relevant today (Adler 2009). The value of syndemic theory is that it seeks to clarify the impact of biosocial interconnections and relationships (Singer 2009).

Syndemic Theory and Vulnerable Populations

Syndemic theory has been used to study many vulnerable populations including sex workers (Romero-Daza et al. 2003; Silliman and Bhattacharjee 2002), drug users (Romero-Daza et al. 2005; Van Tieu and Koblin, 2009), marginalized workers in the Dominican tourism sector (Padilla et al. 2012), and urban minorities (Senn et al. 2010; Singer 1996). One of the most important contributions to medical anthropology is the conceptualization of the interconnections between three health and social problems: substance abuse, violence, and AIDS (SAVA) (Singer 1996). This was the first syndemic to be labeled as such and it emphasized that all three conditions were interactive

(Singer 2009). From this perspective, Singer (2009) found that drugs, violence, and AIDS, in the inner-city context, are so entwined with and shaped by each other that it is impossible to accurately understand them as distinct problems. Moreover, syndemics are shaped by local social and contextual factors faced by that affected population. Thus there can exist multiple syndemics, each one shaped by local populations, conditions, and relationships (Singer 2009).

Syndemic Theory and MSM

The SAVA syndemic has been the focus of researchers studying health disparities among MSM (Singer 2009). Stall et al. (2003) were the first to apply the syndemic perspective to this group, in which they surveyed 3,000 MSM in four cities and found associations of substance use, violence, childhood abuse, depression, and increased risk for HIV. Evidence suggests that compared to American men who do not have sex with men, MSM suffer from many health disparities, including: greater rates of substance use (Cochran and Mays 2008), HIV infection (Wolitski et al. 2001), victimization (Herek et al. 1999; Herek and Sims 2008; Purcell et al. 2008), and depression (Cochran, et al. 2004; Cochran and Mays, 2008; Mills et al. 2004). Further, this literature documents the interconnections between HIV infection and other health disparities (Hirshfield, et al. 2004; Koblin et al. 2006).

The theory of syndemic production among urban gay men was proposed in order to address these health disparities as socially produced phenomena (Stall et al. 2008). This theory hypothesizes that the syndemic production among

MSM is the result of “socially produced damages associated with early adolescent male socialization among homosexual men” and the many stressors associated with migration to large urban areas (Stall et al. 2008:254). This theory is widely cited in the literature across a variety of MSM populations, including men with mental health problems (Parsons et al. 2011), Latino men (Mizuno et al. 2011), and Black men (Dyer et al. 2012; Egan et al. 2011).

Syndemic Health Disparities among African American/Black MSM

A brief review of the literature on African American/Black MSM demonstrates the presence of health and social disparities related to substance use (Harawa et al. 2008; Mimiaga et al. 2010; Hatfield et al., 2009; Tobin et al. 2011), HIV transmission or infection risk (Millett et al. 2006; Millett et al. 2007; Oster et al. 2011), arrest history (Lim et al. 2011), inadequate coping skills and social support (Kraft et al. 2000; Shoptaw et al. 2009), and social or cultural barriers (Mays et al. 2004; Saleh et al. 2011; Garofalo et al. 2010; Harawa et al. 2008; Haile et al. 2011), among others. Whereas, one apparent article in the literature has addressed these concerns from a syndemic perspective (Dyer et al. 2012) it was unable to address any larger socio-cultural or structural factors that contribute the specific health disparities among this population. While research among racial/ethnic minority MSM should be made a priority (Stall et al. 2008; Dyer et al. 2012), an understanding of racial/ethnic health disparities should involve inquiry beyond individual risk behaviors (Garofalo et al. 2010). Thus, a significant gap in the literature remains that fails to address these larger

structural factors that are a determining factor in the health of African American/Black MSM.

Syndemic Health Disparities among MSM in South Florida

The theory of syndemic production among MSM has also been used to examine health and social disparities of MSM in South Florida (Egan et al., 2011; Kurtz 2008). In accordance with Stall et al.'s (2008) theory, the South Florida (Miami-Ft. Lauderdale Metropolitan Area) is a well-known migration destination for MSM (Egan et al. 2011). The South Florida metropolitan area has the second highest ratio of same-sex households among large urban centers in the nation (Smith and Gates 2001). These men are attracted to South Florida's wealth of nightclubs, bars, and adult entertainment venues (Kurtz 2008). The modern gay culture of South Florida is influenced by the perennial entertainment culture and tropical climate, in which extensive drug and sex markets thrive. (Kurtz 2008).

Accordingly, in a study of seven urban centers in the U.S., young MSM ages 15-22 from Miami reported the highest use of ecstasy, cocaine, and amyl nitrites compared to their peers in other cities (Thiede et al. 2003). Results from the South Beach Health Survey reveal the high prevalence and association of drug and alcohol use and sex risk among MSM in Miami Beach (Darrow et al. 2005; Webster et al. 2005). There is no apparent discussion of African American/Black MSM in Miami, but among Hispanic men in South Florida, research has found rates of club drug use (ecstasy, cocaine, GHB, crystal methamphetamine, amyl nitrites, and Viagra) that are much higher than results

reported by researchers in other cities (Fernandez et al. 2005). A separate study found that 41% of a sample of 566 Hispanic MSM from South Florida had used club drugs in the past 6 months and nearly a third had never tested for HIV (Akin et al. 2008).

These findings are of particular concern in South Florida because Miami reports the highest HIV and AIDS incidence rates in the U.S. (Centers for Disease Control and Prevention 2009) and almost half (45%) of HIV-positive MSM in a recent Miami study were unaware of their infection (Centers for Disease Control and Prevention 2010a). Syndemic health disparities, such as substance use and sexual risk behavior, are especially significant for MSM who choose to migrate to South Florida. Evidence suggests that almost one third of uninfected MSM who migrate to South Florida become HIV-positive within 5 years (Egan et al. 2011). In spite of the severity of these health and social problems, research focused on intervention to reduce syndemic risk does suggest that resilience outcomes, such as the adoption of HIV testing for men at high risk, are achievable, though the processes leading to these outcomes has not been examined (Herrick et al. 2011).

Conclusion: Application of Resilience Theory to Syndemic Health Disparities among African American/Black Men Who Have Sex with Men

Syndemic health disparities among MSM, including MSM in South Florida are well documented. Research utilizing such a perspective, could uncover political, economic, and other social structures that influence health disparities among this population, however most research to date has primarily examined

individual-level problems. Resilience theory, especially Ungar's (2008) conceptualization of resilience, which focuses on individual agency and social ecology, would contribute to this understanding in that it would investigate how African American/Black MSM in South Florida express agency to successfully cope with such disparities within given social structures. It has been suggested by Ungar (2004) that gang involvement or substance use can actually be examples of hidden resilience for young people who wish to gain a sense of control or find supportive environments. Thus, the expression of culturally bounded hidden resilience among American/Black MSM may also be revealed using such an approach.

A mixed methods approach, including both quantitative and qualitative methods, is useful for the study of resilience (Liebenberg and Ungar 2009). As is outlined in the following chapter, both methods are used to answer the research questions presented in this dissertation.

CHAPTER 3

STUDY DESIGN AND METHODOLOGY

Introduction

Using frameworks of resilience theory and syndemic health disparities, the present study examines the processes by which MSM participating in a longitudinal study have overcome many of the syndemic health disparities prevalent in this population. This part of the research, referred to as Phase 1, developed over the past two years during my tenure as a research associate for the Project ROOM study, a two-armed randomized clinical trial testing the efficacy of a small group intervention compared to a single session counseling condition. In that role I recruited participants, collected survey data, and conducted counseling sessions.

Phase 2 consists of individual in-depth qualitative interviews with a subsample of African American/Black MSM who completed the Project ROOM study. The aim of Phase 2 is to fill in the gap of understanding how men utilize resilience in order to cope with and overcome the syndemic health disparities related to HIV transmission risk they face. This is a key research question in the field of MSM health that has only been theorized and not empirically answered (Herrick et al. 2014).

Phase 1: Quantitative Examination of Syndemic Health Disparities, Structural Inequality, Social Environment, and Changes over Time

The Project ROOM Study

Data used in analysis during Phase 1 were collected as part of the Project ROOM study, which tested the efficacy of a novel small group sexual and substance use risk reduction intervention compared to an enhanced efficacious HIV risk-reduction counseling condition targeting high risk not-in-treatment MSM substance users in Miami-Ft. Lauderdale, Florida. The study has been fully described elsewhere (Kurtz et al. 2013a). Briefly, the study was funded by the National Institute on Drug Abuse and conducted at Nova Southeastern University's Center for Applied Research in Substance Use and Health Disparities (ARSH). In total, 515 participants were recruited between November 2008 and October 2010. Follow-up interviews were completed in December 2011. Analyses presented here were performed using a subsample of 108 African American/Black and 250 Caucasian/White men

Eligible men participating in the study were between the ages of 18 and 55 and met one or more of three substance use inclusion criteria: (1) binge drinking (5 or more drinks) at least three times in the past month; (2) drug use, excluding marijuana, at least three times in the past month; or (3) using marijuana on 20 or more days in the past month; resided in South Florida and intended to remain there through the term of study participation; and provided a mailing address and personal telephone number.

In addition, eligible men also reported recent (past 90 days) unprotected sexual intercourse with a non-monogamous partner(s). Thus, any male could be included in the study, regardless of sexual orientation or gender identity, as long as the eligibility criteria were met. This resulted in a sample that is comprised solely of men who reported having sex with other men or MSM. The use of the term was adopted during the emergence of the AIDS era in order to capture the diversity among men who engage in homosexual sex regardless of sexual orientation or gender identity (Singer 2009).

Men were ineligible if they were newly diagnosed with HIV infection in the prior six months (including tests at study enrollment) or if they participated in an HIV or substance use prevention intervention or substance abuse treatment program in the prior 12 months.

The Project ROOM Study Sampling

Targeting sampling strategies (Watters and Biernacki 1989) were used to recruit men into the study who reported substance use and HIV transmission risk behaviors. As a first step, residential concentrations of MSM, together with social and commercial outlets frequented by them, were mapped to include the full diversity of the population. Multiple recruitment methods were employed, including direct outreach, respondent referral, and internet and print media. The multiple recruitment procedures resulted in a sample of respondents of a wide age range and broadly inclusive of the racial/ethnic makeup of South Florida.

The Project ROOM Study Location

Although initially centered in the South Beach district of Miami, the gay subculture in South Florida has dispersed more widely throughout the urban area over the last decade. Residential concentrations of MSM, gay social venues, drug copping areas, and male commercial sex solicitation strips are located in several Miami-area neighborhoods, as well as in neighboring downtown Ft. Lauderdale and its adjacent suburb of Wilton Manors. The study was conducted at two field offices, one in Wilton Manors (a suburb of Ft. Lauderdale) and one in Miami Beach. The offices were located in standard business office buildings; the Wilton Manors office building was located on the site of a community based organization. Both of these neighborhoods serve as the dominant residential, gathering and recreational centers for MSM in South Florida, are located in adjoining counties, and are situated close enough to each other that there is substantial movement by MSM between the two neighborhoods.

The Project ROOM Study Procedures

Men responding to recruitment messages called the nearest field office and were screened to determine eligibility over the telephone. Those who were eligible and expressed interest in participating were asked to visit the field office, where staff members rescreened for eligibility and administered informed consent using procedures approved by the University of Delaware's Institutional Review Board (predecessor institution for the project). Following consent, locator data were collected, men reporting HIV-negative serostatus were offered

confidential testing, and all enrollees were scheduled for a second appointment for baseline assessment. Enrollees were paid a \$20 stipend for their time and travel expenses.

At the second appointment, all respondents completed a standardized baseline assessment based on the Global Appraisal of Individual Needs (GAIN, v. 5.4; Dennis 2006; see Appendix A). Private offices were used for all assessments using computer-assisted face-to-face interviewing procedures. These interviews lasted approximately an hour and a half. Following completion of the baseline assessment, participants were randomized to the small group or control intervention conditions using a computer-generated random number table. In order to make sure that the experimental intervention small groups (N=5 to 10) could be formed within a short period of time after participants' baseline assessments were completed, randomization proceeded in blocks of 20. Field office staff and participants were blinded to randomization until immediately after the baseline interview. Participants were aware that some were assigned to a small group discussion condition and others to an individual counseling format. Follow-up interviews at 3, 6, and 12 months after intervention completion (one week for the control arm and 5 weeks for the experimental arm) included the same items as the baseline instrument, exclusive of life history items, and lasted about one hour. Participants were offered HIV education literature, condoms, and a \$50 stipend upon completing each assessment.

The Project ROOM Study Measures

Demographics

Demographic measures include age and county of residence for participants at the time of study enrollment. This variable was categorized as either Miami-Dade County or Broward County residence.

Syndemic Health Disparities

Substance use measures included past 90 day frequency of use of each substance, including the non-medical use of prescription medications.

Participants were also asked to use a calendar to calculate the number of days they were either drunk or high all or most of the day during the past 90 days. In addition, for each substance used during the past 90 days, participants were asked how many times that substance was used within two hours before or during sex. The total number of times for each substance was summed and is reported as the frequency that drugs and sex were used in combination.

An extensive battery of sexual behavior questions specific to MSM included counts of past 90 day sexual intercourse partners and unprotected sex frequency. Additional questions asked if, during the past 90 days, a respondent had “used money or drugs to purchase or get sex” and whether he had “traded sex to get drugs, gifts, or money.” Participants also reported if they had had sexual intercourse with women during the past year. HIV transmission risk frequency was calculated by summing the number of times a participant reported any unprotected intercourse during the past 90 days.

Additional syndemic measures, taken from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) include mental distress and substance dependence. The General Mental Distress Scale (GMDS) is comprised of past year DSM-IV symptom counts for depression (9 items), anxiety (12 items), and somatic disorders (4 items). This scale is reducible to classifications indicating clinical significance (subclinical, moderate and severe) (Dennis 2006) and was further dichotomized in the analyses presented here into “severe” and “not severe.” Substance dependence was assessed by the endorsement of three or more of seven DSM-IV criteria in the past year (e.g., needing more drug to get the same effect, experiencing withdrawal symptoms, being unable to quit or cut down). Lastly, victimization was assessed by affirmative responses to the following events: being attacked with a weapon or being beaten so as to cause bruises, cuts or broken bones (physical abuse); being forced to participate in sexual acts against one’s will (sexual abuse); or being made to feel very bad about oneself or one’s life (emotional abuse). For analysis, responses were summed and dichotomized: any lifetime abuse vs. no abuse.

Structural Inequality Indicators

Structural inequality indicators were chosen to reflect larger political and/or economic structures that produce racism, classism, or homophobia. Participants were asked to report the last year completed in school, full-time employment, and homelessness in the past year. Arrest history was assessed by the question, “In your lifetime, about how many times have you been arrested, charged with a crime, and booked?” This measure was dichotomized here into: any lifetime

arrests versus no arrests. Gay identity was assessed by asking participants, “What do you consider your sexual identity to be?” Responses were dichotomized as gay identifying versus not gay identifying. Health care coverage was assessed by asking clients if their medical expenses were covered by any type of insurance, court, or health program.

Physical health was assessed as a measure of individual experience of health disparity. Participants were asked participants, “In the past 12 months, would you say your physical health in general was...?” In these analyses the responses were dichotomized such that 1 = “excellent, very good, or good” and 0 = “fair or poor.” Needing help with physical health was assessed by asking participants, “How soon, if at all, do you need help or more help with your current physical health?” In these analyses the responses were dichotomized such that “right away,” “in the next three months,” and “more than three months from now” indicate being in need of help versus “getting the help I need already” and “do not need any help,” which indicate no need for help. Participant HIV status was assessed by self-report, and seropositivity was verified with a notice of diagnosis or ARV prescription. HIV-positive participants were asked “Are you currently receiving medical care and/or counseling for your HIV infection?”

Social Environment

Given the importance of diverse and supportive social networks to the concept of resilience, (Dolan 2011) *the Social Engagement Scale* assessed, by past 90 day event counts, respondents’ participation in a variety of social settings (e.g., classes, volunteering, public and/or organizational meetings, getting

together with friends and relatives, sports). The mean value was 51 total social engagement events in the past 90 days, with a range of 0 to 160.

The measures for the number of people available for help and support and the level of satisfaction with that support, were based upon the design of the Social Support Questionnaire (Sarason 1983), using questions specifically adapted for this population. Thus, social support was measured with a five-item inventory in which respondents listed from 0-9 people who would offer help or support for each item (e.g., “Whom can you really count on to let you live with them if you lost your housing?”; “Whom can you really count on to help you if you had a health crisis?”). Participants were then asked to rate their level of satisfaction with the overall support available to them for each item on a 6-point scale ranging from “very dissatisfied” to “very satisfied.” The people listed for all questions were summed to generate the inventory of the total number of people offering support, ranging from 0-45. Similarly, the responses to participant satisfaction with social support were aggregated to generate the total level of satisfaction (ranging from 0-25).

The availability and use of emotional support from others was assessed by asking participants to rate their recent coping behavior when under stress by responding to this statement, “I have been getting help and emotional support from other people,” using a four-point scale from “I’ve been doing this a lot” to “I haven’t been doing this at all.” In these analyses the responses were dichotomized such that “a lot / moderately” indicates getting emotional support and “a little / not at all” indicates not. As an indicator of satisfaction with current

living situation, participants were asked if they were either satisfied or not with where they are living.

Phase 1 Analyses

Analyses of baseline data from the Project ROOM study are presented in Chapter 4 and were conducted using IBM SPSS Statistics version 21.

Descriptive statistics were calculated for the variables of interest described above. Initial exploratory analyses revealed that African American/Black MSM were more likely to experience greater health and social disparities than other men from the study. Thus, Chapter 4 presents a comparison between African American/Black MSM and their White counterparts. To create these comparisons, significance tests of differences between African American/Black men and White men were calculated in one of two ways.

In the first, *F*-tests were calculated with analysis of variance (ANOVA) models in order to test the hypothesis that there are differences between the means of African American/Black MSM and Caucasian/White MSM among the variables of interest (Moore and McCabe 2006). Examples of variables analyzed in this way include number of sexual partners and unprotected sex frequency. In the second method, Pearson's chi-square tests of independence were conducted in order to assess whether observations between African American/Black MSM and Caucasian/White MSM are independent of each other (Moore and McCabe 2006). Examples of variables analyzed in this way include categorical variables of substance dependence and severe mental distress. The level of significance, $P \leq 0.05$, was set for all tests.

Chapter 5 presents outcome measures of African American/Black MSM from the Project ROOM study using many of the same variables of interest calculated from baseline data in Chapter 4. Because the outcome measures had positively skewed distributions, log transformations of these measures were used for the longitudinal analyses. The transformations not only reduced the rightward skew of the data, but they also reduced the effect of right side outliers.

Outcome data were analyzed in two ways. In the first, change over time in outcome measures was analyzed using multilevel non-linear growth models (MLMs). Though there are several techniques for measuring change over time, MLMs were chosen for these analyses because they allow for all cases to be used across multiple waves of data, even if there are missing data points. Further, MLMs allow for the inclusion of interaction with time to test whether a predictor's effect varies over time (Raudenbush and Bryk 2002).

During analysis, each MLM was constructed for measures repeated across all waves of data (baseline and follow-up assessments after 3, 6, and 12 months). These models take all available measurement points into account, and quantify the slope and shape of the behavior change curves from baseline to 12 month follow-up. The models controlled for African American/Black race/ethnicity and for HIV serostatus.

The second method of outcome data analysis was the creation of a summary of outcome results by race/ethnicity, including Cohen's *d* effect size statistics and related 95% confidence intervals, is also presented in Chapter 5. An effect size is a measure of the strength of a phenomenon and is a good

indicator of the change in an outcome after experimental intervention (Kelley and Preacher 2012). For ease of interpretation, means and standard deviations are reported for the raw data and effect sizes and confidence intervals are reported for the log-transformed measures. Generally Cohen's *d* effect sizes of 0.2 to 0.3 may be considered "small," while an effect size of around 0.5 is "medium," and 0.8 and larger is "large" (Cohen 1988). The level of significance, $P \leq 0.05$, was set for all tests.

Phase 2: Qualitative Examination of Resilience Processes

Phase 2 of this research consists of qualitative interviews among African American/Black MSM who completed the Project ROOM study. These interviews fulfilled two aims. First, they contextualized the quantitative findings in Chapters 4 and 5, and second, they were used to examine resilience processes, including aspects of agency and structure. Results from the latter are reported in Chapter 6.

Phase 2 Sampling

For the qualitative phase of the study, a quota sampling technique was used in which respondents were drawn from the survey research. A subsample of 21 African American/Black participants in the intervention trial was selected based on the extent of sexual risk behavior change and completed the qualitative interview. During the research design process, the notion of sampling based on behavior change was developed in order to allow for comparison of resilience processes among African American/Black MSM who did and did not experience

a reduction in HIV transmission risk between baseline and 12 month follow-up interviews as part of the Project ROOM study. The qualitative interview sample consists of 5 men who did report HIV transmission risk at 12 month follow-up and 16 men who did not.

All respondents were drawn from among men who completed the Project ROOM study. Permission was granted by the Principal Investigator, Dr. Steven Kurtz, to contact the men. As part of the consent process for the Project ROOM study, all men agreed to provide contact information and be contacted about participating in future research studies. As a result, men were contacted via telephone and/or e-mail and asked if they were interested in participating Phase 2 of this current study. If so, men were given an explanation of the nature of the study, including risks and benefits, and were given an appointment for a day and time to complete the qualitative interview. Before the interview occurred, informed consent was obtained from all participants.

Phase 2 Location

All qualitative interviews took place in ARSH offices. A total of four interviews took place on the telephone and the remainder occurred in person. All interviews were private and took place in a closed room. Conducting the interviews in the ARSH office assisted in making the respondents feel comfortable, as they were used to the study environment.

Phase 2 Procedures

Interviews conducted during Phase 2 took place during May through August 2013. A semi-structured interview protocol was used for the interviews, in which an interview guide (see Appendix B) was followed to ensure that all necessary topics were covered during the interview. Semi-structured interviewing allows for some flexibility so that respondents are provided the space to express themselves in their own terms and at their own pace (Bernard 2011). Using this flexibility, the interviews were conversational in style with topics from the interview guide being discussed as they naturally occurred during the conversation, rather than maintaining a fixed interview format.

All qualitative interviews were digitally audio-recorded. During the data collection process, a data accounting log was used to track all collected data. A contact summary form collected basic information about each participant, in addition to describing and summarizing the most salient themes discussed during each interview (Miles, Huberman, and Saldaña 2014). Transcribed interviews were entered into the ATLAS.ti computer assisted qualitative analysis software package for data management, coding, and analysis.

Phase 2 Analyses

A grounded theory framework guided the data analysis (Glaser and Strauss 1967). In this method, each interview produces key concepts which are later linked together and analyzed in order to form formal theories (Bernard 2011). Using the suggestions of Miles and Huberman (1994), a limited number

of codes were created to begin the coding process based on the literatures on syndemics and resilience. These included theoretically derived codes such as “social support,” religious affiliation,” and “substance use.” However, the vast majority of the coding process was inductive and grounded in participants’ voices, following the traditional approach advocated by Glaser and Strauss (1967).

Upon completion and transcription of each interview, preliminary codes were created using descriptive and in vivo coding. While descriptive codes use words or short phrases to summarize passages of data, in vivo codes use actual language from participants to name concepts and themes (Saldaña 2013). In addition, extensive analytic memos were written after each participant was interviewed and after each interview was coded. Analytic memos were also written throughout the coding process to reflect on code choices, emergent themes and patterns, and conceptual models. Following the last participant interview, all transcribed interviews were coded for a second time to ensure that all coding was consistent throughout the dataset.

Data collection was a cyclical process in which codes and memos were used to guide subsequent interviews, coding, and memo writing, as advocated by Saldaña (2013) and Glaser and Strauss (1967). For example, during the third interview, in accordance with the semi-structured interview guide (see Appendix B), a respondent was asked to describe his life history and his background. In his description, the young man mentioned several times that he had many significant experiences that were unlike those of his peers growing up, such as

having close family friends from other countries. The semi-structured interview guide did not include a question or probe specifically related to diverse experiences such as his. Yet, memos written post-interview and during the coding process facilitated the development of diversity as a theme. Subsequent interviews included probes about diversity across many areas of a respondent's social environment. As a result, these subsequent interviews, in which diversity was described, informed the coding process and encouraged the creation of more detailed codes for different types of diversity, such as diverse experiences or diverse social relationships.

Following this first process, the data were themed (Saldaña 2013). In this process, the final set of codes and their meanings were transformed into longer and more descriptive themes in order to organize recurrent meanings and patterns (Saldaña 2013). For example, after rereading and reflecting on the data and memos, the theme "inner strengths are developed from negative experiences" was created based on existing in vivo codes. Themes emerged that described participants' life experiences, resilience processes, and understandings of African American culture. These themes were particularly useful in data analyses and interpretation for each chapter.

Throughout the analysis process, several methods were used to explore and describe the data. The ATLAS.ti version 7 software contains a function that counts the number of passages of text in which a specific code or coding family was used. The result is a table displaying rows of codes and code families and columns of interview transcripts, with counts of each code per interview

transcript. Important patterns are clearly visible in the table and can aid in the interpretation of the coding process. For example, early in the coding process, the codes, “diversity,” “inner strengths,” and “gay is taboo” were coded nearly twice as frequently as other codes. As a result, these codes were further sub-coded in order to examine specific processes at work in more detail. In addition, the high frequency of these codes during early interviews suggested their importance and these topics were given greater attention in subsequent interviews.

A second method for exploring the data was the creation of matrices to analyze the major variables of interest following each completed interview. As an example, a checklist matrix (Miles et al. 2014) was created to examine religion. For each respondent, the matrix included timing of religious affiliation or spirituality (e.g. early life, adulthood), assessment of religious affiliation or spirituality for each time period (i.e. positive, negative, both, or neither), and for appropriate participants, the benefits of religious affiliation or spirituality (e.g. ability to deal with hardship, stress relief). The completed table provided a way for variables to be more precisely coded and explored for associations with additional variables. Themes such as using religious affiliation or spirituality to cope with substance use were a result of this method of data exploration and assisted in developing the final conceptual model.

Lastly, ATLAS.ti version 7 offers the query and the word cruncher tools, enabling the researcher to see instances of specific words or codes in passages

of text and to visualize the frequency of words across all interview transcripts. As such, they aid in the identification of trends across the data.

The final phase data analysis consisted of creating networks and constructing models of resilience. Using the work of Miles et al. (2014) as a guide, a step-by-step process ensued that included generating a list of antecedent, mediating and outcome variables, building within-case causal networks, and finally, constructing a cross-case causal network. The aim of constructing networks is to map out the most important variables and the relationships among them in order to illustrate the stream of variables leading to a specific outcome (Miles et al. 2014). This analytic approach was advantageous for the present research as it allowed for the construction of a model of resilience based on the direct experiences of participants.

Miles et al. (2014) explain that in causal networks, an antecedent variable is said to lead to one or more mediating variables, which leads to a specific outcome. However, the current research uses a modified version of this method, in which a constellation of antecedent variables (e.g., homophobia, religious affiliation, supportive family) are conceived of as leading to mediating variables that form a constellation of resilience processes (e.g., disclosure of sexual orientation, syndemic experiences, engaging in the Project ROOM study intervention), which lead to the outcome variable, HIV transmission risk. There are three reasons for such a modification. First, it is impossible to determine which variable in the constellation of antecedent variables comes first. Second, it may not even be the case that one variable comes before another. Third, for the

purposes of this research the temporal order of antecedent and mediating variables may not be relevant. For example, in understanding the background characteristics of one particular participant, it may not be possible to know whether societal homophobia, childhood religious affiliation, or familial support, have a chronological order in which the emergence of one variable has direct consequences on another. It is possible, however, to understand how the constellation of these antecedent variables affects the constellation of mediator variables (e.g., disclosure of sexual orientation, syndemic experiences) and ultimately lead to the outcome of HIV transmission risk. This modification is clearly labeled on the final model.

The process of creating causal models used here followed an inductive approach described in Miles et al. (2014). In essence, recurrent behavior and trends in the data and memos were used to generate piecemeal streams and networks for each participant. Such initial networks from each participant were then used to guide the generation of a table of antecedent, mediating, and outcome variables. This table was built late during the data analysis phase and was useful in interpreting themes across individual participants and hypothesizing about what led to the sexual risk outcome. Using these piecemeal streams, variable table, and existing analytic memos, within-case causal networks were constructed for each participant.

The final cross-case causal network is a thematic display and narrative built upon systematic comparison of the within-case networks. Using a technique called pattern matching, patterns replicated across many cases suggest a

common scenario included in the final network. These replicated patterns form streams or similar or identical patterns across cases, which are shown in the causal network display and described in the accompanying causal network narrative.

Key Concepts

Throughout the course of the analyses, both quantitative and qualitative, two key concepts are used that guided this study. The definitions for these key concepts are described and situated within current literature.

African American/Black

Throughout this dissertation “African American/Black” is used to describe men who participated in the research. This is the same term used by the National Institutes of Health and the Centers for Disease Control and Prevention. As a result, it is commonly used among federally-funded scientists in research publications and public health statistics.

MSM

The concept of “men who have sex with men” or MSM is a term borrowed from the HIV prevention literature that is used to describe men on the basis of their behavior. This specific behavior was an eligibility criteria to enroll in the Project ROOM Study. The definition of MSM includes self-identified gay men, bisexual men, men that self-identify as heterosexual but have sex with other men, and men who engage in many sexual practices and identities cross-

culturally. The use of the term was adopted during the emergence of the AIDS era in order to capture the diversity of men who engage in homosexual sex regardless of sexual orientation or gender identity (Singer 2009). It has been noted, that aside from a purely behavioral description, the term MSM had no meaning and does not address the variety of experiences, perceptions, presentation related to sexuality (Sandfort and Dodge 2008).

Still, much public health research examining HIV transmission risk combines behaviorally and self-identified homosexual men under the term MSM, even though a growing body of literature has identified male bisexuality as a psychosocial risk factor for HIV and/or STI infection (Muñoz-Laboy and Dodge 2007). It has been suggested that inadequate knowledge exists regarding the diversity of experiences of same-sex behavior among men, and especially men of color (Sandfort and Dodge 2008), though recent work in this field has sought to address this gap (see Friedman et al. 2014a for a review).

Examinations of diversity in behavioral and self-identified sexual orientation and same-sex behavior are important to the development of targeted HIV prevention interventions (Muñoz-Laboy and Dodge 2007; Sandfort and Dodge 2008). Though this is not focus of the present study, it should be noted that this limitation has been partially addressed in a separate examination of behaviorally bisexual men from the Project ROOM Study, which demonstrated greater and different health disparities among this population compared to men who reported only same-sex behavior (Friedman et al. 2014b).

Disclosure

As is seen in Chapter 6, disclosure of sexual orientation or same-sex behaviors is a key variable in the causal network analysis. The disclosure of sexual orientation or same-sex behaviors has been problematized across several disciplines. Scholars are generally in agreement that disclosure practices vary depending on personal relationships, context, culture, societal expectations, and may even include tacit disclosure in which assumptions are made about one's sexuality without discussing it, such that men are thought to be both "in" and "out" of the closet simultaneously (Carrillo 2002; Decena 2011). Thus there exists a wide range of disclosure practices among MSM.

For the purposes of these analyses, "disclosure is less of an issue" was conceptualized as men who described themselves as being completely open to nearly everyone with regard to their sexuality and their presentation of it. Conversely, "disclosure is more of an issue" was conceptualized as men who were not completely open to everyone with regard to their sexuality and their presentation of it. As a result, "disclosure is more of an issue" includes a broad spectrum of practices in which men are completely, partially, or tacitly hidden in their sexual orientation or same-sex behaviors.

Human Subjects Protections

The Project ROOM study research protocols were approved by the Institutional Review Board (IRB) at both the University of Delaware (predecessor institution) and Nova Southeastern University (NSU). Prior to beginning Phase 2

research, IRB approval was obtained from both NSU and Florida International University. Informed consent was obtained by having a respondent read and receive an explanation of the study, risks, benefits, and confidentiality prior to signing the consent form. Confidentiality of study data was protected under a Certificate of Confidentiality obtained from the National Institutes of Health as part of the Project ROOM study. In addition, respondents were asked not to reveal their name, names of other people or places, or any identifying contact information during the interview. In these instances, such identifying information was stricken from the transcript.

Methodological Limitations

There are some study limitations worth noting. The Project ROOM study used a nonprobability sampling method to recruit respondents from hard to reach populations (Bernard 2011). Although these recruitment procedures resulted in a sample of a wide age range and broadly inclusive of the racial/ethnic makeup of South Florida, the ability to generalize the findings to other MSM is limited by the study eligibility requirements, including regular substance use and recent sex risk. Syndemic characteristics are likely much more prevalent among high risk substance users than among MSM in general.

The focus of Phase 2 of the current study was limited to African American/Black MSM. As it has been noted in Chapter 2, MSM are a particularly vulnerable population with regard to HIV infection, African American/Black men were chosen as the focus for this study because among MSM, they are most at

risk of HIV infection. Perhaps because of the marginality of the population, a majority of African American/Black MSM from the Project ROOM study were unable to be contacted. Thus, only men who had working phone numbers and e-mail addresses were included. Prior to conducting the qualitative analyses, comparisons of African American/Black MSM who participated in Phase 2 and those who did not were conducted. Across the two groups, measures of demographic, substance use, sexual behavior, syndemic conditions, structural violence indicators, and social environment were not significantly different. Given these results, which are presented in Table 7 of Chapter 6, it would appear that Phase 2 respondents are broadly representative of the larger sample of African American/Black men from the Project ROOM study.

Data from both phases of this study are based on self-report. This could potentially lead to the underreporting of socially undesirable variables. However, as a consequence of the high levels of substance use and sexual behavior reported by the men, the underreporting of these or other stigmatized behaviors would appear to be uncommon. Among African American/Black MSM in Phase 2, qualitative data concerning substance use and sexual behavior were reaffirmed the quantitative data provided during the Project ROOM study assessments. The lack of discrepancies between qualitative and quantitative data and the consistency of men's accounts across interviews are indicators of the validity of the data collected.

The analyses of the Phase 2 qualitative data are based on a total of 21 participants. As is seen in Chapter 6, these 21 men are divided in to two distinct streams, where Stream 1 consists of those who reported HIV transmission risk (unprotected sexual intercourse) following completion of the Project ROOM Study (N=16), and Stream 2 consists of those who did not (N=5). A comparison is made between men in each of these streams in order to examine differences in sociocultural and structural factors associated with HIV transmission risk. However, given the few number of cases on which to base the comparison, these results should be viewed as preliminary.

Because of the key concept definitions of MSM and Disclosure, described above, some caution must be given to the analyses of the Phase 2 qualitative data. As a result of the diversity of behavioral or self-identified sexualities and disclosure practices, it is possible that some nuance may have been lost in the creation of these discrete concepts.

Conclusion

This chapter has explained the methods used in collecting and analyzing the data presented in the present dissertation. Phase 1 consists of longitudinal survey research among men participating in the Project ROOM study, and comparing behavioral, syndemic and resilience measures between African American/Black and White men. In Phase 2, qualitative data were collected from a subsample of African American/Black MSM who completed the Project ROOM study. Both phases are used to examine syndemic and structural health

disparities among African American/Black MSM, in addition to resilience processes used by these men to overcome such disparities. All research complied with IRB requirements.

The next chapter presents quantitative data from baseline assessments collected during the Project ROOM study. These data illustrate the multiple health and social risks experienced by African American/Black MSM. Thereafter, qualitative data is presented to contextualize the quantitative findings.

CHAPTER 4

SYNDEMIC HEALTH DISPARITIES AND STRUCTURAL INEQUALITY AMONG AFRICAN AMERICAN/BLACK MSM IN SOUTH FLORIDA

*You know something, when I get high, I'm more likely
to have unprotected sex. It's like one plus one equals
two.*

-36 year old African American from Miami

Introduction

As evidenced by the discussion in this chapter, the syndemic perspective in examining health disparities plays a significant role in explaining the high prevalence of HIV, substance use, violence, and mental health problems among MSM in the United States. Beginning with the work of Merrill Singer, who developed the term, the present chapter builds on the literature review in Chapter 2 and describes in-depth the syndemic perspective and traces its application among MSM. Evidence is presented showing that factors related to structural inequality, in addition to cultural marginalization, institutionalized stigma, and homophobia, in addition to the social environment, contribute to syndemic conditions in this population. Next, syndemic health disparities among the African American/Black MSM population are reviewed. Next, Chapter 4 presents quantitative data from African American/Black and Caucasian/White participants of the Project ROOM study, followed by qualitative data from a sub-sample of

African American/Black participants of the Project ROOM study. Finally, Chapter 4 ends with a discussion of the quantitative and qualitative findings and answers the first research question, “What structural and syndemic health disparities and/or protective factors were present among African American/Black MSM upon entry into the Project ROOM study intervention trial?”

The Concept of Syndemic Health Disparities

The concept of syndemic production of health disparities comes out of a branch of medical anthropology that is focused on viewing health as the possession of complete physical, mental, and social well-being that must be evaluated within a larger socio-cultural context (Singer 2004). Called critical medical anthropology, this approach has as its goal to “engage and extend the broader political economy of health tradition by marrying it to micro-level understandings of on-the-ground behavior in local settings together with the socio-cultural insights of medical anthropology (Singer 2004:25). As a result, disease is understood to be just as much social in origin as it is biological and viewing disease separately from social contexts minimizes the underlying social processes and relationships that also affect health or contribute to health disparities (Baer et al. 1997; Singer 2004).

A syndemic is defined as the presence of two or more risk factors in an individual, interacting synergistically, and contributing to an excess burden of disease (Millstein 2002). Merrill Singer created the term out of the combination of two Greek words, *synergos*, meaning two or more agents working together to produce an effect greater than the sum of both parts, and *demos*, or people

(Singer 2009). The concept is meant to call attention to the synergistic nature of the health and social problems of the poor and underserved (Singer and Snipes 1992). Though framed by critical medical anthropology, the syndemics model is multidisciplinary and requires collaboration across fields such as public health, social sciences, biology, medicine, etc. (Singer 2009).

The first complex interaction of health and social problems to carry the label syndemic was the tripartite health condition of substance abuse, violence and AIDS, called SAVA (Singer 1996). This was novel in that it emphasized the interaction of each health condition leading to enhanced infection, not simply co-infection (Singer 2004; Singer 2009). Singer (2009) found that drugs, violence, and AIDS in the inner-city context are so entwined with and shaped by each other that it is impossible to accurately understand them as distinct problems. Moreover, syndemics are shaped by local social and contextual factors faced by the affected population. Thus there can exist multiple SAVA syndemics, each one shaped by local populations, conditions, and structural relationships (Singer et al. 2011). The most studied SAVA syndemics are found in populations of street drug users (Romero-Daza et al. 2005; Van Tieu and Koblin 2009), commercial sex workers (Romero-Daza et al. 2003; Silliman and Bhattacharjee 2002), urban minorities (Senn et al. 2010; Singer 1996), victims of domestic violence (Duke et al. 2006; Minnes et al. 2008), and MSM (Dyer et al. 2012; Egan et al. 2011; Parson et al. 2012; Safren et al. 2011; Stall et al. 2003).

Syndemic Health Disparities and MSM

The SAVA syndemic has been the focus of researchers studying health disparities among MSM in order to examine the synergism of substance use and sexual risk behaviors (Singer 2009). Research from a study of 3,000 MSM revealed that a sizeable portion of them reported substance use during their last sexual encounter and/or did not use a condom (Stueve 2002). Literature also shows that drug injecting MSM are more likely to be younger and HIV-positive than MSM who do not inject drugs (O'Connell et al. 2004). The meta-analysis of Marshal et al. (2008) demonstrated that adolescents that identify as gay, lesbian, or bisexual reported rates of substance use 190 percent higher than heterosexual counterparts.

Though the recent work mentioned above has focused on the syndemic nature of substance use and sexual behavior risk, Stall et al. (2003) were the first to apply the syndemic perspective to an MSM sample. They surveyed MSM in four cities and found four interconnected psychosocial health conditions in this population - substance use, violence, childhood abuse, and depression - and demonstrated that each was made worse by the presence of any of the other three. Added to this, Stall et al. (2003) found that men who reported higher scores for measures of any of the above mentioned health conditions were at higher risk for HIV transmission and HIV infection. This led the authors to conclude that the *additive interplay* of these psychosocial health problems magnifies the HIV/AIDS epidemic among MSM (Stall et al. 2003:941). The work

by Stall et al. (2003) affirmed the existence of a SAVA syndemic among MSM (Singer 2009). The four syndemic factors contributing to increased HIV risk among MSM have been demonstrated in additional research as well (Dyer et al. 2012; Egan et al. 2011; Friedman et al. 2007; Klein 2011; Kurtz 2008; Kurtz et al. 2012; Mustanski et al. 2007; Parsons et al. 2012; Safren et al. 2011; Solomon et al. 2011; Welles et al. 2011).

Structural Factors Contributing to Syndemic Production of Health Disparities among MSM

While much evidence exists documenting the presence of a SAVA syndemic among MSM, a critical medical anthropology approach understands that the expression of the SAVA syndemic is shaped by social contextual factors, social conditions, and structural relationships present among MSM populations (Singer 2009). From this perspective, the concept of structural violence takes a primary role in creating and sustaining a SAVA syndemic among MSM. Structural violence refers to violence that is permitted or encouraged within a given society and is systematically exerted by individuals in one certain social order or group toward individuals in another group. Marginalization, exclusion and oppression are reproduced in social relations through dominate discourse, stigma, and ideology (Farmer 2004; Scheper-Hughes 2004). By its very nature, structural violence can be seen as a form of violence that is sanctioned by members of society (Farmer 2004). Structural violence can be a contributing feature of SAVA syndemics and is exerted upon sexual minorities, and/or any

other subordinated population (Singer 2009). While individuals, such as MSM, may experience structural violence on an individual level, structural violence by and large targets classes of people. They are in turn subjected to common forms of lived oppression (Singer 2009). One such example comes from India in which institutional expressions of stigma, discrimination and violence against MSM within families, communities, health care providers, and police have been shown to increase their vulnerability to HIV infection (Chakrapani et al. 2007; Newman et al. 2008).

The theory of syndemic production among urban gay men addresses these health disparities by investigating them as socially produced phenomena arising from structural cultural marginalization (Stall et al. 2008). This theory hypothesizes that the syndemic production among MSM is the result of “socially produced damages associated with early adolescent male socialization among homosexual men” and the many stressors associated with migration to large urban areas (Stall et al. 2008:254). Among MSM, such socially produced damages occurring early in life, such as early forced sex, gay-related harassment and physical abuse are associated with negative health outcomes in adulthood (Singer 2009).

Early Socialization

The idea of systematic lived oppression is at the heart of the theory of syndemic production among urban gay men (Stall et al. 2008). This developmental theory is multi-disciplinary and draws on work from critical

medical anthropology, psychology, and public health. The first part of the theory argues that great emphasis placed on masculine socialization early in life is hetero-normative. Those youth who are unable to achieve masculine goals or conform to masculine norms are punished in socially shaming ways and are met with a surprising degree of violence. Boys who fail to meet hetero-normative developmental benchmarks, such as sexual initiation with females, are less socially valued and are categorized as belonging to a devalued subgroup. Further, the larger cultural phenomena of homophobia, such as hate crimes, anti-gay rhetoric, and public demonstrations in opposition to gay civil rights reinforce these messages of inequality, create a hostile environment, and normalize the expression of these forms of structural violence (Herrick et al. 2011; Farmer 2004).

To support their theory, Stall et al. (2008) cite survey research among a national sample and samples of young people from Massachusetts and California that demonstrate daily violence exerted against lesbian, gay, and bisexual youth. This includes having fear for their own safety at school, being threatened with a weapon at school, or being harassed or assaulted at school (Garofalo et al. 1998; California Safe Schools Coalition 2004; Harris Interactive 2005). Additional recent research evidences similar conclusions (Russell et al. 2011; Hightow-Wiedman et al. 2011; Toomey et al. 2010). Moreover, studies have reported that adults who witness harassment of lesbian, gay, and bisexual youth are less likely to intervene than adults who witness harassment of non-

lesbian, gay, and bisexual youth (California Safe School Coalition 2004; Harris Interactive 2005), and that the amount of support a community has for its homosexual members is an independent risk factor for suicide attempts among lesbian, gay, and bisexual teenagers (Voelker 2011). The disregard for violence against lesbian, gay, and bisexual youth and lack of community support clearly indicate the expression of structural violence against this group. As a result, social inequalities are naturalized and seen as part of the natural order of society, separated from larger social or political origins. Thus the blame for such conditions is placed on those being victimized (Scheper-Hughes 2004).

Migration

Reminiscent of refugee migration to urban centers, the second part of Stall et al.'s (2008) theory underscores the additional stressors and violence that MSM find in adulthood. It suggests that men fleeing homophobic environments during youth and adolescence intentionally seek out more accepting social settings and environment for themselves. However, the authors point out that in addition to the advantage of finding a safe gay community and accepting space, MSM must also deal with creating new social networks and accepting a minority (gay) identity, amidst the presence of high background prevalences of substance abuse, violence, depression, and HIV infection. Further, adult MSM must cope with institutionalized disadvantages that restrict many men from participating in roles that males are socialized to perform such as married spouse, fatherhood, membership in religious organizations, or laws that favor heterosexual men, such

as “glass ceilings” in career advancement and tax laws (Herrick et al. 2011; Stall et al. 2008). External social conditions and structures such as stigma and discrimination aimed at MSM impact men through processes such as internalized homophobia, concealment of self, or expectations of rejection (Wu 2012). These socially constructed barriers extend the expression of structural violence experienced during youth and continue to predispose MSM to experiences of psychosocial problems that then interact with HIV risk to produce a syndemic (Stall et al. 2008; Wu 2012).

To conclude, Stall et al. (2008) describe how the theory of syndemic production among urban gay men, is facilitated through structural violence:

If gay men have responded to homophobic environments by not learning important skills to find and bond with emotionally-satisfying social groups, by repeating relationships in which violence and abuse are assumed, by finding connections to other gay men only through sex or drug use, or by being afraid to access mental health or other social services based on gay identity, they will be more vulnerable to multiple psychosocial health problems [p. 262].

Singer (2009) concurs, adding that gay-related development and the cultural marginalization that occurs during this time are associated with negative health outcomes in adulthood that include HIV infection, substance abuse, and depression.

Health Disparities among African American/Black MSM

It is important to recognize that not all MSM are similarly situated with respect to structural violence. Differences in class, race, and socio-economic status also play large roles in generating syndemic health disparities (Stall et al.

2008). The theory proposed by Stall et al. (2008) was important in advancing discussions and research on health disparities among MSM, however, much of the work dedicated to examining the SAVA syndemic among MSM that followed has focused on structural homophobia and institutionalized stigma, with a concentration on predominately White MSM and ignored sub-groups of MSM differentiated by race/ethnicity or subsumed them within larger studies in which they were not the target population (Dyer et al. 2012). A focus on African American/Black MSM in the United States, with regard to syndemic investigation, was recently initiated, though this work is still scant (Dyer et al. 2012). As evidenced below, several health disparities exist among the African American/Black population in general. Yet African American/Black MSM may experience even greater vulnerabilities as a result of multiple marginalizations.

Syndemic Health Disparities among African American/Black MSM

As Singer (2009) has noted, a synergism exists between substance use and sexual risk behavior, and much research among African American/Black MSM examines both (Mimiaga et al. 2010; Tobin et al. 2011; Harawa et al. 2008). Although substance use is not significantly greater overall among African American/Black MSM than among other MSM (Millet et al. 2006; Shoptaw et al. 2009), in the last few years, several studies have found that African American/Black men report more powder and crack cocaine use than White or Latino MSM (Hatfield et al. 2009; Tobin et al. 2011). African American/Black MSM also experience more frequent and severe consequences of drug and alcohol use than do White MSM, leading to health disparities such as poorer

physical health and increased likelihood of incarceration (Harawa et al. 2008), in addition to higher rates of other health and social risk disparities such as victimization and gang involvement, as compared to other MSM (Garofalo et al. 2010; Mays et al. 2004).

An extensive literature review by Millet et al. (2006) found research on specific risk factors contributing to high HIV prevalence among African American/Black MSM, such as substance use and sexual risk behavior, shows mixed results, with some studies showing greater substance use or sexual risk behavior among African American/Black MSM and others studies finding no differences in these risk factors by race/ethnicity. Millet et al. (2006) reviewed other hypotheses, including greater incarceration rates, less knowledge of HIV status, and greater preference for sex partners of the same race, and found conflicting or insufficient evidence to explain the disparity of higher HIV prevalence among African American/Black MSM. Further, a meta-analysis of research examining greater HIV infection rates among African American/Black MSM generated four hypotheses to explain this disparity: increased prevalence of STDs, high rates of unprotected intercourse among African American/Black MSM early in the HIV/AIDS epidemic of the 1980s, lower utilization of antiretroviral therapy among HIV-positive men, and disproportionately high rates of HIV infection (Millett et al. 2007).

A separate analysis concluded that less knowledge of sex partner HIV status and lower utilization of antiretroviral therapy among HIV-positive African American/Black MSM may partially explain difference HIV prevalence among this

population (Oster et al. 2011). In addition, some research notes that buying, selling, and/or trading sex appears to be important risk factors for HIV among African American/Black MSM (Semple et al. 2010; Miller et al. 2005). Though these studies largely examined individual risk behaviors, the literature has acknowledged that HIV infection rates among African American/Black MSM could potentially involve factors other than individual behavioral risk, including socioeconomic structural and cultural factors, homophobia among African American communities, and/or racist attitudes within gay communities that may hinder their use and acceptance of HIV testing and prevention services (Brooks et al. 2005; Mays et al. 2004; Millet et al. 2006; Millet et al. 2007; Oster et al. 2011; Stokes et al. 1996; Stokes and Peterson 1998).

Structural Inequalities among African American/Black MSM

The relative socioeconomic inequality of African-Americans in the U.S., resulting from institutionalized racial discrimination, has been well documented (Bowleg and Raj 2012). The poverty rate among African Americans is highest among all racial/ethnic groups, and it is nearly double the national poverty rate (DeNavas-Walt et al. 2012). Overall, African-Americans are more likely to be homeless, to be incarcerated, and to experience inequitable access to social, educational, or material resources (Lim et al. 2011, Bassuk et al. 1997; Susser et al. 1993; Brondolo et al. 2009). As cited in Williams et al. (2010), the African American/Black population in the U.S. accounts 48% of individuals living with HIV/AIDS. This is in spite of the fact that African American/Black individuals only comprise 13.1% of the national population (U.S. Census Bureau 2012).

In the same way, though MSM account for more than half of all estimated incident HIV infection (Hall et al. 2008), among African American/Black MSM, HIV prevalence is significantly higher than for other racial/ethnic groups, with estimates of 28% among African American/Black MSM, compared to 16% among Caucasian/White MSM (Centers for Disease Control and Prevention 2010b). African American/Black MSM report nearly as many annual new HIV infections as Caucasian/White MSM, though Caucasian/White MSM comprise a much larger proportion of the population (Prejean et al. 2011). Further, 59% of African American/Black MSM who are HIV-positive are unaware of their infection and therefore not receiving necessary care or treatment (Centers for Disease Control and Prevention 2010b).

Research suggests that substance use, HIV infection, and victimization among African American/Black MSM may be attributed to structural factors both inside and outside of African American communities, such as racism, poverty, homophobia, stigma, or discrimination (Mays et al. 2004). These problems are exacerbated among MSM in African American communities because of the widespread disapproval of homosexuality and the rejection of behaviors or identities associated with same-sex orientation in African American communities (Mays et al. 1998). Such social rejection has been shown to increase the possibility of HIV risk taking and is associated with being behaviorally bisexual (Harawa et al. 2008; Mays et al. 2004). Further, for MSM in African American communities, victimization is much more prevalent than for men in the general population, or among White MSM (Mays et al. 2004).

Social Origins of Health and Disease

Prevention of HIV among African American communities has tended to ignore or only minimally address structural, cultural or historical factors (Williams et al. 2010). In the U.S., African American populations have faced a 350-year long history of chronic oppression which has led to poor health across several areas (Wyatt 2009). Structural factors experienced at the micro-level (such as poverty, lack of health insurance, discrimination in the medical community, or access to basic health care are) and macro-level (such as lack of health services, poor community health resources, lack of culturally competent providers) influence health disparities among this population (Williams et al. 2010).

Research specific to African American/Black MSM has found that among HIV-positive men, they are less likely to be taking antiretroviral therapy and are less likely to have seen a provider for HIV care within three months of HIV diagnosis (Oster et al. 2011). Additionally, incarceration is a risk factor for HIV among African American/Black MSM, although the way in which it increases risk is not clear (Lim et al. 2011). Such data provide evidence for the social and historical consequences of race and class in the U.S. (Baer et al. 1997) though an investigation of these factors as related to HIV is lacking (Oster et al. 2011).

Structural Violence among African American/Black MSM

Though no apparent study has examined structural violence among African American/Black MSM, among African American populations generally, macro-level expressions of structural violence include elevated incarceration rates of African American men, segregation by place of residence, and lack of

access to HIV or STD prevention and treatment (Lane et al. 2004). Research shows the negative impact of poverty, racism, and homophobia on health among minority MSM (Díaz et al. 2008; Maulsby et al. 2014). Others have noted that African American/Black MSM are less likely to be able to afford expensive medical care and in response seek basic health care services through emergency departments (Eisenman et al. 2003). Among African Americans in general, barriers to health care access include poverty and lack of health insurance or a regular source of health care (Parrish and Kent 2008) and racial discrimination, which contributes to a lack of resources among African Americans also has a negative influence on health (Brondolo et al. 2009). Thus, like African Americans in general, it appears likely that poor measures of health are indicative of larger political-economic structural and social inequalities found among African American/Black MSM.

In addition, African American/Black MSM are more likely than other races/ethnicities to be behaviorally bisexual, non-gay identified, and less likely to disclose their sexual orientation and are more likely to be exposed to heterosexist community, family, and religious norms (Balaji, et al. 2012; Maulsby, et al. 2014; Millett et al. 2005). As described in Díaz, Peterson, and Choi (2008), a large body of literature documents structural homophobia within African American communities. Studies show that African American/Black MSM perceive strong anti-gay attitudes among African American communities with reports of negative experiences in African American/Black heterosexual organizations, families, churches, and among friends and neighbors (Siegel and Epstein 1996; Stokes et

al. 1996). In addition, among African American/Black MSM, structural violence based on sexual orientation, can be felt in the form of physical violence (Comstock 1989). For these reasons, many African American/Black MSM feel they are unable to disclose their sexual orientation (Mays et al. 2004). Such feelings also impact health and medical care, as minority MSM are less likely to disclose same-sex behaviors to health care providers (Maulsby et al. 2014).

Social Environment and Resilience among MSM

While well-documented syndemic health disparities and structural violence are prevalent among populations of African American/Black MSM, they are often related to the social environment. Research has shown that the social environment and meaningful social support promote health, and that seeking social support can offer protection from the negative effects of stigma and discrimination (Kubicek et al. 2013; Lauby et al. 2012). However, African American/Black MSM lack adequate coping skills and social support to deal with such issues (Kraft et al. 2000; Shoptaw et al. 2009). Among MSM in general, substance use has been identified as a coping mechanism for men to excuse sexual behaviors that they or society find unacceptable (McKirnan et al. 2001). Qualitative research among African American/Black MSM has strongly confirmed these findings (Harawa et al. 2008). The absence of social support from family, friends, church, and neighborhood is a key determinant in understanding substance use, sexual risk behaviors, and a host of additional related vulnerabilities faced by African American/Black MSM including lack of access to medical care and the experiences of multiple traumas stemming from physical

abuse, gang involvement, incarceration, and violent deaths of family and friends (Mays et al. 2004). In fact, lack of social support among African American/Black MSM may be due to messages against homosexuality and stigma disseminated by many African American churches (Fullilove and Fullilove 1999). Thus, the strong presence of African American churches and the significant involvement in them by many African American families have a negative effect on African American/Black MSM mental health and access to support (Miller 2013; Peterson and Jones 2009). Among African American/Black MSM, the lack of social support is associated with experiences of discrimination, financial hardship, and participation in risky sexual situations (Ayala et al. 2012), while the presence of social support is associated with reduced substance use and sexual risk behavior (Lauby et al. 2012; Maulsby et al. 2014).

In spite of the lack of adequate social support and a supportive social environment among African American/Black MSM, or, perhaps because of it, African American/Black MSM have created organizations to offer needed social resources. One prominent example is the House and Ball communities in several U.S. cities that provide African American/Black MSM with social support, validation, and self-confidence (Kubicek et al. 2013). Such organizations, foster resilience among African American/Black MSM and have a positive impact on HIV transmission risk behaviors. Substance use and sexual risk behavior interventions that offer similar social resources have also met with success among this population (Buttram et al. 2013).

Examination of Health Disparities, Structural Inequalities, and Social Environment among African American/Black MSM in South Florida

Given the literature documenting syndemic health disparities among MSM and further evidence of additional structural vulnerabilities experienced by African American/Black MSM, analyses were conducted to examine differences in characteristics by race among a sample of MSM in South Florida. Using baseline survey data from the Project ROOM study, I compare African American/Black MSM with Caucasian/White MSM. In total, the sampled contained 108 African American/Black MSM and 250 Caucasian/White MSM. Descriptive statistics were calculated for demographics, substance use, sexual behavior, syndemic conditions, structural violence indicators, and social environment and resilience. This comparison illustrates differences not only in substance use and sexual behavior, but also syndemic, structural, and social factors present for each population.

In addition, in-depth interviews were conducted with 21 African American/Black MSM who completed the Project ROOM study to understand better their experiences of syndemic risk and structural violence, in addition to their social environment. Data presented here are drawn from part of a larger interview designed to gather insight into the challenges faced by these men, in addition to resilient behaviors used to cope with and overcome challenges. Questions were open-ended to allow for multiple themes to emerge from the discussion.

Additional details of the methods and data analyses were presented in Chapter 3. Descriptive analyses of the survey data were performed using IBM SPSS Statistics version 21. Qualitative data analyses were conducted using ATLAS.ti software, version 7.

Findings

Presented below are quantitative findings from African American/Black and Caucasian/White men from the Project ROOM study. A presentation of the qualitative data from a sub-sample of 21 African American/Black men from the Project ROOM study follows. The chapter ends with a discussion of the comparison between African American/Black and Caucasian/White men.

Findings: Project ROOM Survey Data

Demographics and Syndemic Health Disparities

Results for demographics and syndemic health disparities are shown in Table I below. On average, African American/Black MSM were approximately two years younger than Caucasian/White MSM (39.3 vs. 42; $p = .008$). Over half of Black men resided in Miami-Dade County (52.8%), compared to only 10.8% of White men ($p < .000$).

Rates of binge drinking (5 or more drinks at one sitting) and the misuse of prescription sedatives and opioids in the past 90 days did not significantly differ by race/ethnicity. Compared to Caucasian/White MSM, Black men were more likely to report marijuana (75.9% vs. 60.0%; $p = .004$), powder cocaine (59.3% vs. 35.6%; $p < .000$), crack cocaine (40.7% vs. 15.6%; $p = .000$), and ecstasy use (27.8% vs. 14.8%; $p = .004$). White men reported more frequent

methamphetamine use (28.4% vs. 13.0%; $p = .002$) than African American/Black MSM. However, African American/Black MSM reported nearly two and a half times the number of days high (34.4 vs. 14.0; $p < .000$) and nearly double the number of times drugs were used in combination with sex (77.7 vs. 40.2; $p = .000$) than White men.

Table 1: Demographics and Characteristics of Syndemic Health Disparities by Race/Ethnicity (N=358)

	Black MSM		White MSM		Chi-square or F statistic	P
	N=108	30.2%	N=250	69.8%		
Demographics						
Age ¹	39.3	(9.1)	42.0	(8.546)	7.185	0.008
Miami-Dade County residence	57	52.8%	27	10.8%	74.004	0.000
Substance Use Behavior²						
Alcohol (binge drinking)	89	82.4%	208	83.2%	0.034	0.855
Marijuana	82	75.9%	150	60.0%	8.387	0.004
Cocaine (powder)	64	59.3%	89	35.6%	17.251	0.000
Crack cocaine	44	40.7%	39	15.6%	26.767	0.000
Methamphetamine	14	13.0%	71	28.4%	9.926	0.002
Ecstasy	30	27.8%	37	14.8%	8.350	0.004
Prescription sedatives	31	28.7%	90	36.0%	1.794	0.180
Prescription opioids	26	24.1%	68	27.2%	0.381	0.537
Days high ¹	34.4	(33.6)	14.0	(22.96)	44.245	0.000
Drugs and sex used in combination ¹	77.7	(97.4)	40.2	(49.60)	23.157	0.000
Sexual Behavior²						
Partners ¹	14.7	(21.2)	13.2	(18.86)	0.440	0.508
Unprotected sex times ¹	27.8	(51.0)	20.8	(27.54)	2.764	0.097
Bought sex	53	49.1%	44	17.6%	37.822	0.000
Traded or sold sex	39	36.1%	46	18.4%	13.066	0.000
Sex with women (past year)	42	38.9%	21	8.4%	48.347	0.000
Syndemic characteristics						
Severe mental distress	63	58.3%	141	56.4%	0.115	0.735
Substance dependence	46	42.6%	60	24.0%	12.509	0.000
Victimization history	83	76.9%	212	84.8%	3.286	0.070

¹Mean; SD

²Past 90 days

The mean numbers of sex partners and unprotected sex frequency were not significantly different for Black and White MSM. Buying sex during the past 90 days was nearly three times more prevalent among African American/Black MSM (49.1%) than non-Black MSM (17.6%; $p < .000$). The number of African American/Black MSM who traded or sold sex during the past 90 days was also higher (36.1%) compared to non-Black men (18.4%; $p < .000$). Further, reporting sex with women during the past year was reported over four times as often among African American/Black MSM compared to Caucasian/White MSM (38.9% vs. 8.4%; $p < .000$).

More Black men met criteria for substance dependence (42.6% vs. 24.0%; $p < .000$) than White men. Other syndemic variables were not significantly different.

Structural Inequality Indicators

Rates of health care coverage did not significantly differ by race/ethnicity, though all other structural violence indicators were significant. African American/Black MSM were less likely to report high school completion (82.4% vs. 92.8%; $p = .003$) or four or more years of college (14.8% vs. 40.0%; $p < .000$) than White men. Fewer Black men reported working full-time (11.1% vs. 30.4%; $p < .000$) than White men. Past year homelessness was more likely to be reported by African American/Black MSM compared to Caucasian/White MSM (44.4% vs. 21.2%; $p < .000$), as was arrest history (82.4% vs. 60.4%; $p < .000$).

Fewer Black men endorsed gay identity compared to White men (58.3% vs. 90.8%; $p < .000$). HIV-positive serostatus was more prevalent among African American/Black MSM than Caucasian/White MSM (63.9% vs. 46.4%; $p = .002$). Compared to White men, fewer Black men reported good physical health (65.7% vs. 76.4%; $p = .037$) and more Black men reported being in need of help for physical health (41.7% vs. 26.0%; $p = .003$).

Table 2: Comparison of Structural Inequality Indicators by Race/Ethnicity N=(358)

	Black MSM		White MSM		Chi-square or F statistic	P
	N=108	30.2%	N=250	69.8%		
Education - 12 years	89	82.4%	232	92.8%	8.790	0.003
Education - 16 years	16	14.8%	100	40.0%	21.841	0.000
Work full time	12	11.1%	76	30.4%	15.136	0.000
Homeless (past year)	48	44.4%	53	21.2%	20.120	0.000
Identify as gay	63	58.3%	227	90.8%	51.667	0.000
HIV-positive	69	63.9%	116	46.4%	9.237	0.002
Health care coverage	63	58.3%	166	66.4%	2.129	0.145
Good physical health	71	65.7%	191	76.4%	4.366	0.037
Need help with physical health	45	41.7%	65	26.0%	8.697	0.003
Arrest history	89	82.4%	151	60.4%	16.531	0.000

Table 3 shows HIV-positive MSM receiving medical care and/or counseling for their HIV infection. Among these men, African American/Black MSM were less likely to be receiving care than Caucasian/White MSM (79.7% vs. 93.1%; $p = .006$).

Table 3: Comparison of HIV Care By Race/Ethnicity among HIV-Positive MSM N=(185)

	Black MSM		White MSM		Chi-square	P
	N=69	37.3%	N=116	62.7%		
Receiving HIV counseling or care	55	79.7%	108	93.1%	7.407	0.006

Social Environment

The mean number of people available for support among African American/Black MSM was 12.0 (SD 8.5; range 0-45) compared to more than 17 for Caucasian/White MSM (SD 10.3; $p < .000$). Fewer African American/Black MSM than White men reported coping by getting help and emotional support from others (38% vs. 52.8%; $p = .010$) and being satisfied with their living situation (64.8% vs. 76.4%; $p = .024$).

Table 4: Comparison of Social Environment by Race/Ethnicity N=(358)

	Black MSM		White MSM		Chi-square or F statistic	P
	N=108	30.2%	N=250	69.8%		
Number of people available for support ^{1,2}	12.0	(8.5)	17.2	(10.3)	21.664	0.000
Satisfaction with available support ^{1,3}	16.9	(7.1)	18.0	(6.3)	2.095	0.149
Getting emotional support from others	41	38.0%	132	52.8%	6.648	0.010
Satisfied with living situation	70	64.8%	191	76.4%	5.124	0.024

¹Mean; SD

²Range 0-45

³Range 0-25

Findings: Qualitative Interview Data

Syndemic Health Disparities

By and large, participants described using a range of substances, including alcohol, marijuana, cocaine, and crack cocaine. Eligibility criteria ensured that all participants were heavy substance users; however by the time they participated in the qualitative interview, no participants seemed to truly enjoy alcohol or drug use. As one participant said, “Drugs are not fun. Whoever tells somebody drugs are fun is lying. Drugs are not fun.” Implicit in this statement is

a feeling of fatigue, as nearly all participants described drugs and alcohol being a part of their lives for many years. While participants spent the majority of those years using alcohol or drugs, often drugs and alcohol were present from a very early age. When asked to describe his family, one participant described his childhood in this way, “My family is kind of, like, either they’re uppity with their nose in the air, or they’re like, drug addicts.” This participant went on to say:

Growing up [drugs] was all I seen. My mom, like, my mom worked pretty much all the way to her death, so from 10 to about 16, 17, I was always home by myself, or she’ll have them over there to, like, babysit me. Well, what she don’t know is they were smoking weed and smoking crack inside of her house, so growing up that’s all I seen was drug abuse, alcohol... My mom was an alcoholic, so drug abuse, alcohol abuse, so... It got to the point where I think now that subconsciously it’s like, “Oh, this is a normal thing to do.”

Over the course of their substance use careers, men began to make connections between alcohol and drug use and HIV. This theme emerged when the men were asked to describe their use of alcohol or drugs. As was stated during one interview, “You know something? When I get high, I’m more likely to have unprotected sex. It’s like one plus one equals two.” None of the participants discussed substance use and HIV in terms of a syndemic, but the concept was a daily lived experience that the men knew very well. Thinking about other African American/Black MSM he has known, one young participant described it this way:

I was started – I started on alcohol, I went to weed, from weed I went to cocaine, from cocaine I went to partying every night, maybe not so much as all the time unprotected sex, but most of the time unprotected sex, and then I could have very easily went... There was only two more steps:

crack and... bam [HIV]. So that's why, like, if the circumstances would have changed, if the moon would have aligned just right, it could have easily have been me.

A majority of participants saw the negative consequences of substance use from an early age. Moreover, there was the awareness that substance use, especially crack cocaine, seemed to lead to an HIV-positive diagnosis for many men.

However, HIV was not the only thing men connected to substance use. Mental and psychosocial problems, including loneliness, depression, and stigma or discrimination as a result of same-sex behavior were also themes that emerged. As a result, participants described being on the “down low,” in which men actively conceal sexual behaviors, and using alcohol and drugs to help men on the “down low” cope with feelings of inadequacy. As one man stated, “Drugs are used to fill the void of loneliness associated with being gay and to deal with the gay issue. It’s a way for us to let down our inhibitions.” In the words of another participant, “Black gay guys have no outlet, except maybe drugs, because there’s no acceptance. Drugs and depression go hand in hand.” Like the syndemic nature of substance use and HIV, men were also aware of the syndemic nature of substance use and other mental, emotional, or psychological problems they were facing.

In addition to using alcohol or drugs, buying, selling, or trading sex in exchange for money or drugs were mentioned by four participants as a coping behavior, two of whom had histories of sex trading. For both of these men, trading sex was used as a coping mechanism. One participant described low

self-esteem and feelings of being unwanted as facilitating his belief that he could only meet men through an exchange of drugs for sex. Another participant described selling sex as a way of healing from life's disappointments or limitations and from feeling pain. Both men, however, also described the excitement associated with it. "I had a 9 to 5 and I wanted excitement. It was a way to feel hot or wanted, to do something wild," said one man. In the words of another, "I didn't know of it in Georgia when I came down here, I found it fascinating how easy it was, the choices, the variety. I was almost overwhelmed with excitement." Though not all men participated in buying, selling, or trading sex, it was noted by one participant that if someone is using drugs and in a relationship, trading sex is essentially what he is doing, whether he admits it or not.

Participants' use of alcohol, drugs, or sex to cope with mental health problems or stigma was a cycle for many participants. Yet, some participants had additional need for substance use as a coping mechanism. Victimization, particularly childhood victimization was described by three participants. The desire to numb these feelings with substance use, in addition to other stressors, was seen as necessary to survive.

Structural Inequality Indicators

Structural inequalities experienced within African American communities also weighed heavily on many men. These also impacted substance use behaviors. Several participants described feelings of stress induced by a lack of money, jobs, and healthcare, which in turn led to coping behaviors that involved

alcohol and drug use. In contrast to other men in the study, “Black guys have more hardships; White and Hispanic guys have jobs, healthcare.” Another participant described himself upon enrolling in the Project ROOM study in this way, “Usually I would’ve been like, “Aw, man, I ain’t got no job. How am I gonna pay these bills?” and that would have drove me to, like, get high and drink, and, like, drink it all away.” While this was a theme that emerged during the interviews, some men described more severe problems than others:

I feel inadequate in pretty much every situation. I mean everybody – you listen to everybody and they talk about their jobs and the kind of house they have, the kind of car they drive. And you’re on the bus. You’re renting an apartment. You’re on Social Security disability. You’re HIV-positive. You know, that kind of thing.

All men participating in the qualitative interviews currently described themselves as gay. However, the majority of men described openly identifying as gay or portraying oneself as gay in the African American community as unacceptable and potentially dangerous. “You mention the word ‘gay’ and the next thing you know, you’re ousted,” said one participant. He went on to say, regarding not identifying as gay, that “You avoid a lot of the fights. You avoid the possible conflict.” This theme was echoed by nearly all men with reasons for such attitudes ranging from churches that describe same-sex behavior as sinful, to the influence of slavery in which African American men were historically emasculated, leading to the development of a hyper-masculine persona. Participants stated that the avoidance of being identified as gay causes many men to also have sex with women, or to embrace a “down low” identity.

Similar to experiences of men in other African American communities, men in the sample reported histories of arrest, jail, and juvenile detention. In these discussions, two sub-themes emerged. In the first, participants told about intentionally breaking the law. For example, one young participant described being in and out of jail and juvenile detention centers for five years in this way, “You know, like anything that I do, I dedicate myself to it, and I do it well. So, when I was a badass, I got in trouble and I got in trouble pretty good.” In the second sub-theme, participants told of not breaking the law and being punished for uncommitted crimes. For instance, one participant, stated, “I was 15 years old, did 13 years for a crime I didn’t commit, and it was a sex charge. And, like I said, I didn’t commit it, but my family was poor, I was poor, we could only afford a public defender, and that’s what happened.” The consequences of criminal justice system involvement by African American/Black MSM were known by all men, which included limited educational and employment opportunities, mental distress, and increased substance use as a coping behavior.

Among HIV-positive participants, all men reported currently receiving medical care for their HIV infection. About half of these men described their care as good and had not had any issues with the medical community. Two participants received HIV care through the Veteran’s Administration. The other half of the qualitative sample of men noted that they had at least one poor experience with the medical community since being diagnosed with HIV. For two participants, their problems stemmed from the antiretroviral (ARV) medicine AZT (Retrovir). One man said, “At the beginning I didn’t trust the system because

people kept dying taking the meds. They were dying faster by taking the meds. It was AZT and you have to keep taking it. You can't stop. I was very alarmed by that." Another man said, "After four years of ARVs I had a big distrust. I didn't believe what they had to say. AZT was the first medicine and it made me so sick. Now I just take the meds for a few months and then take a medication vacation." Another participant was told by his doctor to go somewhere else after he refused to take the medications. "She was very forceful to make me take the meds," he stated. This negative experience however was followed by a positive one when the participant found another doctor who closely monitors his laboratory tests and does not force HIV medication upon him.

Confidentiality concerns were the second cause of negative experiences with the medical community among HIV-positive African American/Black MSM. One man stated that after receiving an HIV-positive diagnosis, he delayed treatment because he didn't want to "blow my confidentiality" and have others tell that he was infected. Another participant had a similar concern, "When I was first diagnosed there was still a very big stigma. I was still in Georgia and it was called a gay disease." The presence of stigma in the social environment led to fears of not only having HIV-status, but also sexual orientation disclosed that caused discomfort for this participant.

Social Environment

The social environment of participants affected many aspects of their lives. One participant described the process of choosing friends based on what a potential friend could offer, "The people I would search out would be drug

addicts, alcoholics, partiers, because I'm like, "Okay, I don't have a car, but if I get with this person and they wanna go out, I've got a ride to the club and back," or, you know, "Maybe if I run out of money, this person's got the same habit I do. So maybe they'll have something and I'll go over to their house." Another participant described himself as being, "not the most savvy" when it came to alcohol and drug use, however, his social circle was heavily involved in it and influenced his substance use behavior and his access to drugs. Because of substance-use-centered relationships such as these, a majority of participants described a lack of social support within their family and friendship networks. While some participants mentioned having insufficient material support, a majority described being in need of emotional support. Given the stigma and discrimination associated with same-sex behavior in many African American communities, many participants did not have anyone to talk to about such problems, feelings, or emotions. As one participant described:

If you give a black guy support, they'll be your friend for life...it's not always money support either. Somebody to talk to, somebody to be there, and somebody to hang out with that's positive, other than, like, what they're use to – the drugs, the alcohol, the gangbangers, the thugs, the criminals – you know, somebody positive.

The biggest reason African American/Black MSM were not satisfied with their current living situation was related to their financial circumstances. Participants reported living in undesirable neighborhoods or apartments or with objectionable people because they did not have the financial freedom to go elsewhere. One participant living in Miami Beach described the city as "not

cheap” and “a great place to be if you have money.” He, on the other hand, was unable to find work and described it as “an economically difficult time.” Another participant told about his small, affordable housing unit in downtown Miami. It was here that he began interacting with “partier-types” of people, which had a major impact on his behavior. In addition, many men reported histories of bad living situations from which they eventually removed themselves. In particular, one participant grew up in Miami’s Liberty City neighborhood, and has vivid memories of riots, seeing many of his friends go to jail, poor schools, and a host of daily struggles. Another man described his living situation in the Overtown neighborhood of downtown Miami. The rampant drugs and violence, including the shooting of a four year old girl, contributed to his mental distress and feelings of insecurity. Though for several years he could not afford to go elsewhere, he moved away as soon as he was able. Still others told of growing up in racially segregated neighborhoods in northern cities before eventually moving to South Florida.

Discussion: Vulnerabilities of African American/Black MSM Compared to Caucasian/White MSM

Presented above are the results of both quantitative and qualitative findings. Quantitative results demonstrate that many differences exist between African American/Black and Caucasian/White men in the sample with regard to substance use, sexual behavior, education, employment, homelessness, HIV status, health care, arrest history, and social support. African American/Black men in the qualitative sample richly described many of the connections between

these measures. The discussion below summarizes and contextualizes these main findings from both the quantitative and qualitative data.

Syndemic Health Disparities among African American/Black MSM

Much of the literature discussing African American/Black MSM substance use and sexual risk behaviors references the multitude of syndemic problems that are also present in this population (Mays et al. 2004; Millet et al. 2006). The men in this sample were no different. All of the men, regardless of race/ethnicity, reported high levels of substance use and sexual risk behaviors. However, African American/Black MSM reported greater frequency of use of marijuana, cocaine, crack cocaine, and ecstasy. In addition, African American/Black MSM also reported being high all or most of the day and using drugs during sex more than White men. Thus, the fact that African American/Black MSM were also more likely to meet DSM-IV criteria for substance dependence is not surprising.

Literature supports the idea that substance use is not significantly greater among African American/Black MSM than other MSM (Millet et al. 2006; Shoptaw et al. 2009). However, several studies have found that African American/Black MSM report more frequent use of marijuana and powder and crack cocaine than other MSM (Hatfield et al. 2009; Irwin and Morgenstern 2005; McKirnan et al. 2001; Tobin et al. 2011). African American/Black MSM in this study also reported more powder and crack cocaine use, compared to White men. This is somewhat worrisome considering that crack cocaine has a documented role in stimulating sexual activity and involvement in sex exchange (Guss 2000). In fact, the association of crack cocaine and HIV risk was

specifically mentioned by one participant during the qualitative interviews.

However, other men simply described the ubiquitous nature of substance use in their lives from a very early age.

African American/Black MSM in the sample were much more likely to report buying, selling, or trading sex and having sex with women. These behaviors mostly occur, in conjunction with substance use, as a response to the inability to disclose sexual identity (Mays et al. 2004). Like Harawa et al. (2008), qualitative data illustrate that substance use not only enhances sexual encounters, but also motivates sex with other men, and allows and rationalizes same-sex activity. Further, sex trading is used as a means of coping with mental, emotional, or psychological problems, while having sex with women is largely used to hide same-sex behaviors and avoid stigma and homophobia.

The finding that African American/Black MSM are more likely to use drugs and sex in combination would appear to be potentially related to structural stigma and homophobia among African American communities, as it allows men to temporarily escape full awareness of same-sex desires, widespread disapproval of behavior, and internalized homophobia, in addition to the well documented stressors associated with life as African American men (Harawa et al. 2008). Qualitative interviews with participants support these conclusions as many men described not having an outlet other than alcohol or drug use.

Harawa et al. (2008) note that research suggests same-sex behavior and elevated HIV rates among African American/Black men may be due to political-economic structural stressors such as unemployment, low socioeconomic status,

or elevated incarceration rates resulting in survival sex, in which disadvantaged men trade sex for food, shelter, basic needs or drugs. These same problems are evident among the sample of African American/Black MSM described here.

Qualitative data among these men did not find examples of survival sex.

Structural Violence Indicators among African American/Black MSM

The men in this study do experience many structural inequalities as a result of structural violence. African American/Black MSM have fewer years of education, at both the high school and college levels, less full-time employment, and greater rates of homelessness and history of arrest among African American/Black MSM compared to White men. These findings are not surprising, given the existing literature. Moreover, when considering the fact that African American/Black MSM report such increased vulnerabilities across so many areas, compared to Caucasian/White MSM, is alarming, especially considering that social discrimination and financial hardship among minority MSM are associated with increased risk for HIV infection (Ayala et al. 2012).

Results from the qualitative interviews suggest that such hardships also influence mental health, in the form of stress, depression, and substance use as a means of coping with such stress. As a consequence, syndemic health disparities are exacerbated. Adding to financial hardships is the involvement of many African American/Black MSM in the criminal justice system. While not all men interviewed had been arrested, all of them knew somebody in their communities who had been. Further, for men who had been arrested, the negative consequences impacted the men in terms of syndemic disparities such as substance use as a coping behavior,

greater mental distress, and increased structural problems such as educational attainment and employment opportunities.

African American/Black men in the sample were much less likely to identify as gay, compared to Caucasian/White MSM. Such findings are widely supported in the literature, with indications that among African American communities, same-sex behavior or identity can often be accompanied by homophobia and victimization (Díaz et al. 2008; Comstock 1989; Stokes et al. 1996). Qualitative data indicated that in addition to conflict or physical violence, African American/Black MSM may experience the loss of social connections as a result of disclosing their sexual orientation. The impact of this was felt across several areas of life including increased mental distress. Because African American/Black MSM in this study describe substance use and increased sexual risk as coping behaviors, the loss of social connections and increased mental distress further marginalizes an already vulnerable population. Further, maintaining a discreet or “down low” identity is often used as a survival tool in order to maintain one’s place in the African American community and protect against the loss of social or economic resources (Mays et al. 2004).

While there was not a significant difference in health care coverage by race/ethnicity, fewer African American/Black MSM reported being in good physical health than Caucasian/White MSM. Further, more African American/Black MSM stated that they were in need of help for their physical health compared to White men. Physical health and needing help with it were not themes that directly emerged from the qualitative data. However, men did report feeling healthier now

than when they first enrolled in the Project ROOM study. This was largely attributed to a reduction in substance use. However, the effects of poverty, racism, and homophobia on the health of minority MSM is a documented concern (Díaz et al. 2008; Maulsby et al. 2014). Thus, reducing the disparity in physical health care need and access between African American/Black MSM and White men would likely require addressing additional social inequalities as well.

Data reported here document high HIV prevalence among Black men compared to Caucasian/White MSM. This finding is consistent with HIV prevalence rates found in prior research among MSM (Oster et al. 2007) and national surveillance data that indicate HIV prevalence and incidence rates among African American/Black MSM are disproportionately higher than for MSM of other races/ethnicities (Centers for Disease Control and Prevention 2010b; Peterson and Jones 2009). While this finding is not novel, the data described here illustrate the syndemic nature of HIV infection, substance use, and a host of other health and social disparities among African American/Black MSM.

For African American/Black MSM who are HIV-positive, engagement in HIV counseling or medical care is necessary to maintaining overall health. The finding that African American/Black MSM are less likely to be receiving care for their HIV infection when compared to Caucasian/White MSM is unsurprising given the lower overall levels of health care among African American/Black MSM and their higher levels of syndemic disparities and structural inequalities compared to White men. HIV-positive African American/Black MSM are less likely to have access to HIV care and treatment services and be adherent to HIV medications, which is thought

in part to be explained by severe mistrust of the medical community among African American/Black MSM (Maulsby et al. 2014). Approximately half of HIV-positive men participating in the qualitative research reported some form of distrust or confidentiality concern with their HIV medical care providers. Research demonstrates that HIV-positive African American/Black MSM often face stigma found in public, institutional, and social life that negatively impacts the care they receive from state and social service agencies (Haile et al. 2011). Thus, HIV-positive African American/Black MSM find themselves in an even more marginalized position than their HIV-negative counterparts, as is evidenced by the entirety of the data presented in this chapter.

Social Environment among African American/Black MSM

Data presented here show African American/Black MSM to be more vulnerable than Caucasian/White MSM when considering the social environment and resilience measures. Studies show that meaningful relationships and social support promote health, and, among minority MSM, those who report strong supportive relationships are more likely to test for HIV and are less likely to engage in high risk sexual behavior (Lauby et al. 2012). Yet, African American/Black MSM from this sample reported having fewer people available for support and were less likely to report getting help and emotional support from others than White participants. Stigma and discrimination against African American/Black MSM is well documented (Mays et al. 2004; Haile et al. 2011; Harawa et al. 2008; Lichtenstein 2000), and was a theme that emerged in the

qualitative interviews. Men noted that identifying as gay could lead not only to victimization, but also social exclusion within the community. Moreover, there is an association between lack of social support and increased risk factors related to substance use and sexual risk behavior (Harawa et al. 2008 Mays et al. 2004). As was noted by nearly all of the participants, negative coping strategies, such as substance use, may be undertaken in the absence of needed social support among African American/Black MSM.

Among men in this sample, African American/Black MSM are less likely to be satisfied with their current living situation, compared to Caucasian/White MSM. Based on the qualitative data, it would seem likely that this finding is related to the higher rates of homelessness and histories of arrest among African American/Black MSM, in addition to the limited access to education and full-time employment, compared to Caucasian/White men. Moreover, one's living situation is also likely to be negatively impacted by substance use, mental distress, victimization, and limited resources, including education, employment, health care, and social support.

Conclusion

The purpose of this chapter is to review existing literature on syndemic health disparities, structural violence, and social environment among populations of African American/Black MSM. Data were presented from a sample of African American/Black MSM in South Florida and analyses revealed that many of the theoretical concepts, study findings, and conclusions from the literature are applicable to this sample. Syndemic health disparities, structural inequalities, and

the social environment are all intertwined and mutually influence and interact with each other. This was illustrated by the ways in which men discussed these issues during the qualitative interviews.

In sum, this sample of African American/Black MSM from South Florida report elevated syndemic health disparities, greater structural inequalities, and fewer coping and social support resources than Caucasian/White MSM.

Individually, the findings from each section of this chapter are not novel. In fact previous research shows that in addition to substance dependence problems and increased sexual risk behavior, African American/Black MSM also experience more frequent and severe consequences of drug and alcohol use than do Caucasian/White MSM, leading to health disparities such as poorer physical health, increased likelihood of incarceration, and higher rates of other factors, such as victimization and gang involvement (Garofalo et al. 2010; Harawa et al. 2008; Mays et al. 2004).

However, the results from this chapter represent the first apparent study to utilize both quantitative and qualitative data to formally describe the presence of syndemic health disparities, structural inequality indicators, and social environment among a sample of African American/Black MSM. While any one of these disparities can have a negative impact on a population, the high prevalence of such a great number of these factors is especially worrisome.

Though African American/Black MSM in the sample are more vulnerable than their White counterparts, such vulnerabilities are not static. In the following chapter, changes in these same characteristics between baseline and 12 month

follow-up interviews from the Project ROOM study will be examined among African American/Black MSM and compared to Caucasian/White MSM.

CHAPTER 5

RESULTS OF A BEHAVIORAL INTERVENTION FOR SUBSTANCE-USING MEN WHO HAVE SEX WITH MEN IN SOUTH FLORIDA: AFRICAN AMERICAN/BLACK MSM COMPARED TO WHITE MSM

It was like, "Damn. Did I just do that...?"

-49 year old African American from Ft. Lauderdale

Introduction

As reviewed in Chapter 4, HIV risk among MSM is very high. Estimates from the Centers for Disease Control and Prevention (2010b) show that 60% of all new HIV infections are among MSM and at the same time, African American/Black MSM are at greater risk for acquiring HIV. Moreover, substance-using MSM are also among the populations most at risk for HIV infection (Carey et al. 2009; Chesney et al. 1998; Plankey et al. 2007; Stall et al. 2008)).

Understanding the social environment in which syndemic health disparities related to substance use and HIV transmission risk are experienced is vital to preventing the spread of HIV among vulnerable populations, and especially African American/Black MSM. For that reason, developing efficacious interventions for heavy substance-using MSM is an essential strategy for reducing HIV transmission among the U.S. population (Herbst et al. 2005).

This chapter reviews current research investigating substance use and HIV transmission risk among MSM and further examines research specific to

African American/Black MSM. In addition, Chapter 5 presents outcome data from the Project ROOM study, followed by qualitative data from a sub-sample of African American/Black participants from the Project ROOM study. Finally, Chapter 5 ends with a discussion of these data and addresses the research questions, “How did the presence or magnitude of syndemic health disparities change during the 12 month follow-up period following the Project ROOM study intervention participation, and what resilience processes occurred during that time to effect change?”. The specific focus of the analysis is the comparison of African American/Black MSM to White MSM.

Intervention Studies among Substance-Using MSM

As seen in previous chapters, the connection between substance use and HIV transmission risk among MSM is a well-documented phenomenon. Often described as a syndemic relationship, ample descriptive studies demonstrate the association between substance use and increased HIV transmission risk (Singer 2009). Research among MSM has also produced evidence-based risk reduction intervention trials aiming to reduce HIV transmission risk among not-in-treatment substance-users (Stall et al. 1999; Shoptaw et al. 2005; Mansergh et al. 2010; Kurtz et al. 2013a).

Stall et al. (1999) published the first randomized controlled trial (RCT) to evaluate the effects of an HIV risk reduction intervention among not-in-treatment substance-using MSM. Among a sample of 456 (78% Caucasian, 9% African American, 4% Hispanic, and the remainder identifying as Native American or Asian/Pacific Islander) MSM entering substance-use treatment, the sexual risk

reduction intervention was delivered as part of a 16-week substance-use recovery treatment group. Widespread reductions in sexual risk behavior, such as unprotected intercourse, were common across men in both groups. The authors found no differences between men who received the experimental intervention, compared to those who participated in recovery treatment groups without the sexual risk reduction intervention.

The second RCT conducted among not-in-treatment substance-using MSM focused on methamphetamine dependence and sexual risk behaviors (Shoptaw et al. 2005). Like Stall et al. (1999), this study included a sample of men undergoing substance abuse treatment. The sample of 162 men (80% Caucasian, 13% Hispanic, 3% African American, 3% Asian, and 1% Native American) was assigned to one of four arms of the study comparing various behavioral therapy models, one of which was enhanced to include referents to cultural norms and values of urban MSM. The authors found significant differences in reduction of methamphetamine use among men assigned to either of two contingency management-based study arms. Though there was near universal reduction in sexual risk behaviors, no differences were found between study arms.

Unlike Stall et al (1999) and Shoptaw et al. (2005), the third RCT among not-in-treatment substance-using MSM did not target a treatment-based sample (Mansergh et al. 2010). Instead 1,686 men were recruited from direct outreach and advertisements in Chicago, Los Angeles, New York City, and San Francisco. This sample was more diverse than the previously mentioned studies (40%

Caucasian, 31% African American, 19% Hispanic, and 10% other). Following baseline assessment, men were randomized into one of three arms: a standard HIV testing and counseling condition; an intervention arm consisting of six weekly two hour group sessions which addressed substance use and sex risk; or an attention-control group of equal time that consisted of discussions unrelated to substance use and sexual risk, including relationships, spirituality, and racism. All three groups significantly reduced substance use and sexual risk behavior, though these outcomes were not different from each other at any follow-up assessment.

Finally, the latest RCT among not-in-treatment substance-using MSM is the focus of the present analysis. The study, called Project ROOM (men Reaching Out to Other Men), has been described in detail in Chapter III and final outcomes have recently been published (Kurtz et al. 2013a). To briefly summarize, the sample of 515 MSM was diverse (49% Caucasian, 26% Hispanic, 21% African American, and 4% other) and were recruited from direct outreach and targeted online and print advertising. Men were randomized to a four session small group intervention arm compared to an enhanced standard of care HIV counseling condition. Men in the study universally reduced substance use and sexual risk behavior, though no differences were found between study arms at any follow-up assessment. The authors note in the conclusion that African American/Black MSM in the study reduced their risks at a greater rate than other MSM, though a specific examination of this phenomenon was not conducted until now.

RCTs conducted among vulnerable MSM which aim to reduce substance use and sexual risk behavior have demonstrated that these risks can be reduced and sustained. One limitation to the published RCTs among substance-using MSM is the dearth of diversity among the samples with regard to race/ethnicity. Though samples from Mansergh et al. (2010) and Kurtz et al. (2013a) were considerably more inclusive of men of color than the others, Kurtz et al. (2013a) did note that some differences exist between African American/Black MSM compared to MSM of another race/ethnicity.

Intervention Studies among African American/Black MSM

Randomized Controlled Trials

Literatures shows that African American/Black MSM are disproportionately burdened by HIV/AIDS, yet at the same time there has been a shortage of research on HIV interventions for these men (Maulsby et al. 2014). To date, there are 5 published reports of HIV risk reduction interventions for African American/Black MSM using an RCT design, of which two were for HIV-positive African American/Black MSM (Coleman et al. 2009; Williams et al. 2013), one was for HIV-negative and HIV-positive men (Koblin et al. 2012), one was for HIV-negative men or men with unknown HIV status (Wilton et al. 2009), and one was for HIV-negative men (Peterson et al. 1996). None of these RCTs of interventions for African American/Black MSM were specifically targeted toward substance-users or included substance use as an outcome measure.

Coleman et al.'s (2009) RCT for HIV-positive African American/Black MSM aged 50 and over consisted of a sample of 60 men who participated in four

two-hour classroom-like group sessions. Participants were randomized to an HIV risk reduction group, that aimed to increase consistent condom use, or to a control group focused on general health. At three-month follow-up assessments, men in the HIV risk reduction group were twice as likely to use condoms consistently compared to the control group, however this difference did not reach statistical significance.

The RCT conducted by Williams et al. (2013) was designed for men who have sex with men and women (MSMW) with histories of childhood sexual abuse. The study consisted of 6 two-hour small-group sessions, with participants randomly assigned to either a stress reduction intervention or to a general health promotion intervention. The study yielded mixed results. Though the stress-focused intervention was more efficacious in decreasing insertive unprotected sex and reducing depression symptoms, other sexual risk and mental health outcomes measures were not significantly different by study condition.

For HIV-negative or unknown African American/Black MSM, the Many Men, Many Voices (3MV) Project (Wilton et al. 2009) included 338 men randomly assigned to either the 3MV intervention or to a wait-list comparison condition. The intervention consisted of a weekend long retreat. Outcome measures were mixed, with the experimental intervention arm showing significant differences at 6-month follow-up in the number of insertive unprotected sex times partners, any occurrence of UAI in the past three months, and receiving an HIV test in the past three months. Other sexual risk behavior measures, including receptive UAI and consistent condom use did not reach statistical significance.

Peterson et al.'s (1996) RCT used a three-arm design in which 318 African American/Black MSM participants were randomly assigned to a single session intervention, a three session intervention, or to a wait-list control. Participants in the three session intervention greatly reduced the frequency of UAI at 12- and 18-month follow-up, compared to only slight decreases among the single session participants and no decreases among the wait-list participants. These results suggest superiority of a three session intervention; however, the authors were unable to statistically demonstrate its superiority over the other arms.

In the final RCT conducted among African American/Black MSM, 283 men were randomly assigned to an intervention arm consisting of 5 two-hour group sessions focused on creating a group environment and reducing sexual risk or to a non-intervention control arm (Koblin et al. 2012). At three-month follow-up, no significant differences were found between study arms for any sexual risk behavior outcome measure or for the psychosocial outcome measures of social isolation or psychological distress.

While intervention studies among African American/Black MSM show mixed results, this research is responding to the need to develop efficacious interventions for men most at risk for acquiring or transmitting HIV. What is missing from many of these RCTs is an examination of substance-using African American/Black MSM, especially given the well-documented connection between substance use and HIV.

Non-Randomized Controlled Trials

While not RCTs, two recent intervention studies address substance use among African American/Black MSM, in addition to HIV transmission risk. Both of these pilot projects used a pre- and post-test study design to examine the effects of the intervention. Though not RCTs, both pilot studies indicate promising results that could inform future RCTs.

Connect with Pride, an HIV/STI prevention intervention among methamphetamine-using African American/Black MSM couples, was conducted by Wu et al. (2011). A total of 68 men (34 couples) attended 7 sessions adapted from an existing evidence-based intervention designed for heterosexual couples. At two-month follow-up, participants reported significantly fewer sexual partners, fewer episodes of UAI, and greater condom use with their main sexual partner. Participants also reported significantly less frequent use of methamphetamine and other illicit drugs, and fewer numbers of illicit drugs used.

The Bruthas Project was an intervention designed to reduce HIV risk behavior among African American/Black MSMW (Operario et al. 2010). This study enrolled 36 men, recruited from street and/or venue-based outreach and advertisements. During a series of one-to-one counseling sessions, men discussed HIV risk factors, sexual dynamics and risk behaviors, motivations and triggers for unsafe sex, and personal risk reduction goals. At three-month follow-up, the authors found that participants significantly reduced UAI with male partners, fewer male and female partners for unprotected sex, and decreased frequency of sex while under the influence of drugs. The authors also found

increased social support, self-esteem, and reduced loneliness among men at follow-up.

Both of these studies address a critical need to address the lack of research among substance-using MSM, especially among African American/Black MSM. However, as pilot projects, their promising conclusions are of somewhat limited utility. While Connect with Pride targeted methamphetamine-using couples, the Bruthas Project targeted MSMW who engage in secretive sex. Both are important areas of research among vulnerable populations of African American/Black MSM, but do not address the needs of more general populations of African American/Black MSM. However, the Bruthas Project not only demonstrated reductions in HIV transmission and substance use risks, but also found improvements in psychological well-being and resilience-related measures of social support, self-esteem, and loneliness.

The Bruthas Project was built upon formative research among African American/Black MSMW and was designed to address the social context of HIV for this population. The authors found that African American/Black MSMW value secrecy and do not form personal identities or community connections based on sexual identity (Operario et al. 2010; Operario et al. 2008). This finding, and the development of an intervention based upon it make a positive contribution to this area of research. However, no discussion dealt with the relationship of social context of HIV to the psychological well-being and resilience-related measures in the study. While it can be assumed that feelings of anxiety about disclosing sexual behavior for these men precluded them from developing social support,

self-esteem, or overcoming loneliness, the authors do not address it. As evidenced in previous chapters, the social context of HIV for African American/Black MSM contains many health and social syndemic disparities and structural risk factors as well as one's social environment. Thus, a key gap in the literature is how the intervention works within the social context of HIV.

The Project ROOM Study

The Project ROOM RCT targeted substance-using MSM and contained a diverse sample. It has been fully described in chapter 3 including the study site, measures, sample and procedures. Below is a description of the intervention and outcome analyses of the study, which compare African American/Black MSM to Caucasian/White MSM. Qualitative data contextualize the reasons why African American/Black MSM made the changes they did, and the specific elements of the study that helped produce those changes.

Project ROOM Study Interventions

The design of the 4-session small group experimental arm of the study was grounded in psychological empowerment, the process by which people gain mastery of issues of concern to them (Zimmerman 1995). In an individual context, empowerment is a process through which individuals come to perceive a connection between their goals and the means to achieve them, and between their efforts and the desired results (Mechanic 1991). Psychological empowerment theory asserts that goals can be achieved based on one's efforts to fulfill those goals, but achievement is also subject to interactions among current risk factors (social isolation, substance use), strengths (perceived control,

coping skills, critical awareness), and awareness of resources (Zimmerman 1995).

Empowerment theory was used in the intervention as a means to help participants better cope with syndemic health disparities specific to MSM, rather than to alter the root causes of the syndemic health disparities. Thus, the individual-based experimental intervention focused on assisting high risk MSM substance users in: 1) strengthening the skills needed to exercise control over their lives; and 2) taking a third person view of the interactions of drugs and sex among gay men, and examining the good and bad experiences associated with them; 3) broadening their spheres of social engagement; and, 4) identifying achievable life goals and action plans to move toward them.

The intervention employed two main tools to help men achieve these aims: 1) guided group discussions that emphasize the building of trust and intimacy with other men, and the sharing of men's diverse experiences, strengths, and approaches to problem solving; and, 2) individual take home exercises that promoted self-awareness, social diagnostic skills, and social connectedness.

In accordance with psychological empowerment theory, goals were entirely participant-identified, and included a wide diversity of efforts, including: educational, vocational, hobby and volunteering pursuits; substance abuse treatment entry; changing friendship networks; and exiting abusive relationships. Intervention sessions were scheduled one week apart. Each group session lasted about two hours, and was facilitated by two staff members. Participants

who missed a group session were invited to attend the other sessions for their group, but they were not permitted to attend other groups for the session(s) they missed.

One week after completion of the four group sessions, men in the experimental arm of the study attended an individual goal achievement counseling session with a staff member. In keeping with the psychological empowerment framework, staff used an extensive compendium of resources, including health and social services and opportunities for employment, education, and social engagement to assist men in identifying action plans to initiate the achievement of the goals they identified for themselves during the group sessions. Potential barriers to goal achievement were also discussed, as well as possible ways these might be overcome. Comprehensive referrals were made for any health and social service needs. Individual counseling sessions lasted about one hour.

The single session individual control arm included sexual and substance use risk assessment and risk reduction counseling using the RESPECT model (Kamb et al. 1998). Because of the high levels of vulnerability and need of the target population, and guided by a resilience theoretical framework that focuses on assets and resources to overcome risk (Fergus and Zimmerman 2005), the control arm was enhanced based on key domains of resilience that emphasize understanding and separating oneself from risk, strengthening positive relationships, and fostering initiative, creativity and morality (Wolin and Wolin 1995). Examples of the implementation of these approaches included re-forming

friendship networks to reduce substance use, using humor to negotiate condom use, and taking the initiative to develop alternative social engagements to drugs-sex involvement. Each session lasted 30 to 45 minutes, and concluded with a written individualized risk reduction plan. Staff used the same set of resource references as for the experimental arm to assist with referrals to needed health and social services.

All intervention sessions were audio recorded; transcripts of all group discussions were reviewed for fidelity to the intervention protocols, as were 20% of all individual counseling sessions. Participants in both study arms were offered condoms and a \$30 stipend to cover time and travel costs at the completion of each intervention session.

Examination of Project ROOM Study Outcomes

Presented in this chapter are outcome measures examining substance use and HIV transmission risk, with the aim of understanding the effects of study participation. Similar to the analyses presented in Chapter 4, this chapter presents a comparison between African American/Black MSM and Caucasian/White MSM. All outcomes were examined using all of the data available from the final follow-up assessments. There were 315 cases available for analysis for the baseline to 12 month outcomes.

To examine change over time in the outcomes, multilevel non-linear growth models (MLM) for repeated measures were constructed, controlling for African American/Black race/ethnicity. These models take all available measurement points into account, and quantify the slope and shape of the

behavior change curves from baseline to 12 month follow-up. To complement the MLMs of primary outcomes, a summary of primary and secondary outcome results by race/ethnicity, including Cohen's *d* effect size statistics and related 95% confidence intervals are also reported. The effect size analyses confirm the results of the MLMs by illustrating changes in additional measures related to both syndemic health conditions and resilience.

To contextualize the quantitative findings and to better understand why behavioral changes occurred, results from in-depth interviews with 21 African American/Black MSM who completed the Project ROOM study are presented. Data are drawn from part of a larger interview designed to gather insight into challenges faced by these men, in addition to their resilient behaviors to cope with and overcome challenges. Questions were open-ended to allow for multiple themes to emerge from the discussion.

Additional details of the methods and data analyses are presented in Chapter 3. Outcome analyses of the survey data were performed using IBM SPSS Statistics version 21. Qualitative data analyses were conducted using ATLAS.ti software, version 7.

Findings

Presented below are quantitative findings from African American/Black and Caucasian/White men from the Project ROOM study. Following the quantitative data, is a presentation of the qualitative data from a sub-sample of 21 African American/Black men from the Project ROOM study. The chapter ends with a discussion of these data.

Findings: Project ROOM Survey Data

Presented in Table 5 below are the results of the MLMs of longitudinal changes in the frequencies of the log transformed outcome measures, controlling for both race/ethnicity and for HIV status. Findings from Model 1: Days high in the past 90 days are shown in the first two columns. The fixed effect, Time, is the linear slope of the model and indicates a decrease in the outcome ($P<0.01$). Time² is the quadratic term indicating the rate of change. This too is significant ($P<0.01$) and denotes a nonlinear and decreasing rate of reduction in this outcome over time.

Table 5 Multilevel Model of Longitudinal Change in Outcome Measures (Natural Log Transformed) (N=353)

	Model 1: Days High		Model 2: HIV Transmission Risk	
	Estimate	S.E.	Estimate	S.E.
Fixed Effects:				
Intercept	1.41 [†]	0.12	2.18 [†]	0.1
Time	-0.42 [†]	0.09	-0.66 [†]	0.08
Time ²	0.10 [†]	0.03	0.16 [†]	0.02
Race ^a	1.02 [†]	0.17	-0.16	0.14
Race*Time	-0.24 [†]	0.06	-0.23 [†]	0.06
HIV Status ^b	0.39*	0.15	0.31*	0.13
HIV Status*Time	-0.09	0.06	-0.06	0.05
Random SD:				
Intercept	1.34*	0.16	0.99	0.12
Residual	1.01*	0.06	0.74*	0.04
Linear Slope (time)	0.07*	0.02	0.07*	0.02

^a Reference White

^b Reference HIV Negative

[†] $p<0.01$

* $p<0.05$

In Model 1, the effect of race is significant at baseline, indicating that African American/Black MSM reported more than double the number of days high at baseline, compared to White men ($P<0.01$), however the effect of Race*Time shows that African American/Black men reduced the mean number of days high by a 24% greater rate than Caucasian/White MSM ($P<0.01$) at each wave of data collection (3, 6, and 12 months post-intervention). Also present in the model are controls for HIV status, which are not significant over time.

HIV transmission risk is shown in Model 2. Results are similar to Model 1. The fixed effect, Time, indicates a decrease in the outcome ($P<0.01$) and the quadratic term, Time², represents a nonlinear and decreasing rate of reduction in this outcome over time ($P<0.01$). At baseline, there were no significant difference in mean number of HIV transmission risk times by race/ethnicity, however, African American/Black MSM reduced the frequency of HIV transmission risk times by a 23% greater rate than White men ($P<0.01$) at each wave of data collection (3, 6, and 12 months post-intervention). HIV status was not a significant predictor of behavior change over time.

Effect sizes for the changes in both primary and secondary syndemic and resilience measures between baseline and 12 month follow-up are shown in Table 6. With a few exceptions, effect sizes are greater for African American/Black MSM than for Caucasian/White MSM. Confirming the results of the MLMs, the effect sizes for the primary outcome measure of days high was moderate for African American/Black MSM (0.58; $P<0.001$) and small for Caucasian/White MSM (0.33; $P<0.001$) and similarly the effect size for HIV

transmission risk was high for African American/Black MSM (0.78; P<0.001) and moderate for Caucasian/White MSM (0.39; P<0.001).

Table 6. Baseline to 12 Month Change Scores – African American/Black compared to Caucasian/White

	Baseline (N=358)		12 Month Follow-up (N=315)		Mean Difference: Baseline to 12 Months	Effect Size	CI for Effect Size Difference		P
	Mean	SD	Mean	SD			Lower	Upper	
Days High^a									
Black	32.27	(33.32)	16.09	(27.57)	1.14	0.58	0.29	0.88	<0.001
White	13.58	(22.74)	8.75	(19.21)	0.50	0.33	0.14	0.52	<0.001
HIV Transmission Risk^a									
Black	25.03	(45.65)	5.88	(13.69)	1.62	1.10	0.78	1.40	<0.001
White	21.22	(28.67)	14.51	(24.56)	0.75	0.58	0.39	0.77	<0.001
Substance Dependence									
Black	1.07	(0.82)	0.53	(0.75)	0.54	0.58	0.29	0.89	<0.001
White	0.76	(0.80)	0.28	(0.59)	0.48	0.61	0.43	0.81	<0.001
Drugs and Sex in Combination^a									
Black	70.47	(78.07)	18.29	(26.67)	1.77	0.98	0.67	1.28	<0.001
White	34.08	(27.20)	18.31	(23.58)	1.07	0.72	0.53	0.91	<0.001
Mental Distress^a									
Black	8.42	(6.70)	4.93	(6.01)	0.65	0.71	0.41	1.00	<0.001
White	8.53	(6.04)	5.26	(5.71)	0.60	0.59	0.4	0.78	<0.001
Number of People Available for Support^a									
Black	12.29	(8.70)	13.37	(8.76)	-0.14	-0.18	-0.47	0.11	0.09
White	17.22	(10.29)	17.74	(10.64)	0.00	0.01	-0.02	0.19	0.87
Satisfaction with Available Support									
Black	17.07	(7.08)	18.78	(6.56)	-1.71	-0.26	-0.6	0.03	0.014
White	17.96	(6.20)	18.44	(6.50)	-0.48	-0.01	-0.3	0.11	0.246

^a Effect size (Cohen's *d*) and related 95% confidence intervals are for natural log transformed measures

Changes in effect sizes for substance dependence were moderate (0.58 for African American/Black MSM and 0.61 for Caucasian/White MSM; P<0.001), while effect size for reductions in the frequency of drugs and sex used in combination were higher for African American/Black MSM (0.98; P<0.001),

compared to Caucasian/White MSM (0.72; $P < 0.001$). The effect size for mental distress was moderate, but slightly higher for African American/Black MSM (0.71; $P < 0.001$) than for Caucasian/White MSM (0.59; $P < 0.001$).

The effect size was non-significant for the number of people available for support, however it was very close to significance for African American/Black MSM ($P = 0.09$) with a small effect size (-0.18) indicating an increase in the number of people available. The satisfaction with available support was significant for African American/Black MSM ($P = 0.014$), but not for Caucasian/White MSM, with a small effect size (-0.26) indicating an increase in satisfaction.

Findings: Qualitative Interview Data

Self-Reflection and Increased Mindfulness during Baseline Assessments

During qualitative interviews, men were asked about their participation in the Project ROOM Study and the most frequently mentioned theme was the importance of the baseline assessment. Briefly, the baseline assessment was a standardized questionnaire that took about two hours to complete and was administered by a trained interviewer using a laptop computer to record the quantitative data. The first half of the survey focused almost exclusively on quantifying substance use (number of drugs and frequency of use), and sexual risk behavior (number of partners, frequency of sex, both with and without a condom). Later sections of the survey inquired about mental health, feelings of loneliness and shame, and social relationships.

Nearly all men spoke of the interviews as being a time in which they had to be honest with themselves, reflect on their actions, and evaluate the consequences of those actions. The process of calculating frequencies of substance use and sexual risk behaviors was especially thought provoking.

Common sentiments expressed included:

- “[The interviews] made me look at myself differently – look at my life circumstances differently and what I was doing.”
- “Having to answer questions about my drug use and my sexual behaviors sometimes, you know, that – it made me think about those situations.”
- “Those interviews in the beginning about the drugs and stuff, that was thought provoking.”
- “[The interviews] made me aware, more aware of what I was doing.”
- “It helps put it in perspective sometimes, what you are doing.”

A common misconception among men in the study was that the interviews were part of the intervention process, or at the very least, the interviews had a purpose other than collecting data. In the words of one Miami man, “I always felt like the interviews were like just trying to make you aware of what you are doing.”

For nearly all participants, this was the first time they had ever been asked questions about frequencies of their substance use and sexual risk behaviors, and at times this could be somewhat uncomfortable. A young man from South Miami said, “Some of those questions are like...you don’t want to answer them, but the fact that you don’t want to answer them says something.” While another respondent described it as, “They were embarrassing, but they cause you to look

at yourself too. You take a look at yourself and say, 'This is what I am doing,' and then, 'Perhaps I need to make some changes here.'"

While momentary discomfort may have been experienced by men the first time they were asked about substance use and sexual risk behaviors, the interview process eventually became something the men looked forward to and thought of as "cool," "good," and causing respondents to "feel great." One man described it in this way,

The follow-up I kind of liked, because I was able to see my progress. I was able to actually see from where I came from this point to this point, and I left, and I'm like, "Damn. Last time I answered this, this way. This time, it's this way. The first initial interview I'm like, "Oh my God. Shut the hell up. I'm ready to go and get some drugs." (Laughs). But that was the first one, but after the second one, I'm like, "Wow. It's..." Especially, like, now, I was like, "Wow, I really came a long way," and you don't actually see it until, like, somebody is interviewing you about it, and you think about what you answered the last time. You're like, "Damn. Was that me?"

The follow-up interviews were especially useful in assisting participants to maintain decreased substance use and sexual risk behaviors. There was a common sentiment among participants that knowing they would need to return to complete a follow-up interview played a role in reducing risk because men did not want to report increased risk behaviors during the follow-up. Participants stated that follow-up interviews, "kept me on an even keel," and would, "push me a little bit more."

One of the most important things gained by men during the Project ROOM study, was increased mindfulness and self-realization of the risks of their substance use and HIV transmission risk behavior. Men described the insight

gained during the baseline assessments as instrumental in the decision to make changes in their lives. The follow-up assessments had a similar effect in that they motivated men to continue with their progress in reducing substance use and HIV transmission risk.

Self-Reflection and Increased Mindfulness during Intervention Components

The other part of study participation men frequently discussed during the qualitative interviews was the intervention components, both the group and individual sessions, which had an impact on their risk behaviors. Participants assigned to the individual session did not have observations about the impact of their intervention beyond their comments about the interview assessments. Men assigned to four session group discussion arm of the study overwhelmingly found the diversity of the groups to be the key influence on their behavior change. Participants were impressed by the fact that men who were vastly different than they were could have so many similarities. This led to a recognition that the “this could never happen to me” attitude was false, and that addiction, HIV infection, and related difficult life circumstances do not discriminate. Common descriptions of the experience of participating in the group intervention included:

- “You were able to share and meet different people from different ethnicities and viewpoints, and that part...makes you reflect on different things.”
- “Everybody’s walk of life was different, but we was all the same. There were two people in there that had – was HIV-positive, and I’m like ‘Wow. I never would’ve thought you had HIV, and maybe that could happen to

me.’ So, you know, it made me take precaution. It make me look at myself differently – look at my life circumstances differently and what I was doing.”

- “I thought it was awesome. To see people from so many different backgrounds, have so many things that they agree on, so many similarities. So one minute you are sitting in a room with a bunch of strangers and yet you have all these common denominators of everything we face in real life.”
- “You could look at each one and be like, ‘If that wasn’t me, that could’ve – the path that you chose, it could have very easily have been me.’ That’s what I got out of everybody.”

For men who participated in the group intervention, it was their first experience in discussing such topics with other men. This was particularly impactful for men who wanted to make different choices, especially with regard to HIV transmission risk.

Influence of Study Participation on Internal Assets: Mental Health Improvements

Much of what men obtained from the assessments and the group intervention affected them internally. Men reported improvements in mental health that occurred alongside reductions in substance use and sexual risk behavior, and changes in social relationships. Calling it a “domino effect,” one young Miami man stated, “I have less stress now, because I’m not hanging out with them people, so I’m not more inclined to, like, drink and drug as much as I used to.” Two other men found that study participation facilitated feelings of self-

confidence and self-esteem, as related to being African American/Black MSM. As one Ft. Lauderdale man said, “I think I gained a lot of self-confidence. I’m a pretty confident person anyways, but I do think I gained a lot more self-confidence about being gay and being in the life and that means a lot to me right now to just be comfortable in yourself and to be strong.”

Influence of Study Participation on Internal Assets: “Grow up”

Accompanying improvements in mental health was the use of internal assets to make changes in health and social risks. Nearly half of men described their changes as being due to a sense of fatigue and the need to “grow up.” The notion of growing up described by men included expressions of the need to mature, develop, and behave responsibly. While one man stated that his drug use slowed down gradually as he grew out of that phase of his life, other men described specific moments in which they came to such self-realization.

One young man living in downtown Miami described his apartment as a “central hub” where he and his friends would frequently congregate before late-night parties. As he recalled, “I was there for a couple of years, and I’m like, ‘Why am I still here?’ I’ve had enough. I was like, ‘Have you been here too long? Why aren’t you happy any longer?’” Another, participant in his mid-40s told of seeing an older man in a nightclub with a “Peter Pan complex” who did not want to grow up and deal with life. He remembered thinking to himself, “I don’t want to be that guy that’s all like old and in the club trying to do it. Mind you I can do it, but I just don’t choose to anymore. I find myself going for something. Peter Pan has to go, I mean you have to settle down and get a grip and just chill out.”

This participant called this a “self-realization” that he became aware of as he has gotten older.

Influence of Study Participation on Internal Assets: “Keep Moving”

An important recurring theme from the qualitative interviews, mentioned by a third of participants, is “keep moving.” This is a phrase that comes directly from the words of participants encompassed in it is the notion of making progress, learning from past struggles, and not being held back by adversity. Upon recognition of some aspects of their lives which made them uncomfortable, men seemed to use the notion of “keep moving” to both figuratively and literally move away from substance use and HIV transmission risk environments. Common sentiments included:

- “I want to keep moving. I don’t just mean moving further, [I mean] moving to someplace that’s better for my mental state, because I wasn’t happy anymore. My parents are that way, and my brothers and sister are that way also. We were trained.”
- “Because really, in the scheme of things, it’s done. You can’t do anything about it. Whatever it is. No matter how you might have thought you were wrong, even if you tried to, you won’t be able to correct that wrong, so move on. Keep moving forward.”
- “Just keep going. Just keep moving. Okay, you know, you have certain experiences that are gonna help you dealing with upcoming experiences. You know what I mean? Your little bit of experience will help you get

through your next experience, and that'll build, so I'm not worried. I'm just going."

- It takes some courage and it takes some saying goodbye to some things. But if you're not willing to say goodbye to some things, you're always continually looking back, and never able to move forward."

"Keep moving" did not originate from participation in the Project ROOM study, nor was it a component of the interventions. Many men reported learning such an attitude from their parents or previous life experiences. However it was the increased mindfulness gained from study participation that seemed to spark such a recognition that men had this skill to draw on. As a result, men explained that reduced risk behaviors and fewer negative social relationships were made possible by utilizing the notion of "keep moving."

Influence of Study Participation on External Resources: Social Support

In combination with reductions in substance use and sexual risk behaviors, participants reported changes in their social connections as well. A theme mentioned by a majority of men was the natural separation of themselves and individuals they perceived to be of poor influence. Of their social environment, one young man from Miami stated, "No support at all. They were just either sex friends, drug friends, drinking friends, or party friends," and "I haven't spoken to a lot of people [since the conclusion of the Project ROOM study]. In my head I'm like, "what the fuck was I talkin' to those people for?" A majority of participants had similar experiences. Descriptions such as this one

illustrate that with respect to substance use and sexual risk behavior and associated social relationships, men experienced a new mindfulness.

As a result, a majority of participants began to search actively for positive social connections and supportive relationships. One young man said the interview assessment questions about friendships and relationships helped him to realize he needed to reach out to people he may not have reached out to before and be more social. One Ft. Lauderdale man said he had been “trying to hang out with more positive people, more positive influences,” seeking out different social events and outings in which to make new friends, and making it a point to go out and meet new people. In addition, a third of the respondents reported reconnecting with friends and family social supports. In the words of one young participant in describing his new social supports, “A lot of them was people that I always had, but I was too high to see it.” Other participants had similar experiences and reported reconnecting with family members who provided both material, financial, and emotional support.

Another aspect of social support frequently cited as a benefit from participating in the study was the opportunity to “vent” or share opinions, or meet people. Some men, especially those who had prior experience with support groups, were attracted to a venue in which they would be asked to respond to questions and possibly participate in a group. Conversely, many others were anxious or intimidated by the possibility of being interviewed by strangers and having to share thoughts and feelings with other men. As one man from Miami

stated, “I was anxious and nervous about someone asking me questions about my life. That turned into something that I kind of maybe looked forward to.”

Participants described being able to talk and share things for the first time, which had a large impact on their reductions in risk behaviors. One respondent attributed his behavior change to the fact that he had someone listening to him in a confidential setting. In his words, “I used to live for it. I used to couldn’t wait to get there. I used to say, ‘I just can’t wait to get off my feet, get there and be comfortable and just speak out on things...’” Other men had similar feelings as they described sharing their opinions and “venting” during the interviews and the camaraderie of the group sessions. For many, such an experience was novel and the impact was felt across many aspects of their lives. As one Ft. Lauderdale man said, “Well, I think coming to the groups, and then reflecting, and talking to people, and also meeting people in the groups that were HIV positive, and the whole just coming in and doing the whole thing – the whole research thing, the whole questioning, the whole, you know, your opinion matters, and you matter, and, because if your opinion matters, then you matter.”

One particularly moving story was told by a Ft. Lauderdale man who described himself as a “homebody” and stated that he didn’t go anywhere or do anything, “so it was kind of nice being forced to interact with people.” This participant always wanted to form stronger social relationships with others, but felt too inadequate to do so. Thus, when he was able to disclose that he was a substance user and HIV-positive during the group sessions, it was a big milestone for him. In his words, “Those are very personal things. I don’t know

why I was able to do it, but I did it. I felt kind of relieved as a matter of fact, especially about the HIV thing. So it's a relief for me to let them know so you don't have to wonder anymore. And maybe people aren't wondering, but I think they are wondering. I mean, I guess I just wanted them to know be better is pretty much why I did it."

His comments speak to the social support felt by many of these men, both from the staff and from other men in the groups. Such is often lacking among African American/Black MSM, and it was frequently mentioned by men when describing their substance use and sexual risk behavior. As one young Miami man said:

A lot of [White and Hispanic men] don't have the hardships that a lot of Black males have, and I think, so when Black males get into a warm and a nurturing environment where they can really be themselves, and people seem to not be judgmental and open to them or whatever, I think they can't help but to thrive in there. I think [Black men] are a little bit more appreciative, because I think they that they have to deal with a lot more in life. I mean, let's get real. Black men have the highest incarceration rate, the highest incidence of AIDS, the highest homicide rate, the highest murder rate, the highest suicide rate... That's a recipe for disaster, so I'm saying, so yeah, so when [Black men] come into any environment like this, of course it's going to be a positive benefit for them.

Many men expressed similar comments and described the hardships African American/Black MSM face and the impact that feelings of social support from the study had on them. There was a sense of feeling among the men that when someone shows care or concern, it ignites a deeper sense of care within

themselves. Thus, men described reduced desire to engage in such substance use and sexual risk behaviors.

Influence of Study Participation on External Resources: Financial Support

Besides the benefits of reduced engagement in substance use and HIV transmission risk behaviors and increased social support, one of the most frequent reasons men stated for choosing to enroll in the study was the financial incentive. Men reported needing money and the financial incentive was a major perceived benefit. In the words of a young Miami man, “At first I thought to enroll because I was unemployed, and I needed, like, some extra cash, and I’m like, ‘Okay, I qualify. I might as well go,’ and that was the thing that got me in.” An older man from Miami described the study as a “win-win” because “I got money that I desperately needed.” As described in Chapter 4, many respondents were not financially stable. Therefore, the small compensation offered for time and travel was extremely important for these men.

The Influence of Diversity

Another key element from the study for men who were randomized into the group intervention was the presence of people different than themselves. The men in the groups were diverse with regard to a range of factors including age, race/ethnicity, HIV status, socioeconomic status, etc. Participants noted how different all the men in the groups were from each other, and yet there were, “common denominators,” “so many things we agree on; so many similarities,” and “everybody’s walk of life was different, but we was all the same.” In such an environment, participants felt like they were able to learn from the experiences of

others and realize, “I’m not the only one.” This was an important realization, as many men felt so isolated that no one would understand their particular struggles or feelings. Seeing other men who were different and yet the same, facilitated feelings of social support between group participants and bolstered behavior change.

Discussion: Greater Reductions in Risk Behaviors and Improvements in the Social Environment among African American/Black MSM

As seen in the results section above, risk reduction among African American/Black MSM in the Project ROOM study was nearly universal. When compared to White men, data from the multi-level models indicate that African American/Black MSM experienced a significantly larger and more rapid rate of reduction of substance use and HIV transmission risk over time. In addition, men were able to maintain these risk reductions at the 12 month follow-up interview. When looking at the baseline to 12 month changes in the mean values of the primary and secondary outcome measures, African American/Black MSM experienced greater changes in not only frequencies of days high and HIV transmission risk, but also reduced mental distress, and increases in the number of people and satisfaction with social support compared to Caucasian/White MSM. These changes further demonstrate the successful risk reduction in syndemic health disparities by African American/Black MSM.

These results are important and demonstrate that among such a vulnerable population, heavy substance-using MSM, significant changes in risk reduction are achievable. As has been well documented among the literature

and data from Chapter 4, among MSM, African American/Black MSM have even greater vulnerabilities. Thus, the fact that they are able to achieve substance use and HIV risk reduction greater their Caucasian/White MSM counterparts is especially encouraging.

Moreover, the decreases in mental distress and increases in social support measures illustrate that changes made during participation in the Project ROOM study had spillover effects into other aspects of their lives. These data allude to the syndemic nature of African American men's problems. In addition, they suggest that reductions in syndemic health disparities correspond to increases in protective factors, namely social support.

The risk reductions reported by the high risk MSM substance users in the Project ROOM study were as large or larger than those achieved by other efficacious interventions for MSM now being diffused as tools in standard public health practice and are particularly impressive given their achievement in such a high risk population, however no significant differences were found between interventions arms (Kurtz et al. 2013a). One of the strengths of the Project ROOM study was that it demonstrated that targeted brief intervention is just as efficacious as the longer more time intensive group intervention.

Among African American/Black MSM, intervention RCTs to reduce HIV transmission risk have shown mixed results (Coleman et al. 2009; Koblin et al. 2012; Peterson et al. 1996; Williams et al. 2013; Wilton et al. 2009). Further, a majority of them involve time intensive or multi-session interventions. None of these intervention trials reported measures of substance use as outcomes. This

is especially worrisome as the syndemic relationship between substance use and HIV is well demonstrated (see Singer 2009 for a review).

While two intervention studies among African American/Black MSM do address both substance use and HIV transmission risk, neither of them are RCTs, thus their outcomes have not been fully demonstrated as efficacious. However, one study in particular, the Bruthas project (Opario et al. 2010) does seem to have some promise. Its results showed reductions in substance use and HIV transmission risk in addition to improvements in social support, self-esteem, and loneliness. Further, the study states that it sought to address the social context of HIV. The weakness of this study is that it does not connect any of its results to the lived experiences and social environment of the men in the study. Consequently, there is no way in which to determine why reductions in substance use and HIV transmission risk occurred.

A strength of the present study is that it does examine reasons why risk reductions occurred using qualitative data collected from 21 African American/Black MSM who completed the Project ROOM study. As seen in the data, participation in the study enhanced men's resilience processes though increased mindfulness and self-realization, with nearly all men describing these phenomena as occurring during the baseline and follow-up assessments. Further, men participating in the group intervention arm of the study described the interaction with other men as facilitating self-realization about the dangers of substance use and HIV transmission risk.

Men's stories shared during qualitative interviews suggest that accessing and using internal assets and external resources was key to their risk reduction processes. Internal assets, bolstered by study participation, include motivation to continue behavior change, a desire to "keep moving, or a recognition of the need to "grow up." External resources include the new or improved social supports obtained by men, the use of Project ROOM study components as means of sharing, communicating, or venting, and the ability to earn compensation for their time and travel, which was important for men with limited financial resources.

As is seen above, many studies investigate HIV as an independent outcome variable, without regard for the social environment of study participants. Qualitative data presented here suggest that risk reduction interventions that are tailored to the social context of HIV will have better success. The Project ROOM study addressed the lack of social support among African American/Black MSM. The fact that many African American/Black MSM have little social support was described in Chapter 4. By providing this necessary resource, the Project ROOM study was able to positively affect the social environment of African American/Black MSM and in turn, African American/Black MSM were able to achieve positive changes with respect to their syndemic health disparities.

Conclusion

The purpose of this chapter is to review existing literature on risk reduction interventions for MSM and African American/Black MSM. Quantitative data presented in this chapter demonstrate the sizable risk reductions among African American/Black MSM following completion of the Project ROOM study. When

compared to White men, the changes made by African American/Black MSM were significantly greater. Qualitative data suggest that all parts of the study, both the assessments and the interventions, were instrumental in assisting African American/Black MSM in reducing their behaviors related to syndemic health disparities. These reductions can be attributed to accessing and utilizing internal assets and external resources, both of which are key components of resilience theory (Zimmerman and Arunkumar 1994; Kolar 2011). Thus, qualitative data indicates that the Project ROOM study did have a positive impact on men's expression of resilience. Chapter 6 explains men's resilience processes in greater detail and specifically describes the internal assets and external resources used. Further, Chapter 6 examines resilience using a framework of agency and structure in order to further investigate the social environment as it relates to HIV transmission risk.

CHAPTER 6

AGENCY, STRUCTURE, AND RESILIENCE PROCESSES AMONG AFRICAN AMERICAN/BLACK MEN WHO HAVE SEX WITH MEN IN SOUTH FLORIDA

You have certain experiences that are gonna help you dealing with upcoming experiences. You know what I mean? Your little bit of experience will help you get through your next experience, and that'll build, so I'm not worried.

-23 year old African American man from South Miami

Introduction

This chapter examines resilience among African American/Black MSM who completed the Project ROOM study. Previous chapters have documented many syndemic health disparities and structural inequalities, in addition to descriptions of great resilience with regard to reducing substance use, HIV transmission risk behaviors, and additional health and social disparities. With this in mind, this chapter conceptualizes resilience as: 1) located within the relationships between individual agency and structure, 2), built upon African American/Black MSM access to social, economic, and cultural capital, 3) exposure to adversity within the social environment. Using this framework, this chapter will address the final research question, “How did the presence or absence of individual agency and social environment resources affect the

resilience processes for African American MSM in overcoming HIV transmission risk and related syndemic health disparities?”

While not explicitly naming it as such, cultural anthropologists and other social scientists have been studying resilience among MSM (including transgender MSM) for decades. Examples include ethnographies and historical analyses highlighting unique cultural expression (Newton 1979; Newton 1993; Levine 1998; Chauncey 1994; Herdt 1993; Valentine 2007) and the development of sexuality theory (Connell and Dowsett 1992; Herdt 1997). Explicit in all of these works are the foundations of resilience, which is successfully coping with or overcoming risk or adversity.

Moreover, though similar resilience frameworks have guided investigations of health disparities among women in urban Tanzania (Obrist 2006) and among adolescents (Ungar 2004), this is the first apparent study to examine resilience among this population with regard to HIV transmission risk and related syndemic health disparities. Using qualitative data from 21 substance-using African American/Black MSM, this chapter will describe a constellation of background characteristics associated with resilience among this population, and the specific forms of individual agency employed by these men to access assets and resources necessary for them to exhibit resilience. In addition, this chapter will also highlight lessons learned from the field that will guide future work in this area. The chapter begins by extending the review of the literature from Chapter 2.

Structure and Agency in Resilience Literature

Over the last 40 years, the field of psychology has produced a great body of literature theorizing the concept of resilience. Through the work of Garmezy (1973; Garmezy and Streitman 1974; Garmezy et al. 1984), Rutter (1985; 2000), Masten (Masten 2001; Masten and Powell 2003; Masten and Obradovic 2006), Luthar et al. (2000), and many others, consensus has built around that idea that resilience is not an individual trait or state of being. Rather it is a dynamic process in which individuals are capable of positive adaptation or resistance, recovery, coping, and success within the context of adversity (Luthar et al. 2000; Masten 2001). The process of positive adaptation occurs through protective factors, or assets and resources that facilitate a positive outcome for individuals exposed to risk (Wright and Masten 2006). Thus, in order for an individual to be resilient, they must have experienced some form of risk and utilized protective factors in order to adapt positively (Kolar 2011). While risk exists for everyone, and risk factors and disparities need to be assessed, the emphasis of resilience research is on protective or enabling factors (Obrist, et al. 2010).

Recent literature advances the idea that resilience is also a quality of an individual's social environment (Liebenberg and Ungar 2009). In his social ecological definition of resilience, Ungar (2008:225) proposes that resilience is the capacity of individual to *navigate* to resources (psychological, social, cultural, and physical) that sustain their well-being, and their capacity to *negotiate* for resources to be provided and experienced in culturally meaningful ways. Thus, resilience, as a form of agency, is dependent on the culture in which the

individual is situated and the capacity of that culture, and its associated structures, to make resources available and accessible in ways that are meaningful to the individual.

Ungar's Four Principles for Conceptualizing Resilience

The work of Ungar (2008; Liebenberg and Ungar 2009) implies that individual agency and structure are primary determinants of one's capacity for resilience. Ungar's (2011) definition of resilience is based upon four principles. The first, "decentrality," refers to the fact that an examination of resilience must simultaneously involve the study of the individual's successful change that occurs in addition to the broader community-level and socio-economic variables. This decentralized focus investigates individual agency by exploring what individuals do as a result of the capacity that the wider environment has to provide.

"Complexity" is the second principle and by this, Ungar (2011) refers to changes in an individual's ability to express resilience over the course and experience of time, in addition to changes in one's context and social environment that occur over time. Thus, the resilience that one is able to express through individual agency is variable depending on time and broader contextual and structural factors.

Ungar's (2011) third principle for conceptualizing resilience is "atypicality," which describes the expression of resilience in ways that are not typically thought of as successful coping behaviors. In order to understand how such individual action may be viewed as successful, the larger context must be considered in which such behaviors may be seen as resilient when defined within local

contexts. In this instance, resilience is manifested in ways that may be understood to be deviant by outsiders, but such actions are necessary as a result of specific social environmental context. Lastly, Ungar (2011) describes “cultural relativity.” Resilience is understood to be embedded within culture in which dominant structures and cultural elites largely have the power to define what is successful with regard to health or development. Discourse emanating from structures largely determines what actions are available to cultural minorities in order to be resilient. Thus resilience for minority populations will only be seen as successful when dominant structures and cultural elites are convinced that minority expression of resilience and solutions to problems are valid.

Navigation and Negotiation

As seen above, Ungar’s (2008) social ecological definition of resilience, based on four key principles, is comprised by the capacity of individuals to navigate and negotiate. This two-part definition expands previous individual-focused conceptions of resilience and incorporates anthropological understandings of agency and structure. The result is a more complete understanding of individual and social determinants of health and well-being.

Navigation

Central to Ungar’s (2008) definition of resilience is the notion that individual agency is both constrained and enabled by structure. The concept of navigation describes ways in which individuals must exercise personal power in order to acquire necessary resources to cope successfully with risk (Ungar 2010). According to Ungar (2011) the concept implies personal agency because

individuals must be motivated to actively seek out or physically move toward the required resources. Yet, this agentic exercise occurs within established physical, social, and cultural environments. Navigation takes these structures into account and understands that resources are selected from those that are both available and accessible within these environments (Ungar 2010).

However, Ungar (2008) also contends that structures constrain agency. Navigation also means that resources necessary for individual resilience must be available and accessible within one's specific environment. Yet, for individuals who are part of a minority or disadvantaged population, these resources may not be made both available and accessible by dominant structures or powerful elites (Ungar 2011). This agentic exercise is therefore constrained by the structures in place. Navigation, then, is a multidimensional concept that accounts for the way that resilience, expressed through individual agency, is both constrained and enabled by structure. This is a key difference between Ungar and much of the earlier resilience focused on the individual capacity to act and individual environment, but did not consider the capacity of the environment to provide (see Kolar 2011 for a review).

Negotiation

The second key component of Ungar's (2008) definition of resilience is negotiation, in which individual agency sustains the reproduction of structures, but also makes it possible for them to be transformed. Negotiation describes the process by which individuals not only seek out resources needed to be resilient, but also the process by which individuals request or demand that these

resources be available and accessible in culturally meaningful ways (Ungar 2010). In doing so, the established physical, social, and cultural environments are challenged. Disharmony between negotiating individuals and the powerful elites creates conflict and potential transformation. Negotiation entails not only the capacity to secure resources successfully, but also the discursive power to define one's self and one's coping strategies as successful in the face of dominant structures (Ungar 2010). It is through the negotiation for health-sustaining resources that transformation of structure occurs. If successful, negotiation creates a pathway by which those in power must not only provide resources, but do so in a way that the marginalized or disadvantaged find meaningful (Ungar 2011).

Hidden Resilience

A major contribution to resilience theory is the idea of *hidden resilience*, or, "patterns of coping that allow individuals to experience their lives subjectively as successful whether or not others outside their culture and context see them that way" (Ungar 2010: 417). Individuals, especially minorities or those who are disadvantaged, live within physical, social, and cultural environments and these environments are dominated by those in power (Ungar 2010; 2011). As an example, Ungar (2010) describes the process of some racial/ethnic minorities who do not finish secondary school. Though literature suggests that generally only formal education is seen as valuable, for these marginalized individuals formal education may not be accessible or useful, especially given structural barriers to post-graduation employment or advancement. Thus, leaving school,

in an effort to earn money or provide for one's family, is an expression of resilience, given the specific context (Ungar 2010). In this example, secondary school is a resilient resource that is not being provided in a way that meets marginalized students' needs. Students acting within these constraints are able to make choices and seek resources that will allow for successful coping in the presence of risk or adversity. Though it may not appear so by dominant social standards, these students are demonstrating resilience and exercising agency within such structures.

The discursive power to define one's own form of resilience is also a key component of hidden resilience. Expressions of hidden resilience involve unconventional behaviors and attitudes, and cause confusion, discomfort, and even anger for those in power or individuals operating within the dominant structural environment (Harvey 2012). However, when successful negotiation occurs and the structural environment gains the capacity to provide resources in culturally meaningful ways, hidden resilience is no longer hidden.

Transformation in the broader structures generates new ideas about what is and is not successful coping, and those who are viewed as marginalized or disadvantaged are no longer perceived as such.

The Role of Social, Economic, and Cultural Capital in Agentic Expressions of Resilience

Obrist et al. (2010) are in agreement with Ungar (2011; 2008; Liebenberg and Ungar 2009) and suggests that theories based on agency and structure are not only the most appropriate for studying resilience, but can also sharpen the

analytical focus. Guided by the work of Bordieu (1984; 1986) and Ortner (1984), Obrist (2006; Obrist et al. 2010) are particularly interested in the relationship between agency and structure.

In the view of Obrist (2006; Obrist et al. 2010), human capacity to act is constrained by structures that are shaped by economic, political and social forces. Like Bordieu (1984; 1986), Obrist et al. (2010) understand agency as being determined by material and non-material resources composed of social, economic, and cultural capital. Building off of Bordieu's (1984; 1986) notion of a social field, Obrist (2006; Obrist et al. 2010) puts forth the idea that individuals have varying access to capitals, and in addition, individuals are exposed to the same risk or adversity to varying degrees. Thus, in the expression of resilience, individuals come from social environments with varying structural barriers and opportunities. At the heart of this anthropological conceptualization of resilience is the notion that resilience is built in these social environments when individuals are able to access different forms of capital. Those unable to access necessary capital will be less likely to express resilience. From this perspective, individual agency is both constrained and enabled by social, economic, and cultural capital made available within existing structures.

Addressing Previous Gaps in Resilience Literature

One of the key things Ungar and Obrist have attempted to do is define resilience in a way that is not full of subjective assumptions about what is and is not a positive outcome. The criterion that constitute resilience are often constructed by researchers at a macro level and therefore positive adaptation is

frequently constructed from White, middle-class, Western values (Glantz and Sloboda 1999; Ungar 2004, 2005; Obrist et al. 2010). Three points from the literature address this criticism. First, the notion of *hidden resilience* is used to describe patterns of coping or creative solutions that mitigate risk and allow individuals to experience their lives as subjectively successful (Ungar 2010:417; Ungar 2004). Second, it is important for researchers to assess whether individuals recognize a risk, believe it can be overcome, and highly prioritize the risk (Obrist et al. 2010). Lastly, researchers must broaden the study of resilience to include diverse populations, including adults and minorities outside of the mainstream (Liebenberg and Ungar 2009).

Recent Contributions from Resilience Literature to Investigations HIV and Health Disparities among MSM

Social and behavioral scientists have recently begun to take note of agency and structure with regard to HIV prevention (Auerbach et al. 2011; Kippax et al. 2013; Kippax and Stephenson 2012; Arreola et al. 2013). From their perspective resilience exists when individuals have the capacity to manage risk present within their environment (Auerbach et al. 2011), and resilience is a product of a dynamic interplay, shaped by the environment, between agency and community. In order to study HIV from this perspective effectively, research must use a socio-cultural framework in which HIV prevention is seen as engaging with and integrated into social relationships, lives, and the environment (Kippax and Stephenson 2012).

One such population receiving much attention with regard to resilience and HIV prevention is MSM (Herrick, et al. 2011; Herrick, et al. 2014; Herrick et al. 2013; Kubicek, et al. 2013; Kurtz, et al. 2012). Some researchers have taken on the task of designing a specific theory of resilience for MSM. Based on hypotheses developed by prominent MSM researchers and thought leaders in the field of gay and bisexual men's health, Herrick et al. (2014) developed an initial theory and measures of resilience which included many individual, social, and community factors thought to be important in developing resilience among MSM, with respect to HIV prevention. While several components are similar to those developed in the field of psychology, such as altruism and optimism, many are specific to MSM, such as sexual and gender identity, level of "outness," integration with gay life, connection to queer history, and queer family bonding. However, what is missing is an in-depth understanding of variables that both support and hinder resilient actions among MSM (Herrick et al. 2014).

While Herrick et al. (2014) are the first to propose a theory for understanding resilience among MSM, a limited number of studies have examined resilience characteristics among populations of MSM. The measures used were mostly limited to psychosocial health measures related to HIV, such as coping skills, internalized homophobia, and peer and family support (Kurtz et al. 2012; Herrick et al. 2013; Kubicek et al. 2009; Mustanski et al. 2011). Other, recent research, has attempted to reframe this by taking a wider view of MSM sexual health. While not looking specifically to resilience theory, Arreola et al. (2013) argue that to reduce HIV risk among Latino MSM, interventions should

focus on developing a sense of agency, facilitating an awareness of structural oppression, and incorporate both individual and structural elements into constructions of sexual health. However, a comprehensive examination of resilience and its relationship to agency and structure among MSM remains lacking.

Resilience research among African American/Black MSM, though very limited in scope, has focused on individual spirituality (Kubicek et al. 2013). However, to understand agentic practices of resilience among this population fully, as it relates to HIV transmission risk, an in-depth examination of structural constraints of the social environment and cultural context is necessary (Liebenberg and Ungar 2009 ; Obrist et al. 2010). As described in Chapter 4, African American MSM experience HIV infection and prevalence rates well above those of other populations of MSM (Centers for Disease Control and Prevention 2010b; Prejean et al. 2011). African American/Black MSM also experience a host of related syndemic health disparities, including substance use, victimization and gang involvement, incarceration, poor physical health, etc., at greater rates than other MSM (Hatfield et al. 2009; Tobin et al. 2011; Harawa et al. 2008; Garofalo et al. 2010; Mays et al. 2004). Moreover, African American/Black MSM are subject to additional structural inequalities such as poverty, lack of adequate education, discrimination, and incarceration, that are specific to African American/Black populations in the United States (Bowleg and Raj 2012; DeNavas-Walt et al. 2012; Lim et al. 2011, Bassuk et al. 1997; Susser et al. 1993; Brondolo et al. 2009; Schnittker et al. 2011).

Díaz et al. (2008) describe a large body of literature documenting structural homophobia within African American society. Further it has been suggested that some of the most significant health inequalities among African American/Black MSM, such as HIV infection and victimization, may be attributed in part to homophobia and stigma within African American society (Mays et al. 2004; Harawa et al. 2008). As a result African American/Black MSM are less likely to disclose sexual orientation and are more likely to be exposed to heterosexist community, family, and religious norms (Balaji, et al. 2012; Maulsby, et al. 2014; Millett et al. 2006). Further, African American/Black MSM are less likely to have access to adequate social support (Mays et al. 2004), which may in part be due to social structural messages against homosexuality and stigma disseminated by many African American churches and the involvement of many African American families (Fullilove and Fullilove 1999; Miller 2013; Peterson and Jones 2009). The absence of social support is also associated with many other adversities, including financial hardship (Ayala, et al. 2012).

Examination of the Resilience Process – Cross Case Analysis

As seen above, it is clear that African American MSM are embedded within a unique social environment, when compared to other MSM. The first step in examining resilience processes among these men is to examine the context in which resilience is exhibited. As described in Chapter 3, the examination of resilience presented here consisted of qualitative interviews with 21 African American/Black men from the Project ROOM study. Though qualitative interview

respondents were selected based upon their ability to be contacted, these men were generally not different from the other African American/Black MSM.

Shown in Table 7 are selected characteristics of African American/Black MSM who did and did not participate in the Phase 2 qualitative interviews.

	Non-Phase 2 Respondents		Phase 2 Respondents		Chi-square or F statistic	P
	N=87	80.6%	N=21	19.4%		
Demographics						
Age ¹	38.9	(9.4)	40.8	(8.197)	0.685	0.410
Miami-Dade County residence	46	52.9%	11	52.4%	0.002	0.968
Substance Use Behavior (past 90 days)						
Days high ¹	34.9	(33.3)	32.2	(35.50)	0.187	0.667
Drugs and sex used in combination ¹	79.7	(101.3)	69.4	(81.16)	0.104	0.748
Sexual Behavior (past 90 days)						
Partners ¹	14.3	(21.2)	16.3	(21.91)	0.152	0.697
Unprotected sex times ¹	28.4	(49.3)	25.1	(58.60)	0.072	0.790
Syndemic conditions						
Severe mental distress	52	59.8%	11	52.4%	0.380	0.538
DSM-IV substance dependence	64	73.6%	14	66.7%	0.401	0.527
Victimization history	65	74.7%	18	85.7%	1.151	0.283
Structural violence indicators						
Education - 12 years	69	79.3%	20	95.2%	2.960	0.085
Homeless (past year)	40	46.0%	8	38.1%	0.426	0.514
Identify as gay	49	56.3%	14	66.7%	0.745	0.388
HIV-positive	58	66.7%	11	52.4%	1.496	0.221
Social Environment						
Number of people available for support ^{1,2}	11.5	(8.3)	14.1	(9.3)	1.642	0.203
Satisfaction with available support ^{1,3}	16.8	(7.3)	17.4	(6.3)	0.114	0.736

¹Mean; SD

²Range 0-45

³Range 0-25

The table illustrates that there are no significant differences between the samples with regard to demographics, substance use, sexual behavior, syndemic characteristics, structural violence indicators, and social environment. Therefore,

it is likely that the findings from the qualitative data presented below are representative of the African American/Black MSM from the Project ROOM study.

With qualitative data obtained from the sample of 21 African American/Black MSM, a variation of a causal network analysis was conducted (see Chapter 3 for a full description of the methodology). A true causal network analysis uses study variables to illustrate the processes by which a chain of variables (each one leading to the next) is linked to the final outcomes(s) (Miles et al. 2014). However, the variation of the causal network analysis utilized here illustrates how a constellation of social environment characteristics (e.g. religious affiliation, familial support) lead to a constellation of resilience processes (e.g. issues with disclosure of sexual orientation; coping with syndemic health disparities), and these ultimately lead to the outcome, that is the focus of this study, whether or not men continued to engage in HIV transmission risk behaviors, measured by unprotected sexual intercourse, following completion of the Project ROOM study.

Described below, men in the causal network analysis fell into two distinct streams illustrated in the diagram below (Figure 1). Each stream is accompanied by a narrative which essentially tells the story of each stream, expanding upon the variables appearing in the diagram (Miles et al. 2014). Variables described in the streams are identified by a number in parentheses, which corresponds to a numbered variable in Figure 1 (Note: the numbers in the diagram are used to solely to assist the reader). Taken together, the diagram and the narrative text

communicate more than either could alone (Miles et al. 2014). A comparison of the streams illustrates how each set of social environment characteristics is associated with a specific set of resilience processes. The social environment characteristics and the resilience processes in each stream ultimately lead to different outcomes regarding HIV transmission risk.

Stream 1

Men in this stream (N=16) were nearly evenly split between those who had a background of strong ties to African American churches (1) and those who did not. However, among men in this stream, expressed in the phrase, “gay is taboo,” there was a feeling that homosexuality was unacceptable in society and in African American culture (2). Such feelings were exacerbated when combined with a family that was unsupportive or intolerant toward same-sex behaviors (5). All of these men experienced low SES and lack of access to necessary social, economic, or cultural capital during adulthood (4). As a result of these background characteristics, their resilience processes were based on the fact that disclosure of sexual orientation or same-sex behaviors was more of an issue (7), as doing so would lead to further marginalization and a loss of their already limited access to capitals. Thus, in this way, men in Stream 1 are understood to be engaging in *hidden resilience*. Largely due to their social environment, men were exposed to syndemic risks, including substance use, HIV, violence, and structural social inequalities (9). However, drawing upon internal strengths and accessing external assets and resources, including the Project ROOM study intervention as described in Chapter 5 (10), resilience processes continued for

these men. As a result, by their completion of the ROOM study, men in this stream did not report any HIV risk (11).

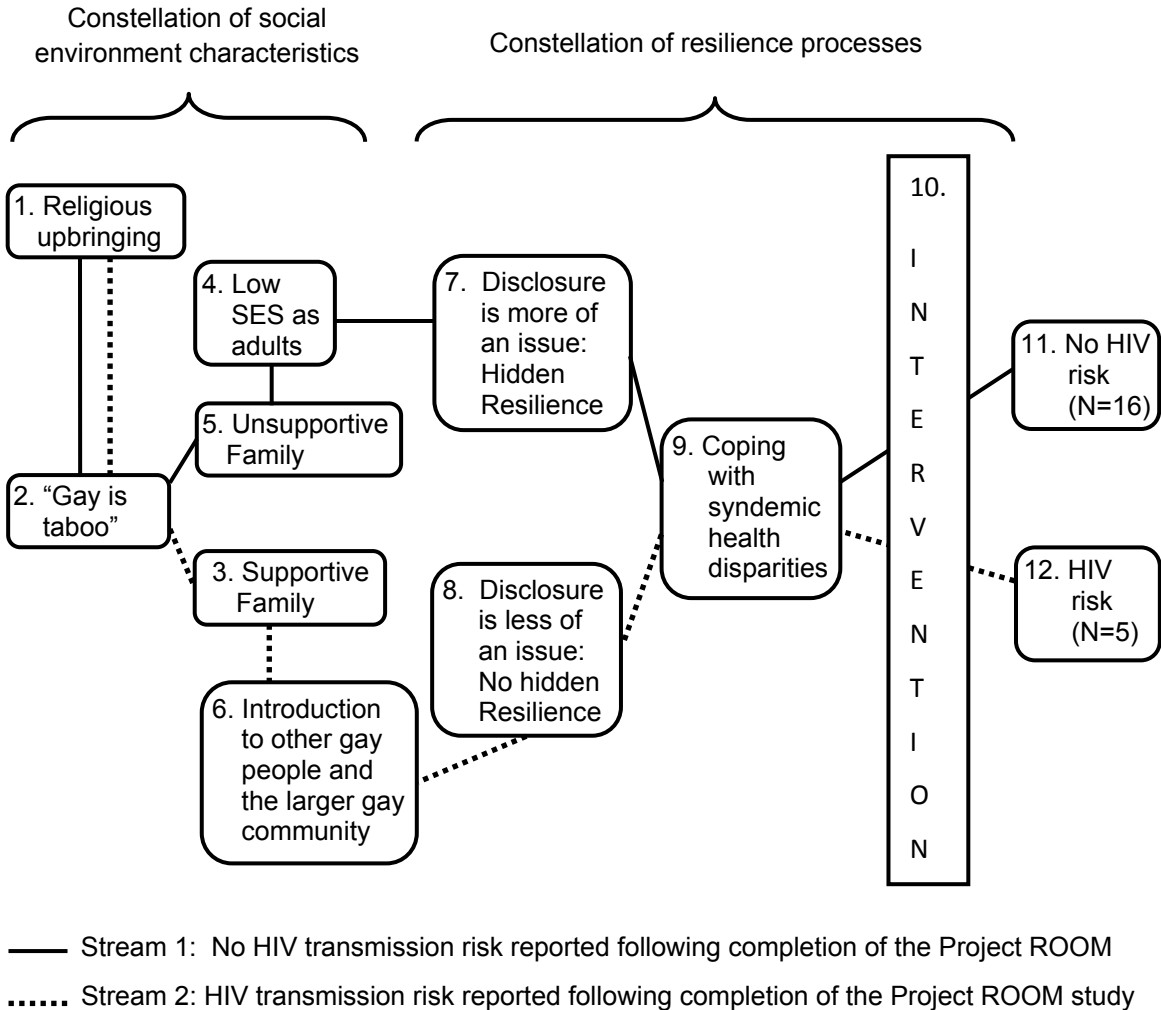


Figure 1: Cross-Case Analysis of Resilience Processes Associated with HIV Transmission Risk (unprotected sexual intercourse)

Stream 2

For the men who did report HIV transmission risk following their completion of the Project ROOM study (N=5), all but one had a background of strong affiliation with an African American church (1) and all men had

experiences of homophobia in society and in African American culture, and they identified with the notion of, “gay is taboo” (2). However, they also had a supportive family who were tolerant of sexual orientation or same-sex behavior (3). Further, men described having gay individuals in their social networks or experiences in the gay community early on (6). Because of their more supportive and diverse backgrounds, disclosure was less of an issue for men in this stream (8). However, their exposure to syndemic health disparities (9) was attributed to their association with the gay community. These men used internal strengths and external assets and resources to exhibit resilience and lessen the burden of syndemic risk exposure. However, upon completion of the Project ROOM study intervention (10), these men reported continuing HIV risk behaviors (12).

Examination of Resilience Processes – Key Themes

Data described here follow two unique streams of experiences of African American MSM. The first stream is that of men who did not report HIV transmission risk (unprotected sexual intercourse) following completion of the Project ROOM study. These men generally had more experiences of homophobia and a lack of family support, which led to concerns over disclosing sexual orientation or same-sex behaviors. Stream two consists of men who did report HIV transmission risk (unprotected sexual intercourse) following completion of the Project ROOM study. While men in this stream also experienced homophobia, they generally had a supportive family and also made connections with gay men and the gay community.

Stream 1: Homophobia–African American culture, religion, and family

The most important influence on the lives of men in Stream 1 (those men who did not report continuing HIV transmission risk) was homophobia. Indeed, in discussions of men's lives, homophobia seemed to be ever-present and intertwined with African American society, religion, and social relationships. This in turn affected the men's relationships, decision-making, and daily existence.

Many men described their sexual orientation or sexual behavior as being "taboo" within African American society. Illustrative of this are sentiments from three respondents. The first, a young Miami man stated, "Well, mostly in the Black culture, being gay is a taboo, and, you know, it's not really accepted among the Black community, especially here in Florida." Second, another man said, "Homosexuality was a big taboo, which was one of the reasons I, you know, I decided to leave and go off to college," and lastly, an older respondent stated, "In my religious circle, it was very, very taboo." Others had similar experiences, with one man describing African American society as being "hardcore" with regard to negative attitudes toward MSM.

A majority of men had religious families and were raised in African American churches. Thus, their view of African American society was heavily influenced by their religious affiliation. As one man stated, "Most of those people, you know, if they're in the church, they're like 'This is God's vengeance upon you; this is - this is AIDS that has come down to cleanse the Earth and this is your, this is your punishment for laying down with the same sex.'" Other men

described religious messages of, “homosexuality is damnation,” and the fear associated with it. This had a profound impact on some participants, summed up by one older man, “They would talk like you were going straight to hell. So I think that was more of a problem for me than, you know, the community stigma. The knowledge or the idea that I was going to hell, I think that was my biggest fear.”

Homophobia found in society and religious institutions was often present in family relationships also. For most men, families were reluctant to be accepting of the men’s sexual orientation or same-sex behavior. In describing disclosure of same-sex behavior, one man stated that, “For a Black boy or Black girl, it’s you know, twice as hard, cause it’s just not acceptable. It is not acceptable.” One older man described his family this way,

I was saying to my mother, I said, "I've got all of these strikes against me." I said, "I'm a black man in America," I said, "I'm HIV positive," I said, "and I'm gay," and she said, "You're gay?" And she kept saying, "You're gay?" And I'm thinking to myself, "Now, she didn't say nothing about me being HIV positive, but she is stressing all of this about me being gay," you know, but I have this illness that we have no cure for, that we know - this was back in the '90's - that we know almost nothing about, and she's focusing on the fact that I'm gay.

The fact that this participant’s mother’s homophobia was stronger than her concern for his HIV infection, considered fatal at that time, was quite surprising to him. However, the strength of such homophobic attitudes among men’s families was not uncommon. A large number of participants’ experiences similar to that of this man,

You know my family, they don't know about my sexuality, they don't know about me. You know growing up in the

church, African American [gay] marriage wasn't accepted and it was like, you know, the gay people that they saw were always feminine. They wasn't regular people. And so, you know, they and my brother and all the family members talked bad and down about gay people, and that's something that I kept to myself.

While many men did not disclose, those who did often engaged in avoidance of discussing or mentioning it around family members. Participants stated that having unsupportive families had a negative impact on their family relationships. "I'm cordial with my family. I speak to them, but I don't have a relationship with them. I don't have a personal relationship where they know what's going on in my life or what I don't do and do," stated one man. Another participant said that he had been cutting down his visits to his family to only holidays or special occasions as a direct result of their non-acceptance of him.

A common sub-theme related to homophobia was that lack of disclosure or avoidance of disclosure of sexual orientation and behaviors was a direct response to homophobia and stigma, not just among family members, but in the men's larger social environment. One older man said, "Like my mother once told me, 'You can be gay. Just don't be gay around me.' I never really understood what that meant, but in a way I did, you know? And I think to this day I'm still gay, but I'm not gay around certain people, if you get my meaning." One young man had a similar experience and described his family's attitude as, "I still love you but that doesn't mean that I have to accept what you do." He went on to say, "That's no problem, I understand. Just because [I] want to live a certain way doesn't mean that everybody has to accept that, and I got that in my head."

Attitudes such as these heavily influenced men's behavior and decision making. As a common response to societal, religious, or familial homophobia, respondents described the notion of "D.L." or "down low," in which men actively conceal their sexual behaviors. Many men had experiences similar to those of one Ft. Lauderdale respondent who said, "I played the game. I had a girlfriend, which I think a lot of men do." He went on to say that, "Everyone's doing it." Other men corroborated his story and stated that "down low" behavior is prevalent in African American and Black society in an effort to "satisfy the masses; to satisfy the people around them." One man from Ft. Lauderdale said that it is not uncommon, "to see guys running around with their pants half off their butts, looking like gangsters and everything like that, and they'll play that role out in public, but privately you know, they're still hooking up with other guys."

From these examples, it is evident that a lack of disclosure was accepted as an appropriate and necessary response to societal, religious, and family stigma. For the majority of men, the decision to not disclose had positive consequences for men's lives. Several men mentioned the avoidance of abuse and violence as a benefit of not disclosing sexual orientation or same-sex behavior. Respondents described pervasive verbal abuse directed toward young men open about their sexual orientation. One older participant said the name calling was, "worse than stepping in some dog doo doo," while another man stated while he did not experience physical violence, "the words themselves could be just as painful." One young man from central Miami said, "Well, the ones that were, you know, decided to come out were teased." He went on to say

that, "Teasing always, in one way or another, leads to that inevitable fight, because sooner or later, you get tired of it, and just like if you hit a dog enough to where he's backed in a corner, I don't care what type of dog it is, he's gonna come out fighting, so that's the same with the average individual." Others described openly gay men from their neighborhoods or schools getting beat up or, "having the gayness beat out of you."

Another sub-theme related to homophobia was the maintenance of built social, economic, or cultural capital as a result of non-disclosure. Social capital, in the form of family and social relationships, and the loss of that capital, was a big motivator for men to not disclose sexual orientation or same-sex behaviors. Men described the pain of not being accepted by their parents or by African American society. As mentioned above, family relationships often suffered as a result of disclosure with men feeling forced to limit social relationships with unaccepting family members. For men who had not disclosed, they had heard stories. As one man said,

I heard stories from, you know, my friends when I was in the army how some of them would get beat up by family members, and how different people they knew, their own mothers put them out. And some of these people were actually thrust away from their family at 15 or 16 years old, you know? And I was like, 'Whoa...' And, I don't know, because I was very close to my mother, and I was always close to family like my grandmother, so if they had turned their back on me at that age, I don't know what would have happened to me.

Another, younger, man described the need to maintain familial relationships in this way, "Oh yeah, affection, and, uh, I mean affection and the

loss of your family, I mean that's crazy. The loss of...when your family turns their back on you...your family is all you really have in this lifetime. And that loss could be, yeah, incredible." Several men mentioned loneliness as a result of what limited disclosure they had undertaken. Moreover, two other respondents also mentioned that in addition to the loss of family, it was also important to maintain social capital in other relationships, including with friends and neighbors. Disclosure would mean that a man, "wouldn't be able to hang out with the same crowd," or maintain, "contacts within the community."

Related to the desire to maintain social relationships is the need to use those relationships to foster individual economic well-being. Thus, economic capital was another motivator in avoiding disclosure of sexual orientation or same-sex behaviors. Men who have jobs and economic opportunities do not want to lose them due to homophobia, and the same is true for men looking to earn money. In addition to not wanting to lose one's family relationships and friendships, participants expressed a fear of losing money. By not disclosing, one participant said, "You're able to live in the – probably stay in the church. Then possibly there could be business contacts that you may be able to, you know, elevate your income or your living situation." As seen above, some men learned not to "be gay" around family members or that family members are not accepting. Men carried these attitudes into their jobs, workplaces, and employment opportunities. One man stated, "Like, when it comes to work, I'm very focused at work. I don't mix my personal life with work and so forth," while another one acknowledged that in an effort to avoid disclosure he intentionally

sets a tone of not asking anything personal about coworkers so that they will not ask anything personal about him.

Lastly, cultural capital was a sub-theme that emerged among respondents. Men stated that disclosure of sexual orientation or same-sex behaviors not only could lead to losses of social and economic capital, but also the loss of one's place in African American society. For example, one young man from Liberty City said, "You mention the word 'gay' and the next thing you know, you're ousted." Another man corroborated this statement by saying that family, friends, church, and the African American community were all he has ever known. Thus, he asks, "If I left, where would I go?"

Stream 2: Alternate Experiences with Homophobia–African American culture, religion, and family

All interview respondents described some experience of homophobia. However, a small minority of four participants, from Stream 2 (those men who did report continuing HIV transmission risk), did not experience homophobia in their family relationships. Two men described their mothers as "always being there for them," while two other men noted that they had supportive families. Early introduction to other gay people, in addition to supportive families, was influential for two respondents. For one older man, he became more comfortable with this sexual orientation, not just because of his positive family experience, but also because during his adolescence his family moved from a small town to a large city and he began to see other people like himself and realize that he was not alone. A younger participant had a similar experience during his adolescent

years when he was a competitive dancer. In his words, “Dance is...it’s interesting. Being young and being around other males who dance who were not heterosexual was influential.”

As a result, this small group of men did not experience the negative family relationships, or the fear of losing social, economic, or cultural capital due to their sexual orientation or same-sex behaviors. Instead, these men found it easier to be more open and to form connections to gay communities. These four participants, plus one additional man, all from Stream 2, found themselves with a social environment that was not only more “gay friendly” but also made up of other gay men. One man from Ft. Lauderdale described how he made friends and connections with other gay men and as a result, “we have this core group of, like, maybe like 12 of us, and we get together for holidays, and if it’s one of our birthdays, we pick a restaurant and go out and we celebrate. We’ll go dancing once in a while. We go to the film festivals.” Another man from Ft. Lauderdale described it as, “a good place to be at, out of the closet, and a lot of social network going on, and a lot of things to do. You know they weren’t against that, and you know, celebrated the gay lifestyle.” This small group of men did not experience the extent of homophobia and fear that was such a common experience for men in Stream 1, though it did not alleviate all problems.

Experiences with Syndemic Health Disparities

As described in Chapter 4, all men from this study experienced syndemic health disparities when compared to men in the general population. This is primarily due to the eligibility criteria for participating in the Project ROOM study.

However, the ways in which men described the co-occurrence of substance use and HIV transmission risk in their own lives varied somewhat between men in each stream.

Stream 1: Substance Use and Sexual Behavior as Coping Mechanisms

Among men in Stream 1 (those men who did not report continuing HIV transmission risk – measured by unprotected sexual intercourse), a large majority described their substance use and sexual behavior as related to coping with mental distress resulting from experienced homophobia and the toll it takes on their decision making and behavior. For many, substance use was a means of dealing with depression. One young respondent described substance use among African Americans in general saying, “Well, as for African Americans, basically, we don’t tend to talk about our problems, and basically, you know, you’re carrying a load, and your main recourse is drugs and alcohol, so to be able to lift the burden off your shoulders...” He went on to say that among African American/Black MSM the situation is even worse and that, “Drugs and depression works almost hand in hand. You look for an outlet, and, you know, not having – not having the acceptance within the community, you know, being bullied from within the community.” An older man from Ft. Lauderdale agreed stating that, “I think we tend to numb ourselves or something. I think the pain of the past, the pain of maybe not being accepted by parents, the pain of still not being accepted by society...I think that to fill the void of whatever they feel is missing in their lives, they turn to other things to fill those voids.”

Two men described substance use as intimately connected to sexual behavior, in that African American/Black MSM have difficulty being intimate as a result of homophobic experiences. For one older man from Ft. Lauderdale, he said of substance use,

That's your escape of something that you was already willing to do. I was in that. That was me for umpteen years. That's why I was so deep into the bottle of alcoholism, and smoking my weed, and my crack because that gave me that, like, to put on the g-sign that says 'Hey, hello, I'm gay,' so that when something happened I said, 'Oh my God, I've must of been real messed up when we did that.' No, I knew. But I had an excuse to fall back on.

Another older man from the Overtown neighborhood of Miami described his experience this way,

The majority of the sex that I've had is gotten through the use of drugs. I think I originally got into it because I had a difficult time getting into the gay scene. I didn't feel like I fit, or I didn't really know how to approach other gay men, and that seemed to be the only way I could really get, you know, with someone. You know, I was very shy with very, very low self-esteem.

While he initially would only purchase drugs for the partner, in time, he began using too. He says that eventually he came to recognize that, "I was trading drugs for sex. My self-esteem was so low to where I was unable to get anyone without the use of drugs, and that's pretty much it." Still another man engaged in substance use and sex trading as a coping mechanism. He says, "That was my way of healing from life's disappointments or limitations; to have some fun as a result of feeling pain inwardly."

Stream 2: Alternate Experiences with Substance Use and Sexual Behavior

The majority of men in Stream 2 – (those men who did report continuing HIV transmission risk – measured by unprotected sexual intercourse) described syndemic behaviors as related to mental distress. However, for the 5 men who did report HIV transmission risk following the completion of the Project ROOM study, their experiences with substance use and sexual behavior were somewhat different than those of men in Stream 1.

Men in this stream were much more likely to have attachments to the gay community, and this influenced their experience with syndemic risk behavior. One Ft. Lauderdale man describes the gay community as being “open” in which he found himself, “to be more around gay friends and building up [his] own self-confidence versus being an outsider and being the minority in the straight world.” He went on to say that, “I find myself moving away from a lot of straight venues and straight people. Being in Wilton Manors and being in this area it kind of just reinforces who I am and what I’m about.” This respondent describes the bars and bathhouses in his neighborhood as “incredible,” though he acknowledges that some men are “reckless” when it comes to substance use and sex. For him, however, he says, “I have a certain level of discipline.” Thus, while he enjoys the openness and active night life and social scene of the gay community, he actively reinforces a balance in his life so that he is still able to go to work the next day.

When asked about substance use and sex, one Ft. Lauderdale man stated that it is more prevalent in the gay community. This man added that for him, “When I wasn’t busy at work and, you know, being productive, [the gay

community] increased my appetite to start doing drugs and having unprotected sex.” Another Ft. Lauderdale man had similar feelings, and stated, “I still have my, you know, I have my sexual preferences and I like bareback [unprotected] sex,” and also added, “I do like poppers [amyl nitrites]. I guess that’s a substance and that hasn’t changed.”

The two other men in this stream did not connect their syndemic risk behaviors to their connections to gay men and the gay community. Instead, other circumstantial reasons influenced their substance use and sexual risk behavior. One young man from Miami said that after recently turning 21, he began going out more and drinking more and added, “I try to refrain from [unprotected sex], but it has happened.” Another older man from Miami said that there are times when he does not use a condom, but it was most likely a situation in which there were not condoms available and he had known his partner for a long time.

Resilience Processes

While the reasons for syndemic risk behavior varied somewhat between the two streams, the risks are the same. Further, all men acknowledge the risks involved, especially with regard to HIV transmission. As a result, each respondent described assets and resources they utilized to either desist from or mitigate HIV transmission risk behavior. As can be seen in Table 8, the assets and resources utilized by respondents were somewhat different by stream, but different in important ways.

Inner Strengths

The most frequently mentioned resilience assets were coded as “inner strengths.” This category consists of individual attitudes, values, and behaviors, in addition to lessons learned from experiences of hard work and negative situations. During the interviews men described their inner strengths as simply part of who they are, “embedded,” or “inside” of themselves. The title “inner strength” signifies that these assets come from inside of the individual and are utilized as a result of individual agency, though they may be influenced by external factors.

	Stream 1 (N=16)		Stream 2 (N=5)	
	N	%	N	%
Inner strengths	12	75%	3	60%
Social support	12	75%	4	80%
Diversity	8	50%	5	100%
Spirituality	10	62.5%	2	40%
Growing up	7	43.6%	3	60%
"Keep moving"	5	31.3%	2	40%
Negative Neighborhood	2	12.5%	3	60%
Altruism	5	31.3%	1	20%
Creative outlet	3	18.8%	2	40%
Role model	2	12.5%	0	0%

Individual attitudes, values, and behaviors were mentioned across both streams, though men in Stream 1 were slightly more likely to describe using inner strengths than men in Stream 2 (75% compared to 60%). A prominent sub-theme was that although bad things happen in life, or some parts of life are out of an individual’s control, men can be happy with the good things in life and work

toward fixing the bad things. One older man from Miami described having a philosophy of “life is good,” which energized him and made him remember that he is happy with himself. He went on to say that even if he doesn’t have a job or bad things happen in life, he remembers that life is good and that, “You can only do but so much. If something happens, you can only do ‘A,’ ‘B,’ and ‘C,’ so go get to doing ‘A.’ If that doesn’t work, get to doing ‘B,’ and if that doesn’t work, get to doing ‘C,’ and that’s all you can do.” Another respondent from North Miami said that, “You’ll never have it right in life. Just do what you have to do to take care of this situation and take care of that situation, and live that day, and then, go to the next day. If that same situation is there, deal with it again.” A young man from Miami’s Liberty City neighborhood compared his approach to life to a game of chess, in which he is thinking three moves ahead and looking for how to take care of himself now and for the next couple of years. Even if some parts of life, there are surprises that prevent him from strategizing and planning, he is still approaching it that way.

Men also described individual qualities that they rely on to be resilient, such as “strong-willed,” “independent,” “having a strong work ethic,” “intuition,” “strength,” “humility,” “motivation to succeed,” and a desire to learn. The internal strengths mentioned by respondents are varied and this speaks to their unique personalities and experiences. However, the commonality is that those men who mentioned having and utilizing one or more inner strengths, were able to cope with structural disadvantages of being an African American, the prevalence of

homophobia in their social environment, or substance use and HIV transmission risk.

A sub-theme is the notion that hard work and previous experiences can build and strengthen a person's inner strengths. One young man from South Miami described learning a lot about himself and about life while training 20 hours per week in "blood, sweat, and tears," for dance competitions. An older participant from Miami's Overtown neighborhood told about his childhood saying, "daily chores of feeding the chickens, pulling weeds out of the garden," and said that, "it builds integrity." Still another man from South Miami described living in his own place and having to work from a very young age. These examples are illustrative of the ways in which men describe their life experiences as shaping their lives and, by extension, their inner strengths.

Life experiences, especially negative ones, were also important in developing inner strengths for these men. Describing his experiences with homophobia, one older man from Miami realized how strong he actually is and said, "I've been through some difficult situations, and I've survived them all alone. I've been through some things, and I've wandered them by myself, and I couldn't tell nobody, and I didn't." A young man from downtown Miami said that after going through his "dark phase" he had to humble himself and begin to rebuild his life. Doing so taught him that he is capable of such resilient actions and knows that everything is cool and will be okay. Similarly, one young man told about his experiences being on probation, after which he had to work hard to rebuild his reputation. He says, "One of the things that I learned is that people can change."

An older man from Miami said that, “If something was considered a mistake, it’s a learning lesson, you know, where I try not to do it again. I point blank learn from it.” Still other men noted the ways in which they started with nothing and “carved out a nice life” or learned to have a positive attitude after a bad work relationship with a coworker. These experiences, though different from person to person, further illustrate the ways in which inner strengths were developed and utilized individually, even if influenced by other social environmental elements.

“Keep Moving” and “Growing Up”

Two specific inner strengths came to light during the qualitative interviews. The first is the notion of “keep moving” or “moving forward” and the other of “growing up.” Both of these concepts were coded using the respondent’s own words and both concepts were mentioned frequently. These inner strengths, like many others, are the result of life experiences and exposure to adversity. “Keep moving” (described in Chapter 5) implies forward movement in the face of adversity. It is an attitude of not being held back when bad things happen. Men attributed such an outlook to their parents, however it was their involvement in the Project ROOM study that further ignited their desire to utilize this inner strength.

The concept of growing up (described in Chapter 5) is another inner strength the men cited as a way to cope with adversity, but specifically related to substance use and HIV transmission risk. Men largely described substance use as being a part of their lives from an early age (see Chapter 4). Similarly, once men became sexually active, the combination of substance use and sexual risk

behavior also became quite common. In time, these experiences led to fatigue not only with substance use and sexual risk behavior, but also their consequences. This idea was expressed by a man from Ft. Lauderdale who said he believes that older people have cycles and that eventually they get tired of things. To him, men usually experience something that causes them to see the negative outcomes of their actions, which makes men grow up.

During interviews, men stated, “my mindset is just getting older,” and, “Sooner or later, you’ve got to come to reality with yourself,” and “You get older, you get wiser.” Men who described growing up, not only found added insight, but used this inner strength in changing behavior. “It doesn’t interest me anymore. I like sitting at home and reading, like a book or something. I guess with age comes wisdom or something,” said one Ft. Lauderdale man. Another man from Miami, in describing his desire to fill the void of loneliness stated, “I grew out of it. Yeah, I grew out of it. What I thought I was getting out of it, I really wasn’t getting out of it anyway, because at the end of the day, I was still alone.” Another Ft. Lauderdale man also stated that he did not believe there was anything to be gained from a one night stand anymore.

Role Model

One aspect of inner strengths mentioned by two participants (12.5%) in Stream 1 is having a role model. Both men described the profound impact their role models had on their lives and on developing their own inner strengths. The first, described his maternal grandfather who was a member of an all-Black baseball team that traveled all over the country and to Cuba. In describing his

grandfather, the man said, “When the White man would come to the house, they had to speak to [my grandfather] on the porch. He wouldn't allow any of them in his house and he had to speak with him right there on the porch. That may not mean anything to you but it meant something to me. He was controlling who and what, when, and where, and he didn't take shit from anybody. So, definitely a role model.” In addition to feeling strong admiration for his history-making grandfather, this young man also stated that he learned how to behave and react to people from instances such as that one.

A second man described his childhood in which he grew up in a working class family with little exposure to the world outside of his own community. After struggling with a poor family life and strong homophobia in the home, he says:

The thing that turned me around was this um, my neighbor, and she worked in corporate America and so she used to take me and my brother downtown and her friends were professional people. And so I saw these, and this was my first time really seeing professional people and you know being in a business environment and seeing all of that and I thought it was really exciting, the tall buildings. You know me, I'm an African American man and you know seeing Black men in suits and, you know, and meeting the presidents of companies and managers, you know, seeing all of these positive people I'm like, 'Wow!' This is what I want.

It is clear from each of these stories that these role models made a clear impression on both men during their childhoods. The impressions, helped facilitate the development of inner strengths, which both men say they draw on today.

Social Support

A second very common theme regarding resilience assets and resources was social support. It was mentioned by men from both streams, but as is seen in Table 8, it was more prevalent among men in Stream 2 (80%), than men in Stream 1 (75%). For men in Stream 1, all but one man described their social support networks as being made up of either family members or non-gay friends. In their stories, resilience processes in response to substance use and HIV transmission risk can be seen. One young man from Miami said of his friendships, “A lot of them was people that I always had, but I was too high to see it. If I get into a financial bind, I have friends that I can call on, and even if they can’t help me, at least they can get me a good solution.” An older man from Miami, upon dealing with this substance use issues, realized that his biggest resource was the lady he works with. She encouraged him to lessen his drug use and included him in her family functions. In addition, through this process he began to become closer to his mother and brother. A similar experience occurred with another man who described finding social support among a pastor and outreach workers at a local ministry. He said, “They, like, see something in me that I couldn’t see in myself. I have somebody to, you know, if I should ever need it.”

Many men also described forming closer connections to family members. An older man from Miami began to get closer to his brother and nephews who help him out with his health issues and living situation. A man from Ft. Lauderdale described a similar experience with a family member who continually

checks on him, makes sure his basic needs are met, and is there for him in times of need. A Miami man said that now, “My sister and mom, they’re my resources.” A man from Ft. Lauderdale stated that his sister has his back and that, “If things really got haywire in any point in my life, I know whatever it took, my sister would be here, as well as I would be there for her.”

Several other men stated that their social support is largely found among friendships that they have maintained for many years. “A couple of straight friends of mine, I’ve had them for a long time. They know that I’m gay; they know my status; they know everything else. I’ve been friends with them for so long it seems like it would be impossible to get rid of them now (laughs),” said one man. Two other men mentioned long-term friendships that have been supportive. As one said, “I have a good number of friends. Financial support, emotional support, talking back and forth, but you know, I mean, my social network is solid I find. These are friends I’ve made over the years.”

Unlike the other men in this stream, one young man who grew up in Miami’s Liberty City neighborhood said that he has many gay friends that he is close to and he developed them after moving to Ft. Lauderdale to “redefine” himself. He also stated, “I still have relationships with my cousins and with some of my friends from back in the old neighborhood, but we just don’t meet quite as often. We’ve become more or less Facebook friends.” However, depending on the type of support he needed, he would try his mother first.

For men in Stream 2, a greater share of their social support was from gay friendships. Further, in contrast to men described above, respondents in this

stream did not feel their social support was lacking and therefore did not strive to make new connections following their completion of the Project ROOM study. This stream included two men from Ft. Lauderdale who described their social support as a product of having a large core group of friends. In addition, two other men from Miami said they had supportive friendships that offered both financial and emotional support.

Diversity

Frequently discussed during the interviews was the diversity of people, experiences, places, and knowledge that heavily influenced men's lives. Diversity was present among men from both streams. However, Table 8 shows that all men in Stream 2 described some form of diversity, compared to only half of men in Stream 1. While inner strengths can be understood as internal assets, and social support can be thought of as an external resource, diversity is neither. Men described the importance of diversity in their lives and its influence on both developing inner strengths and strengthening social support.

Diversity among Men in Stream 1:

Half of the men in Stream 1 (those men who did not report continuing HIV transmission risk) reported some form of diversity in their lives both in the past and in the present. Some men grew up with a diversity of social networks, experiences, places, and knowledge. Three men did not grow up in South Florida and had experiences that were somewhat different than men born and raised in Florida. One older man from Miami Beach said that his father was an airline pilot, which necessitated that the family moved often to many states. He

went on to describe how much he liked travelling and such different places from the Deep South to the Mid-West. He says now that diversity is still present in his life because he mingles with many different types of people.

Another man, who grew up in Massachusetts, described his neighborhood as racially/ethnically diverse, however, his was one of only three Black families in his town. That experience, he says, influences who he is today, “I wanna go to Europe. I wanna go to the hood sometimes. When I’m feeling hoodish, I’ll go to Opa Locka. When I’m feeling European, I’m gonna go to Europe. You go out, expand your mind and meet different people, have different ideas, have different discussions.”

A man from Miami Beach grew up in a part of Southern California that was “very mixed and diversified.” He continued, “There can be racial tensions. There can be socioeconomic tensions. There can be political tensions when you mix a bunch of people together and I think it had its challenges, but I think there are more advantages than disadvantages.” The exposure has made him more open to new things and ideas. Because of the diversity present in his life from an early age, he went on to travel throughout Asia and Oceania and as a result, his social network is varied with friends from many countries. In addition, this respondent stated that, “Traveling around the world gave me a lot of confidence in my abilities of what I can and cannot do.”

For men raised in South Florida, the exposure to diverse social networks, experiences, places, and knowledge was somewhat different. A South Miami man described his family’s strong church involvement and mission activities as

key to his diverse experiences. He said, "I was cross cultured. My parents had us with different ethnicities so I got to be with a lot of different kinds of people."

Looking back, this respondent is able to see the value and uniqueness of his upbringing compared to others in his neighborhood:

Well the funny thing is I never thought that there was a difference, in with people, but I found out there was. Because, uh, people in the neighborhood was, 'who those people coming to your house' or stuff like that. And I never thought it was a big deal until I was growing up and I was like, 'Oh my God there is a difference. A lot of people didn't have what we had. A lot of things a lot of other people didn't do, we did.

A young man from Miami's Liberty City moved to a suburb during his high school years to attend a better school. As a result, he became involved in an academic program for gifted students, extracurricular activities, like the chess club, and was able to mingle with people of other races/ethnicities. Meeting other people in this way, and upon graduation, taking a construction job that required travel, in part inspired the courage in him to move to Ft. Lauderdale and make a better life for himself. He says now of his social network, "Well, culturally, they cross the rainbow, which is a good thing."

For other men, their diverse experiences were a result of participation in the armed forces, in which they lived not only in other states, such as Oklahoma and South Carolina, but also overseas in Germany and the Netherlands. Men described, "learning a lot about other people," and understanding more of the world. In addition to making some lifelong friends, men said they gained, "strength" and "discipline" during their military service.

Diversity among Men in Stream 2

Unlike men in Stream 1, all men in Stream 2 (those men who did report continuing HIV transmission risk) described some sort of exposure to diversity during their lives. As was previously noted, men in this stream had more supportive families and more connection to gay social networks and the gay community, which in themselves are diverse experiences not present in the lives of men in Stream 1. One man from Ft. Lauderdale described his travel experiences in which he visited San Francisco and was exposed to an openly gay environment. This influenced his decision to live in the Ft. Lauderdale suburb of Wilton Manors, a well-known gay enclave.

For others, exposure to diversity was present early on. Two older men described going to integrated schools. Said one man, "It really gave me a broader perspective of people, you know, to see that we're not all the same. It really taught me that people are different." A young man from South Miami also grew up in a community that was racially/ethnically mixed, which is evident in his current social relationships. One man from Stream 2 was a member of the armed forces in which he spent time in Turkey, Texas, and Key West, Florida. In part due to his experience, he says, "Why I love Miami so much is because of the diversity." Thus, his social network is heavily influenced by his desire to maintain diverse social connections.

Religion/Spirituality

Men across both streams, 70% of Stream 1 and 40% of Stream 2, described religion/spirituality as a part of their lives (see Table 8).

Religion/spirituality seems to be both an internal asset that men draw on to be resilient. In addition, it also appears as an external resource, especially when a church or religious organization, offers needed assistance to vulnerable men. Further, men spoke of religion/spirituality in somewhat the same manner as diversity. According to respondents, exposure to religion/spirituality assisted in developing their inner strengths and social support.

Religion/Spirituality and Internal Assets

Many discussions of religion/spirituality began with childhood, as many men reported some sort of religious upbringing. Such an upbringing had an influence on the development of men's inner strengths and the use of inner strengths later in life. One older man from Miami said:

Upbringing in the church makes me hold on to my values and what I feel concerning me. I knew how to pray and the values that were instilled in me, you know, as a child that I found were useful as I got out in the world on my own. I learned to have regards for other people and their feelings, and for people in general. I learned how to go through things.

Another man described a similar experience with his religious upbringing. As a result of his constant church attendance and participation in choir and other programs, he says, "When I became an adult it was, you know, it wasn't just church. I had a relationship with God. I had experiences with God where, you know, he brought me out of things, made peace. He helped me make peace with a lot of things in my life. My faith has always been strong and, you know, believing I can overcome anything."

In fact, inner strengths stemming from religious/spiritual experiences were common. A Miami man said that through prayer he is able to put things into perspective. Another man from Miami stated that, "What has really carried me through life is my faith. Even dealing with the HIV and all, it has kept me going." A young man from South Miami noted that prayer and reflection are things he needs and that, "It helps you keep it moving." For two men, though they aren't actively engaged in religious/spiritual activities currently, just knowing that God loves them has a positive effect on their abilities to cope with problems. Said one of the men, "In my mind, God made me, you know, and he knew what he was doing when he made me. He knew I was gay before I knew I was gay and they say God doesn't make any mistakes."

Religion/Spirituality and External Resources

Respondents also described religion/spirituality as an external resource that they actively seek out. For some, it is a resource to assist in coping with problems. A man from Miami described his most recent experience this way, "I went on Sunday. When I got home it was so peaceful. I went there and I just listened and you think, your problems are not as big as you think they are. It helps you clear your head and say, 'Okay, now I know what's really important.' And I needed that on Sunday." One Ft. Lauderdale man said, "Well I'm really stressed right now and so I really would like to go and get back involved in church." Another man also stated that he wanted to become more involved in church as an usher or choir member in part because of what he could learn from it in dealing with life.

Several other men mentioned more tangible resources that religion/spiritually offer. One older man from Miami's Overtown neighborhood told about his struggles with food insecurity and at times, homelessness. The church he visits provides him with food, items he needs, and assisted him in finding a place to live. He says, "When you give God praises, then he gives you blessings. I feel that, you know, because of me going to that church, not particularly to eat, but just to give God praises for the food that they will be giving later, and the help that we're given, that I got my place a lot faster." As mentioned above, a Ft. Lauderdale man credits the outreach of a local ministry with helping him secure social support, which led to him finding a job and secure living situation. A Miami man describes members from his church recommending books to guide him and help him deal with problems, in addition to counseling services. Another Miami man also mentions that he seeks out motivational reading, in addition to watching religious programs on television and using religious-based applications on his mobile phone for support.

Altruism

Besides social support and religion/spirituality, a small number of men also describe seeking resources in which to help others. Five of the men from Stream 1 (31.3%) expressed such a desire and most of them are actively engaged in some form of altruistic venture. Using skills they already possess, one man from Miami is searching out shelters and soup kitchens in order to serve as a cook, while another man realized he had a desire to teach and currently offers free computer and writing classes at a neighborhood community

center. A third respondent from Ft. Lauderdale has completed the training necessary to volunteer at an animal shelter and is currently scheduled to go to orientation.

For two other men, their desires to help others stem from their own experiences of adversity. An older man from Stream 1 said that following his HIV diagnosis in the 1990s he decided to get involved in the HIV community by volunteering as an HIV tester and peer counselor. For another young man in Stream 2, he said, “I would like to be in a place where maybe I can prevent someone from going through some of the things that I’ve had to go through to learn, what, you know, I know now. That’s one of my aspirations is just to be able to help someone else from going through some of the shit that the world has to dish at you.”

Men say that the wish to help others comes not only from their own experiences, but also because it is an innate desire. Through their volunteer efforts, respondents have also seen benefits in the form of additional social connections, an increase in business opportunities, and positive feelings generated from their efforts.

Creative Outlet

In addition to finding benefits in helping others, a small number of men in the study also reported that having a creative outlet was a positive part of their lives. Three men from Stream 1 (18.8%) reported using poetry, design, and photography as a way to express themselves and feel good. One young man, who has published three books, said, “I think I would go mad if I can’t express

myself in some form of writing.” Another man stated that he is “very creative” and credits his ability to decorate and help others organize and design their homes to watching his mother do similar work in the church growing up. A third man described his love of photography in high school and now, in his early 40s, he has picked it up again. He says, “It’s kind of like a second chance to do it again. You don’t have to really talk, and you just visualize a form of art and click the camera, and I like doing that.” In addition, two men from Stream 2 (40%) describe using choreography and dance and sewing as their creative outlets. For all of these men, doing something creative now only allows them to express themselves, but it also as way for them to spend their time productively.

Negative Influences on Resilience

While many men spoke of what things helped them to be resilient, especially with regard to substance use and HIV transmission risk, 2 men from Stream 1 (12.5%) and 3 men from Stream 2 (60%) noted that parts of the social environment in the gay community negatively impacted their behavior. One Miami Beach man from Stream 1 said, “The people in Miami are, engage in more risky behavior, and that could be because of the alcohol and drugs there are so prevalent. I did notice that I did use more drugs when I was in Miami than I did when I was anywhere else in the world.” In Ft. Lauderdale, the scenario is similar. Another man from Stream 1 said, “Ft. Lauderdale is a mess. Everything is revolving around alcohol a little bit too much.” Regarding sexual risk behavior, a Ft. Lauderdale man from Stream 2 had a similar impression of his experience living in the suburb of Wilton Manors, compared to his current residence in

Washington, DC, “That was a playground. Yeah, I had more sex when I was there than I do when I’m here.”

Discussion: African American/Black MSM Processes of Resilience

As seen in the results section above, men in this study fell into two streams. One stream was comprised of men who did not report HIV transmission risk behavior following the completion of the Project ROOM study, and the other stream was composed of men who did report HIV transmission risk behavior. Men from both streams experienced similar structures, composed of structural inequality and societal homophobia. Where the streams diverged was that men in Stream 1 were unable to disclose sexual orientation or same-sex behaviors. In Stream 2, men had supportive families in which homophobia was less of a problem and they had been introduced to other gay men and had made connections with the gay community that resulted in them having many fewer issues with disclosure of sexual orientation or same-sex behaviors.

In Stream 1, men found themselves within a structure that was bound in large part by African American societal norms prohibiting the expression of homosexuality or same-sex behaviors, a strong religious influence from African American churches that promoted homophobia in its messages, and family structures that, perhaps influenced by both of the latter, were also unable to accept homosexuality or same-sex behaviors. Thus, for men in this stream, a key component of their agentic expression of resilience was non-disclosure. Data from this study suggest that even as men experience structural barriers, agency nevertheless allows them to be resilient.

One primary example of resilience to emerge from men in this stream is the lack of disclosure. While some researchers interested in resilience have proposed that sexual identity, “outness,” integration with gay life, connection to queer history, and queer family bonding are keys to being resilient among MSM (Herrick et al. 2014), the men from Stream 1 in this study demonstrate otherwise. In fact, such obvious connections to homosexuality would negatively impact their ability to be resilient, because of the social structure in which they are situated. Consistent with the work of Obrist et al. (2010) and Ungar (2008), it appears that men’s lack of disclosure in order to maintain social, economic, and cultural capital, is an agentic expression of resilience in which men are navigating to available and meaningful resources. Similar to the concept of *hidden resilience* advocated by Ungar (2010; 2004), it is in this way that men are defining for themselves what it means to be resilient, and expressing agency within their social structure. As was noted in the presentation of the data, men from Stream 1 do experience syndemic health disparities (e.g. substance use, HIV transmission risk, mental distress) which they connect to the homophobic structure and their inability to disclose their sexual orientation or same-sex behavior. At the same time, it is from the perspective of men in this stream that their livelihoods are possible by navigating toward access to and utilization of social, economic, and cultural capital. Thus, building a life, even if it enhances syndemic health disparities, is better than no life at all.

The social environment for men in Stream 2 was somewhat different than that of men in Stream 1. Though men in Stream 2 still experienced African

American societal norms against homophobia, familial support lessened the strain of this structural burden. Agency was expressed by the formation of connections to the gay community which further lessened the strain of structural homophobia in the African American community. For these men, not only did they navigate toward assets and resources provided by the gay community, their connection to the larger gay community allowed them to join in the process of negotiating for assets and resources to be provided in culturally meaningful ways. Thus, even though homophobia was still present in their lives, men in Stream 2 were able to experience acceptance of sexual orientation and same-sex behavior that men in Stream 1 were not. However, men in this stream also experienced syndemic health disparities of substance use and HIV transmission risk, perhaps due to increased gay community affiliation. Thus, in some ways, men in Stream 2 fit well with Stall et al.'s (2008) theory of syndemic production among urban gay men which states that men actively seek out connections to other MSM and a larger gay community.

In addition, men in Stream 2 reported HIV transmission risk following the completion of the Project ROOM study. Data from this study suggest that due to connection with the gay community, substance use and sexual risk are normalized behaviors. This coheres with existing literature on urban gay community life (Kurtz 2009). Thus, it seems that among men with connections to the gay community, recognition of HIV transmission as a risk and prioritizing it as such is lacking. As Obrist et al. (2010) point out, this preliminary step is necessary in achieving a resilient outcome. It is also conceivable that men from

Stream 2 do not define being resilient as abstaining from all HIV transmission risk. It should be noted that men in this study did express concern about HIV transmission risk and all of the men did reduce their risk from study entry. Thus, for men in Stream 2, resilience may be mitigating HIV transmission risk, rather than abstaining from it.

Theories of resilience state that one must experience some kind of adverse event in order to be resilient, because resilience is the act of overcoming or successfully coping with adversity (Kolar 2011). The resilience literature has found similarities in the ways in which people are able to be resilient, including the use of various internal assets and strengths and external resources (Connor and Davidson 2003; Rutter 1985; Kolar 2011; Wright and Masten 2006; Obrist, et al. 2010; Liebenberg and Ungar 2009). Men from this study were no different, and were largely disadvantaged and vulnerable upon study entry and subject to many of the same structural inequalities. As seen in Chapter 4, men had to overcome many structural and social environmental disparities, when compared to White men. However, in spite of these vulnerabilities, it can be seen that across men from both streams, the means by which to be resilient, were the result of individual agency, given their social structural constraints.

Because of the common environment in which men from this study were drawn, the importance of inner strengths as an internal asset, and social support as an external resource, in addition to diversity as a key influence, were common themes among all men in the study. Inner strengths in this study is a broad category encompassing many facets of an individual that included attitudes,

values, behaviors, and lessons learned through life experiences. Social support, too, included a range of social relationships that included family, friends, churches, and role models.

Inner strengths and social support were developed within specific structures, and utilized in response to it. Diversity in men's lives played a significant role in developing the means to be resilient. While diversity is not apparent in the resilience literature as a resilience characteristic, data from this study indicates that it is important in the development of resilience.

Though men had similar experiences, in part due to the similar social environments from which they came, some differences between men in each stream were found. Data illustrate that men from Stream 1 were much more dependent on inner strengths. Their inability to disclose sexual orientation or same-sex behavior, and lack of family support meant that they were more reliant on themselves. Their agency was expressed by navigating to and utilizing the most easily accessible assets, those inner strengths learned and developed over a long period of time. Men from Stream 2 were much more reliant on social support, likely due to the fact that their social environment included supportive families and some form of introduction to other gay people and the gay community. Thus, their agency was expressed through navigating toward making connections to the gay community and simultaneously negotiating for their sexual orientation or same-sex behaviors to be freely disclosed. These conditions meant social support was more accessible for them, in a culturally meaningful way, than for men in Stream 1. In addition, men from Stream 2 were

more likely to report diversity in their lives. Diversity is a big influence on the internal and external assets and resources men are able to develop and use to express resilience. As is seen in the interviews from men from both streams, diversity allows men to see other ways of understanding the world, and thus, not being so constrained by structures in which they are embedded.

These data make clear that resilience is a process that occurs over a long period of time. This study initially aimed to understand the resilience process that occurred over a 12 month period of time, during which men were enrolled in the Project ROOM study. However, men's stories illustrate that resilience was a process that had been going on as long as they could remember. Inner strengths, social support, creative outlets and spiritual connections, etc. are not developed during the course of one intervention, though their use in resilience processes can be enhanced or encouraged, as seen in Chapter 5.

Literature indicates that resilience as a process and as an expression includes elements like creativity and altruism (Wolin and Wolin 1995). Men from this study described both. It is important to note that these things are intimately connected to social, economic, and cultural capital. Evidence of this is seen in the desire to make social relationships and business connections through volunteer work, in addition to writing poetry and dancing that draw on African American culture. Altruism and creativity facilitate employment possibilities, fosters new relationships, and allows men to connect with their culture and address its structural limitations.

The findings also show that the means of being resilient, such as inner strengths, social support, diversity, and spirituality, etc., all build off of and influence each other. Building on the definition of syndemic in which two or more diseases mutually and synergistically interact with each other (Singer 2009), Rock (2013) has recently proposed a syndemic approach to disease prevention, in which disease prevention and the examination of it entails a solutions-focused examination of causal pathways relevant to population health. Based on the work of Rock (2013), Singer (2009), and the data presented here, I propose a syndemic approach to resilience in which protective factors mutually and synergistically act together and lead to successful outcomes in spite of adversity.

The data illustrate that none of the means of being resilient occur alone and that all of these factors, and more, synergistically influence the development and expression of resilience. Thus each one cannot be thought of as a singular factor by which an individual is able to express resilience. Rather they are developed through individual action, social interaction and navigation and negotiation processes that occur within one's social structure. Through agentic action, men are then able to utilize their developed assets and acquired resources to overcome adversity, in addition to seeking out or creating new resources that they lack. Using this syndemic approach to resilience, it can be seen that men from this study were able to express agency and be resilient toward many health risks, but most notably substance use and HIV transmission risk.

Because resilience is a long-term process, it has ebbs and flows. Data from this study suggest that interventions that seek to positively impact men's ability to be resilient, may also lessen the burden of syndemic risk and experiences with health and social disparities. As seen in Chapter 5, for these men, a key component in their expression of resilience was the intervention, in that it sparked an awareness that was previously unknown and encouraged the utilization of means to be resilient that men had already developed over time.

Though outcome measures from the Project ROOM study clearly indicate the expression of resilience, and men were able to describe in detail the factors and long-term processes involved in creating a resilient outcome, structures played a role in how individual agency was expressed. Neighborhood and social environmental factors presented many constraints on resilience processes. As seen in Chapter 4, poor family life, living in neighborhoods with a lot of drug use or violence, or being attached to a heavy risk taking population like the gay community, all impacted men's behaviors. It appears that structural changes to address inequality and homophobia may be beneficial. However, until significant structural changes occur, maximizing an agency-based syndemic approach to resilience among vulnerable African American MSM may be the most effective way to minimize syndemic health disparities among this population.

One limitation specific to this chapter must be noted. As mentioned in the study limitations section of Chapter 3, the analyses presented above are based on a total of 21 cases, divided into Stream 1 (N=16) and Stream 2 (N=5). A comparison is made between men in each of these streams in order to examine

differences in sociocultural and structural factors associated with continuing HIV transmission risk (unprotected sexual intercourse). However, given the few number of cases on which to base the comparison, these results should be viewed as preliminary.

Even when considering this methodological limitation, the comparison between men who did and did not report HIV transmission risk following completion of the Project ROOM Study is of great importance. As mentioned in Chapter 2, metropolitan Miami reports the highest HIV and AIDS incidence rates in the U.S. (Centers for Disease Control and Prevention 2009) and 45% of HIV-positive MSM in a recent Miami study were unaware of their infection (Centers for Disease Control and Prevention 2010a). Further, African American/Black men from the Project ROOM Study reported an average of 27 unprotected sex times and 14 sex partners during the past 90 days at baseline (see Chapter 4). Considering that HIV tests have a window period of up to three months between the time a person is infected until the time the infection can be detected by an HIV test, it is highly unlikely that a sample such as this would be able to truly know their HIV status in order to protect themselves or their sex partners from possible HIV transmission.

Within this context, this analytical comparison between men who did and did not report HIV transmission risk, especially using in-depth qualitative data, illustrates the differences in the social and structural environments that foster or hinder risk or protective measures regarding HIV transmission risk. This

information is critical to designing future prevention, intervention, and education programs to curb HIV incidence rates, especially in high incidence areas, like Miami. Further, these findings highlight the need for structural interventions that addresses syndemic health disparities associated with HIV transmission risk.

Conclusion

The purpose of this chapter has been to show that African American MSM are resilient. Stories from the men interviewed illustrate the ways in which they have expressed resilience throughout their lives. Within this chapter is evidence of practices of *hidden resilience* in addition to more manifest expressions of resilience related to HIV transmission risk. With data presented here, it is hoped that the words and experiences of these men will positively influence resilience theory in general, but also expand conceptualizations of resilience among populations of MSM.

Resilience factors are influenced by and in some cases developed through men's social environment. It is a process by which individual agency and structure interact. Therefore studying only individual action and ignoring the social environment presents an incomplete picture of expressions of resilience. Further, similar to syndemic health disparities, resilience factors, too, are syndemic. Thus, the syndemic approach to resilience is an important conceptual tool for further study of MSM.

The next chapter discusses lessons learned from the data presented in this, and previous chapters. It highlights the specific contributions to the field of

resilience and MSM health research. In addition, it presents recommendations for public policy and intervention among this vulnerable population.

CHAPTER 7

CONCLUSIONS, CONTRIBUTIONS, AND RECOMMENDATIONS

Conclusions

This dissertation has investigated the processes of resilience among African American/Black MSM in South Florida, specifically examining HIV transmission risk and related health and social disparities, as well as the social environment in which these disparities occur. The focus of this research is extremely timely and of the highest significance for public health (Herbst et al. 2005). Rates of HIV infection have not declined in recent years, especially among minority populations and MSM. Among these, African American/Black MSM are the single population most impacted by HIV (Centers for Disease Control and Prevention 2010b). Numerous studies have found a wide range of health and social disparities to be syndemic (interconnected, acting synergistically, contributing to an excess burden of disease), including HIV infection and substance use (Singer 2009). The syndemic approach has been used in a small number of interventions among non-in-treatment substance-using MSM, which have been shown to be efficacious in reducing risky sexual behaviors (Stall et al. 1999; Shoptaw et al. 2005; Mansergh et al. 2010; Kurtz et al. 2013a). Yet, much is still unknown about the social environments in which HIV transmission risk and syndemic health disparities occur.

Given that health and social disparities among MSM are understood to be syndemic, and result from larger structural and environmental factors, this

dissertation examined the sources and experiences by which African American/Black MSM experience syndemic health disparities and successfully cope with and overcome them. Employing a social environmentally-based theory of resilience, based on the works of Obrist et al. (2010) and Ungar (2010; Libenberg and Ungar 2009), this dissertation conceived of resilience as a product of one's ability to employ agency to: 1) access necessary resources from the structural and social environment, and 2) demand that resources be provided by larger structural and environmental forces in culturally meaningful ways.

With this theoretical foundation and background, a mixed method design was employed to investigate resilience processes among African American/Black MSM who participated in the Project ROOM Study, a randomized controlled trial testing the efficacy of a novel small group sexual and substance use risk reduction intervention (Kurtz et al. 2013a). African American/Black MSM from the Project ROOM Study achieved greater risk reductions in substance use and HIV transmission risk behaviors, compared to other men in the study, yet explanations for such findings were unclear (Kurtz et al. 2013a). The specific research questions guiding this investigation were: (1) What structural and syndemic health disparities and/or protective factors were present among African American/Black MSM upon entry into the Project ROOM study intervention trial?, (2) How did the presence or magnitude of syndemic health disparities change during the 12 month follow-up period following the Project ROOM study intervention participation, and what resilience processes occurred during that

time to effect change?, and (3) How did the presence or absence of individual agency and social environment resources affect the resilience processes for African American MSM in overcoming HIV transmission risk and related syndemic health disparities?

Throughout this dissertation, there have been several key findings. First, using both quantitative and qualitative data, Chapter 4 has shown that many health and social disparities related to HIV transmission risk are in fact syndemic and more prevalent among African American/Black MSM than among Caucasian/White men. Specifically, baseline data from the Project ROOM Study, showed that compared to their Caucasian/White counterparts, African American/Black MSM reported greater frequencies of: substance use (including marijuana, powder cocaine, crack cocaine, and ecstasy), days high, drugs and sex used in combination, substance dependence, as well as buying, trading and/or selling sex. Further, African American/Black MSM reported lower levels of educational attainment, lower rates of fulltime employment, health care access and social support and greater histories of homelessness and arrest than Caucasian/White men.

During in-depth qualitative interviews with African American/Black MSM, participants described the syndemic nature of these health and social disparities. The data illustrated the connections between substance use, HIV transmission risk, and mental distress resulting from stigma, homophobia, and social isolation.

These problems were compounded by a lack of economic resources and social support.

Second, the data presented in Chapter 5 also highlight the fact that African American/Black MSM who experience syndemic health disparities can and do make positive changes in their behavior, which reduces their exposure to syndemic health disparities. Multi-level model analyses of outcome data from the Project ROOM study revealed that African American/Black MSM sharply reduced their substance use (frequency of days high) and HIV transmission risk (unprotected sexual intercourse) at greater rates over the course of 12 months following participation in the Project ROOM Study interventions, compared to Caucasian/White MSM. Moreover, Cohen's *d* effect size statistics for changes in the outcomes mentioned above and several secondary outcomes, including drugs and sex used in combination, mental distress, and satisfaction with available social support further demonstrate successful reduction in health and social disparities among African American/Black MSM compared to their Caucasian/White counterparts.

Revisiting the men after their study completion, Chapter 5 also presented qualitative data describing the social environment in which these changes occurred. Increased mindfulness and self-reflection as a result of participation in the Project ROOM Study were significant contributors to individual risk behavior change. However, additional related effects of study participation, such as the growth of positive attitudes, connecting with supportive relationships, and finding

and accessing needed resources also contributed to positive behavior change. Thus, African American/Black men described some lessening of the experience of syndemic health and social disparities.

Lastly, this dissertation has demonstrated that African American/Black MSM are resilient. By comparing African American/Black men who did and did not report continuing HIV transmission risk (unprotected sexual intercourse) following the Project ROOM Study, the social environmental influence on resilience processes became clear. Men who reported continuing HIV transmission had supportive families, less experience with homophobia and stigma, and greater connections to other gay men and the gay community. This resulted in more complete disclosure of sexual orientation and same-sex behavior for these men, which may be considered an expression of resilience. Continuing HIV transmission risk was attributed to affiliation with the gay community, and to the social and cultural norms surrounding substance use and sexual behavior in the community.

Oppositely, African American/Black MSM who reported no continuing HIV transmission had much greater experiences with homophobia and stigma in their communities and families. When combined with few economic resources, men did not have the ability to disclose their sexual orientation or same-sex behavior fully and freely. For these men, lack of disclosure can be considered an expression of resilience, as it allows them to maintain social, economic, and cultural capital and connections with their home communities and families. The

discontinuation of HIV transmission risk behaviors was a further demonstration of resilience among these men.

Integrating the quantitative and qualitative data allowed for the long and complex processes of resilience among these men to emerge. These data showed that resilience is not simply a process of successfully coping with HIV transmission risk and related syndemic health disparities. Rather, it is a lifelong and ongoing dynamic process that is informed by experiences with health and social disparities in the social environment. In addition, these data demonstrate that resilience is a process that occurs through individual agency within the social environment, and is based on the resources made available within larger structures. Within this context, men decide for themselves what it is to be resilient and act accordingly.

Contributions

One of the primary contributions of this dissertation is to the syndemic literature among African American/Black MSM. As is described in Chapter 4, many studies have suggested the evidence of a syndemic among this population; however, no apparent study has used a mixed methods approach to fully understand the phenomenon. The quantitative data illustrated the presence of HIV transmission risk and related health and social disparities among this population, but the qualitative data brought the data to life through stories of men's lives, including the ways in which HIV transmission risk, substance use, mental distress and other health and social disparities are intertwined. Further,

this dissertation examined syndemic health disparities from an agency-structure perspective, contributing to existing literature in novel and important ways.

The inclusion of the constructs of agency and structure in Chapter 6 separate this dissertation from the much of the previous resilience literature among HIV prevention research. Though some work has incorporated theories of agency and structure into conceptualizations of resilience (Ungar; Obrist et al. 2010), it is not common. Thinking of resilience as intimately connected to the social environment broadens the definition of resilience and moves it beyond the investigation of single outcome variables. Moreover, when looking at resilience from this perspective, the development of a syndemic approach to resilience can be seen. This newly proposed theoretical concept, influenced by the work of Singer (2009) and Rock (2013), addresses the many facets of resilience, and corresponds to data presented in this dissertation illustrating the synergistic relationships between resilience components.

In addition, this dissertation contributes to the HIV prevention and intervention literature by demonstrating the specific ways in which African American/Black MSM connected with the Project ROOM Study intervention trial to reduce risk behavior. As seen in Chapter 5, intervention components and interview assessments both had great impacts on behavior change. While some research has demonstrated the impact of interview assessments on behavior change (Kurtz et al. 2013b), this is the first apparent study to do so among high-risk heavy substance-using MSM. Moreover, this dissertation is the first

apparent study to investigate behavior change among MSM in an RCT intervention using qualitative data. Thus, the findings not only show the effects of participation in an intervention trial, but also the resilience processes at work. Studies of this type are scant in the intervention research literature and not apparent in research among African American/Black MSM.

Another key strength of this study is that it adequately addresses the criticism of Glantz and Sloboda (1999), Ungar (2004; 2005), Obrist et al. (2010) and others, that definitions of what is or is not resilience are frequently constructed from White, middle-class, Western values. To begin, though the study used HIV transmission risk (unprotected sexual intercourse) as an outcome by which to examine resilience processes, the approach left room for men to define resilience for themselves. The *hidden resilience*, or, “patterns of coping that allow individuals to experience their lives subjectively as successful whether or not others outside their culture and context see them that way” (Ungar 2010: 417), expressed here by a lack of full disclosure of sexual orientation or same-sex behavior by some men in the sample exemplifies this. It is crucial that future studies examining resilience investigate such *hidden resilience* among populations.

Moreover, data from Chapter 6 show that men who did report continuing HIV transmission risk (unprotected sexual intercourse), do not recognize or prioritize reducing HIV transmission risk behavior. This result points to a specific target for future research among this population. Because individuals will not be

resilient toward an unknown or unrecognized risk, an in-depth understanding of HIV transmission risk will be key to designing interventions, both individual and structural, and facilitating resilience in culturally meaningful ways for African American/Black MSM.

Finally, this study adds minority voices to both the resilience and MSM health literatures. The inclusion of diverse populations is necessary to broaden current understandings of resilience, its development, and the processes by which it is expressed. Specifically related to MSM, this study adds considerably to the existing literature on resilience related to HIV prevention and contributes valuable insights into how African American/Black MSM understand and express resilience. It is the first research to answer the call made by Herrick et al (2014) to undertake qualitative research in order to identify key variables related to resilience and HIV among MSM. Though some of the findings do not correspond with existing research frameworks for investigating resilience and HIV among MSM, the approach taken by this dissertation is important because it expands thinking beyond current boundaries, and forces MSM researchers to conceptualize resilience more widely and with more diversity in mind.

Recommendations

The findings and contributions of this dissertation have several implications for future research investigating resilience among MSM. First, research must incorporate a socio-cultural perspective to understanding health and well-being. Since Stall et al. (2003) began using the syndemic framework to

understand health disparities among MSM, many investigators have incorporated this concept into their research designs. However, a true examination of the social and cultural environments in which MSM live their lives is missing from much of this work. Future research should address this gap and use qualitative methods to understand syndemic health disparities more fully, in addition to the syndemic approach to resilience, as both are intimately connected to and informed by the social structures and the social environment.

Such a perspective would be especially useful in understanding why MSM make decisions regarding HIV transmission risk, how they prioritize (or not) this risk in their lives, and the means by which they mitigate this risk. As HIV prevention research among MSM continues to move toward more biologically based interventions, it is important to remember that HIV prevention initiatives, interventions, and public policy must engage with human beings, structural barriers, and the social environment in which they live (Kippax and Stephenson 2012).

With the promotion of biomedical HIV prevention initiatives such as Pre-Exposure Prophylaxis (PrEP) becoming of increasing interest among scientists, and recently receiving approval from the Food and Drug Administration (2012), and support from the Centers for Disease Control (Smith et al. 2011), future research must address the social environments in which MSM choose PrEP or other biomedical interventions as HIV prevention tools. As was demonstrated in this dissertation, social, economic, and cultural capital contribute to resilience

processes among MSM. Thus, it is likely that various forms of capital will be instrumental in guiding the choices MSM make regarding PrEP or any other HIV prevention technology. Further, research must examine human decisions and agency as they are made within constraining social, political, and economic structures. Research that does not include a socio-cultural perspective will miss these important data.

Findings from this dissertation suggest that for resilience-based HIV prevention interventions to be successful for MSM, it would appear critical to include some of the strategies based on the findings. First, resilience interventions must facilitate increased mindfulness and self-realization about internal assets and external resources, in the same way that assessments in the Project ROOM study facilitated increased mindfulness and self-realization about substance use and sexual risk behaviors. Men from this study clearly demonstrated resilience. Future intervention components that specifically highlight MSM's previous experiences, and the way in which they coped with, overcame, and learned from those experiences will aid in facilitating increased mindfulness and self-realization. Moreover, doing so will alter the conversation from being centered on risky behavior and risk environments, and instead focus on positive actions and health outcomes.

Second, interventions must be designed based upon real world experiences of the people for whom they are designed. The understanding of resilience among African American/Black MSM in South Florida was only

accomplished through in-depth qualitative research that focused, in part, on agency and structure. Similar techniques should inform resilience-based intervention development before new prevention approaches are tested and disseminated.

Specifically regarding populations of African American/Black MSM, similar to the men from this study, resilience-based interventions may do well to include components that address men's lack of access to adequate social, economic, and cultural capital. Similar to the way in which the Project ROOM study interventions provided men with a venue in which to share and communicate in ways they had previously been unable to do, resilience-based interventions should provide social support in culturally meaningful ways. Intervention components offering economic assistance, in the form of facilitating educational attainment or job placement, could also be valuable. In addition, interventions in which men can be comfortable with their sexual orientation or same-sex behaviors that also support connections to African American culture, perhaps using spirituality, creativity or altruism, for example, may be especially beneficial.

It is important to note that structural and environmental determinants of the HIV epidemic and related health and social disparities must be addressed through structural interventions, and especially those targeting the social environment (Adimora and Auerbach 2010; Latkin and Knowlton 2005). Qualitative data presented in Chapter 6 illustrated the social environmental risks associated with HIV transmission risk among African American/Black MSM.

Moreover, these findings demonstrated that men are aware of their social environment and employ individual agency to adapt and adjust their behavior based on their experiences. As such, this dissertation can be thought of as formative research necessary for the development of structural HIV risk reduction interventions (Latkin and Knowlton 2005). Building on this work, the next logical iteration of the present study would investigate agency, as a resilient action, by which African American/Black MSM effect change in the social organizations, structures, and environments currently contributing to increased HIV infection among this population, and use the findings to develop structural interventions (Latkin and Knowlton 2005; Centers for Disease Control and Prevention 2010b). It has been suggested that such a multi-step approach, built upon formative research will be more likely to result in large-scale population impact, sustained behavioral risk reduction and changes in risk behavior norms among targeted populations, such as MSM (Grossman et al. 2011; Adimora and Auerbach 2010; Latkin and Knowlton 2005).

Final Thoughts

The qualitative data presented in this dissertation were obtained by asking men about their lives and experiences and thus it is a collection of their stories. It is hoped that this work will contribute to theoretical knowledge and inform future HIV prevention efforts. However, the greatest hope is that this work, and the findings presented in it will assist in bettering the lives of the men studied. This research project was not undertaken purely for the sake of an academic

exercise. Rather, this study was conducted out of a concern for a vulnerable population and a desire that their stories be known and used to constructively guide future work and to benefit future generations of African American/Black MSM.

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APPENDICES

Q5. Interview day

- — —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q6. Interview Year

- — — —
- 9997 Don't know
 - 9998 Refuse to answer
 - 9999 Not applicable

READ: Please keep this calendar handy and use it as we go through the interview to help you remember when different things happened. As we go through the questionnaire, I will read the questions and record your answers. It is important that you try to answer each question if you can and are willing to. We know that you will not always know the exact answer, but we would like you to give us your best guess if you can. You can also tell us if you simply "do not know" or "refuse" to answer any questions. I also have some cards here that we will use to help answer some of the questions. Do you have any questions before we begin?

READ: Several questions will ask you about things that have happened during the past 12 months or the past 90 days. To help you remember these time periods, please look at the calendar. First, let's find today's date and circle it. Next, count back 3 months which is 90 days or about 13 weeks ago and circle that date.

Q7. Do you recall anything that was happening on or around **[date 90 days ago]**? Probe for holidays, birthdays, events at work or school, vacations, etc. (If unable to recall: Probe for birthdays, holidays, sporting or special events, change in employment, school, or living situation)

When we talk about things that have happened in the past 90 days, we are talking about things that have happened since **[Response to Q7]**

Q8. Now let's go back to a year ago from today and circle that date. Do you recall anything that was happening on or around **[date a year ago]**? Probe for holidays, birthdays, events at work or school, vacations, etc.

READ: When we talk about things that have happened during the past 12 months, we are talking about things that have happened since **[Response to Q8]**

- Q9. Do you have any problems reading English in something like a newspaper or magazine ?
- 1 Yes
 - 0 No
 - 7 Don't know
 - 8 Refuse to answer
 - 9 Not applicable
- Q10. Do you have any problems writing English in something like a job application or resume?
- 1 Yes
 - 0 No
 - 7 Don't know
 - 8 Refuse to answer
 - 9 Not applicable
- Q11. Do you have any problems understanding what you read?
- 1 Yes
 - 0 No
 - 7 Don't know
 - 8 Refuse to answer
 - 9 Not applicable

Background

- Q12. What is your gender? (Choose one)
- 1 Male
 - 2 Female
 - 3 Other
 - 7 Don't know
 - 8 Refuse to answer
 - 9 Not applicable

If Q12 is less than 3, then skip to Q14.

Q13. Describe gender: _____

Q14. What do you consider your sexual identity to be? **[DO NOT read list; record response as mentioned]** (Choose one)

- 1 gay/homosexual
- 2 bisexual
- 3 straight / heterosexual
- 4 homothug
- 5 other
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

If Q14 is less than 4, then skip to Q16.

Q15. Please describe OTHER sexual identity

Q16. What is your birth month? (Choose one)

- 1 January
- 2 February
- 3 March
- 4 April
- 5 May
- 6 June
- 7 July
- 8 August
- 9 September
- 10 October
- 11 November
- 12 December
- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q17. What is your birth day?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q18. What is your birth year?

- — — —
- 9997 Don't know
 - 9998 Refuse to answer
 - 9999 Not applicable

Q19. How old are you today?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q20. Are you Hispanic or Latino?

- 1 Yes
- 0 No
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

Q21. What race do you consider yourself to be? **[If client is unsure]** Which race do you best identify with? **[DO NOT read list; record response as mentioned]** (Choose one)

- 1 Asian
- 2 African American, Black, or Caribbean
- 3 Caucasian or White
- 4 Native Alaskan or American Indian
- 5 Native Hawaiian or Pacific Islander
- 6 Other
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

If Q21 is less than 6, then skip to instruction before Q23.

Q22. Please describe:

If Q20 is equal to 0, then skip to Q27.

Short Acculturation Scale for Hispanics

READ: [USE Hispanic Acculturation Card]

You said that you are Hispanic-- please use the following card for the next few questions.

Q23. In general, what language(s) do you read and speak? (Choose one)

- 1 Only Spanish
- 2 More Spanish than English
- 3 Both Spanish and English equally
- 4 More English than Spanish
- 5 Only English
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q24. What language(s) do you read and speak at home? (Choose one)

- 1 Only Spanish
- 2 More Spanish than English
- 3 Both Spanish and English equally
- 4 More English than Spanish
- 5 Only English
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q25. In what language(s) do you usually think? (Choose one)

- 1 Only Spanish
- 2 More Spanish than English
- 3 Both Spanish and English equally
- 4 More English than Spanish
- 5 Only English
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q26. What language(s) do you usually speak with your friends? (Choose one)

- 1 Only Spanish
- 2 More Spanish than English
- 3 Both Spanish and English equally
- 4 More English than Spanish
- 5 Only English
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q27. Are your medical expenses covered by any type of insurance, court or health program?

- 1 Yes
- 0 No
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

Q28. How many times in your lifetime have you been enrolled in an HIV prevention program?

- — Don't know **Skip to instruction before Q31**
- 97 Refuse to answer
- 98 Not applicable **Skip to instruction before Q31**

Q29. When was the last time? **What year?** (Participant is ineligible if within the past year.)

— — — —

- 9997 Don't know
- 9998 Refuse to answer
- 9999 Not applicable

Q30. When was the last time? **What month?** (Choose one)

- 1 January
- 2 February
- 3 March
- 4 April
- 5 May
- 6 June
- 7 July
- 8 August
- 9 September
- 10 October
- 11 November
- 12 December
- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Social Activity Inventory

READ: The following questions are about different kinds of social activities that some people participate in. If you have engaged in a particular kind of activity at least one time in the past 3 months, then your answer should be at least once in a "typical month" for that activity. If you have difficulty giving an exact answer, please give us your best estimate.

Q31. In a typical month, how many times do you...**Get together with friends or relatives?**

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q32. In a typical month, how many times do you...**Attend public meetings in which there is a discussion of community issues?**

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q33. In a typical month, how many times do you...**Attend a group or organization meeting (not including meetings for work)?**

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q34. In a typical month, how many times do you...**Have friends over to your home?**

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q35. In a typical month, how many times do you...**Volunteer your time?**

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q36. In a typical month, how many times do you...**Attend social events where you might meet new people?**

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q37. In a typical month, how many times do you...**Participate in group leisure activities like sports or exercise classes?**

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q38. In a typical month, how many times do you...**Attend classes where you learn a new skill, like college classes or piano lessons?**

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Substance Use

READ: The following questions are about your use of alcohol and other drugs. Alcohol includes beer, wine, and hard liquor like in mixed drinks. "Other drugs" include such things as marijuana, ecstasy, crystal meth, cocaine and any non-medical use of prescription-type drugs. Please do not include prescription drugs that you have used as instructed under the care of a doctor.

Using the alcohol and drug list card, please circle all of the substances you used at least once in your lifetime.

Q39. Between alcohol, marijuana, cocaine, crystal meth or any other drugs, which one do you like to use the most? (Choose one)

- 01 Alcohol
- 02 Marijuana, (THC) hash, or marinol
- 03 Cocaine (powder)
- 04 Crack (rock or freebase)
- 05 Acid or LSD
- 06 Mushrooms/other nat hallucinogens
- 07 Methamphetamine
- 08 Ecstasy
- 09 Poppers
- 10 Rx sedatives (Xanax, Valium)
- 11 Rx uppers (Ritalin, Adderall)
- 12 Rx pain killers (Oxy, vicodin)
- 13 Ketamine (Special K)
- 14 GHB
- 15 Heroin
- 16 Other
- 97 Don't Know
- 98 Refuse to Answer
- 99 Not Applicable

If Q39 is less than 16, then skip to Q41.

Q40. Describe other substance: _____

Q41. Please use **CARD A** for the following questions:

When was the last time (if ever) you used any kind of **alcohol**? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q41 is less than 3, then skip to Q45.

Q42. During the past 90 days, on how many days have you used **alcohol**? ___

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q43. During the past 90 days, on how many days have you used **alcohol** within two hours before or during sex?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q44. In the past 90 days, how much **alcohol** did you use in a month? [**drinks in a typical month**]

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q45. When was the last time (if ever) you used alcohol until you were drunk (or had 5 or more drinks in one occasion)? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q45 is less than 3, then skip to Q48.

Q46. During the past 90 days, on how many days have you **been drunk or had 5 or more drinks in one occasion?** [*To qualify for alcohol use, R must have used 5+ drinks at least 6 times in past 90 days*]

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q47. During the past 90 days, on how many days have you **been drunk or had 5 or more drinks** within two hours before or during sex?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q48. When was the last time (if ever) you used any kind of **marijuana** (including hash, marinol or other forms of THC)? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q48 is less than 3, then skip to instruction before Q52.

Q49. During the past 90 days, on how many days have you used **marijuana**?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q50. During the past 90 days, on how many days have you used **marijuana** within two hours before or during sex? [*To qualify for marijuana use, R must have used marijuana at least 60 of past 90 days*]

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q51. In the past 90 days, how much **marijuana** did you use in a month? [**joints or equivalent in a typical month**]

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

ATTENTION: *To be eligible for the study, The client must have used either:
5+ drinks at least 6 times in the past 90 days OR
Marijuana at least 60 of the past 90 days OR
Any other drugs a total of at least 6 times in the past 90 days*

Go to next Question and monitor responses accordingly

Q52. When was the last time (if ever) you used **powder cocaine**? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q52 is less than 3, then skip to Q56.

Q53. During the past 90 days, on how many days have you used **cocaine**?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q54. During the past 90 days, on how many days have you used **cocaine** within two hours before or during sex?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q55. In the past 90 days, how much **cocaine** did you use in a month? [**lines, bumps or snorts in a typical month**]

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q56. When was the last time (if ever) you used **crack cocaine** (including smoked rock or freebase)? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q56 is less than 3, then skip to Q60.

Q57. During the past 90 days, on how many days have you used **crack**?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q58. During the past 90 days, on how many days have you used **crack** within two hours before or during sex?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q59. In the past 90 days, how much **crack** did you use in a month? [**rocks in a typical month**]

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q60. When was the last time (if ever) you used **acid, LSD, mushrooms or other hallucinogens** (including mescaline, peyote, psilocybin)? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q60 is less than 3, then skip to Q64.

Q61. During the past 90 days, on how many days have you used **hallucinogens**?

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q62. During the past 90 days, on how many days have you used **hallucinogens** within two hours before or during sex?

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q63. In the past 90 days, how much **hallucinogens** did you use in a month? [**hits, tabs or doses in a typical month**]

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q64. When was the last time (if ever) you used **methamphetamine** (including crank, crystal, tina)? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q64 is less than 3, then skip to Q68.

Q65. During the past 90 days, on how many days have you used **methamphetamine**?

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q66. During the past 90 days, on how many days have you used **methamphetamine** within two hours before or during sex?

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q67. In the past 90 days, how much **methamphetamine** did you use in a month? [**hits, snorts, puffs or slams in a typical month**]

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q68. When was the last time (if ever) you used **ecstasy** (MDMA)? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q68 is less than 3, then skip to Q72.

Q69. During the past 90 days, on how many days have you used **ecstasy**?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q70. During the past 90 days, on how many days have you used **ecstasy** within two hours before or during sex?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q71. In the past 90 days, how much **ecstasy** did you use in a month? [**pills in a typical month**]

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q72. When was the last time (if ever) you used **poppers** (amyl nitrites)? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q72 is less than 3, then skip to Q76.

Q73. During the past 90 days, on how many days have you used **poppers**?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q74. During the past 90 days, on how many days have you used **poppers** within two hours before or during sex?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q75. In the past 90 days, how much **poppers** did you use in a month? [**huffs or sniffs in a typical month**]

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q76. When was the last time (if ever) you used **non-prescribed use of prescription anti-anxiety drugs, tranquilizers or sedatives** (Klonopin, Valium, Xanax, Ambien, Restoril), for instance, to get high, for fun, to relax or to come down? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q76 is less than 3, then skip to Q80.

Q77. During the past 90 days, on how many days have you used **sedatives or tranquilizers** (not as prescribed)?

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q78. During the past 90 days, on how many days have you used **sedatives or tranquilizers** within two hours before or during sex?

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q79. In the past 90 days, how much **sedatives or tranquilizers** did you use in a month? [**pills in a typical month**]

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q80. When was the last time (if ever) you used **non-prescribed use of prescription uppers or stimulants** (such as Ritalin, Phentermine, Adderall, or Concerta) for instance, to get high, for fun, to relax or to come down? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q80 is less than 3, then skip to Q84.

Q81. During the past 90 days, on how many days have you used **uppers or stimulants** (not as prescribed)?

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q82. During the past 90 days, on how many days have you used **uppers or stimulants** within two hours before or during sex?

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q83. In the past 90 days, how much **uppers or stimulants** did you use in a month? [**pills in a typical month**]

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q84. When was the last time (if ever) you used **non-prescribed use of prescription pain killers, opiates, or analgesics** (Codeine, OxyContin, Percocet, Vicodin) for instance, to get high, for fun, to relax or to come down? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q84 is less than 3, then skip to Q88.

Q85. During the past 90 days, on how many days have you used **pain killers, opiates or analgesics** (not as prescribed)?

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q86. During the past 90 days, on how many days have you used **opiates** within two hours before or during sex?

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q87. In the past 90 days, how much **pain killers, opiates, or analgesics** did you use in a month? **[pills in a typical month]**

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q88. When was the last time (if ever) you used **Ketamine or Special K?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q88 is less than 3, then skip to Q92.

Q89. During the past 90 days, on how many days have you used **Ketamine**?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q90. During the past 90 days, on how many days have you used **Ketamine** within two hours before or during sex?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q91. In the past 90 days, how much **Ketamine** did you use in a month? [**snorts, slams in a typical month**]

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q92. When was the last time (if ever) you used **GHB (Gamma-hydroxybutyrate)**? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q92 is less than 3, then skip to Q96.

Q93. During the past 90 days, on how many days have you used **GHB**?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q94. During the past 90 days, on how many days have you used **GHB** within two hours before or during sex?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q95. In the past 90 days, how much **GHB** did you use in a month? [**doses in a typical month**]

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q96. When was the last time (if ever) you used **heroin**? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q96 is less than 3, then skip to Q100.

Q97. During the past 90 days, on how many days have you used **heroin**?

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q98. During the past 90 days, on how many days have you used **heroin** within two hours before or during sex?

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q99. In the past 90 days, how much **heroin** did you use in a month? [**snorts, puffs, slams in a typical month**]

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q100. When was the last time (if ever) you used **steroids or HGH (Human Growth Hormone)**? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q100 is less than 3, then skip to instruction before Q104.

Q101. During the past 90 days, on how many days have you used **steroids or HGH (Human Growth Hormone)**?

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q102. During the past 90 days, on how many days have you used **steroids or HGH** within two hours before or during sex?

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q103. In the past 90 days, how much **steroids or HGH** did you use in a month? [**shots, doses in a typical month**]

— —

- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

If Q100 is equal to 0, then skip to Q105.

Q104. Were either the **Steroids or the HGH** prescribed to you by your physician?

- 1 Yes
- 0 No
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

Q105. When was the last time (if ever) you used **non-prescribed use of antipsychotics or antidepressants** (Such as Zyprexa, Seroquel, Paxil, Zoloft or Wellbutrin)? (Choose one)

- 0 Never **Skip to instruction before Q107**
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to instruction before Q107**

Q106. Please describe Antipsychotic or Antidepressant:

If Q105 is less than 3, then skip to Q110.

Q107. During the past 90 days, on how many days have you used **antipsychotics or antidepressants**?

- —
- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q108. During the past 90 days, on how many days have you used **antipsychotics or antidepressants** within two hours before or during sex?

- —
- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q109. In the past 90 days, how much **antipsychotics or antidepressants** did you use in a month? **[pills in a typical month]**

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q110. When was the last time (if ever) you used **some other drug** such as DXM, cough syrup, nitrous oxide, or anything else? (Choose one)

- 0 Never **Skip to instruction before Q112**
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to instruction before Q112**

Q111. Please describe Other substance:

If Q110 is less than 3, then skip to instruction before Q115.

Q112. During the past 90 days, on how many days have you used **some other drug**?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q113. During the past 90 days, on how many days have you used **some other drug** within two hours before or during sex?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q114. In the past 90 days, how much **other drug** did you use in a month? [**doses in a typical month**]

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

READ: The next questions are about your use of alcohol, marijuana, cocaine, and all other drugs. Please answer the next questions using days.

Q115. During the past 90 days...**on how many days did you go without using 5 or more drinks, marijuana, cocaine, or any other drug?**

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q116. During the past 90 days...**on how many days did you get drunk or were you high for most of the day?**

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q117. During the past 90 days...**on how many days did alcohol or drug use problems keep you from meeting your responsibilities at work, school, or home?**

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

Q118. Please answer using Yes or No. During the past 90 days, did you stop, try to stop, cut down, or try to limit your use of alcohol or drugs?

- 1 Yes
- 0 No
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

Q119. Have you ever attended Alcoholics Anonymous (AA), Crystal Meth Anonymous (CMA), Cocaine Anonymous (CA), Narcotics Anonymous (NA), Smart Recovery (SR), or any other self-help group for your alcohol or drug use?

- 1 Yes
- 0 No
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

Treatment

READ: The next questions are about treatment for alcohol or drug use. Do not count treatment that was only for mental or physical health problems.

Q120. How many times in your life have you been admitted to detox, or had treatment or counseling for your alcohol or drug use?

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

If Q120 is equal to 0, then skip to Q130.

Q121. What substances did you receive treatment or counseling for? **Alcohol?**

- 1 Yes
- 0 No
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

Q122. What substances did you receive treatment or counseling for? **Marijuana (hashish, THC)?**

- 1 Yes
- 0 No
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

Q123. What substances did you receive treatment or counseling for? **Powder cocaine, freebase, or crack?**

- 1 Yes
- 0 No
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

Q124. What substances did you receive treatment or counseling for? **Heroin or other opioid?**

- 1 Yes
- 0 No
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

Q125. What substances did you receive treatment or counseling for? **Methamphetamine?**

- 1 Yes
- 0 No
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

Q126. What substances did you receive treatment or counseling for? **Something else?**

- 1 Yes
- 0 No
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

If Q126 is equal to 0, then skip to Q128.

Q127. Please describe other substance (treated for):

Q128. Are you currently taking medication for alcohol or drug problems?

- 1 Yes
- 0 No
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

If Q128 is equal to 0, then skip to Q130.

Q129. Please describe medication (treatment for alcohol and drug problems):

Q130. Please **USE CARD A:**

When was the last time (if ever) that you received treatment, counseling, medication, case management or aftercare for your use of alcohol or any drug including going to AA or NA? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q130 is less than 3, then skip to instruction before Q137.

Q131. What treatment did you receive?...**Emergency Room?**

- 1 Yes
- 0 No
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

Q132. What treatment did you receive?...**Admitted overnight to a residential, inpatient, or hospital program?**

- 1 Yes
- 0 No
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

Q133. What treatment did you receive?...**Admitted to an intensive inpatient or day program?**

- 1 Yes
- 0 No
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

Q134. What treatment did you receive?...**Admitted to a regular outpatient program (1-8 hours per week)?**

- 1 Yes
- 0 No
- 7 Don't know
- 8 Refuse to answer
- 9 Not applicable

Q135. What treatment did you receive?...**Any other type of treatment or working with a case manager?**

- 1 Yes
- 0 No *Skip to instruction before Q137*
- 7 Don't know *Skip to instruction before Q137*
- 8 Refuse to answer
- 9 Not applicable *Skip to instruction before Q137*

Q136. Please describe what other treatment you have received.

READ: Please USE CARD B.

Next, we want to go over a list of common problems related to alcohol or drug use. After hearing each of the following statements, we would like you to tell us the last time you had this problem.

Q137. When was the last time that...**you tried to hide that you were using alcohol or drugs?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q138. When was the last time that...**your parents, family, partner, co-workers, classmates or friends complained about your alcohol or drug use?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q139. When was the last time that...**your alcohol or drug use caused you to feel depressed, nervous, suspicious, uninterested in things, reduced your sexual desire or caused other psychological problems?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q140. When was the last time that...**your alcohol or drug use caused you to have any physical health problems such as a persistent cough, numbness, shakes, memory lapses, blackouts or kidney or stomach problems?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q141. When was the last time that...**you kept using alcohol or drugs even though you knew it was keeping you from meeting your responsibilities at work, school, or home?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q142. When was the last time that...**you used alcohol or drugs when you were driving a car, or when it made the situation unsafe or dangerous for you such as where you might have been forced into sex or hurt?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q143. When was the last time that...**your alcohol or drug use caused you to have repeated problems with the law?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q144. When was the last time that...**your alcohol or drug use caused you to have social problems like leading to fights or getting you into trouble with other people?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q145. When was the last time that...**you needed more alcohol or drugs to get the same high or found that the same amount did not get you as high as it used to?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q146. When was the last time that...**you had withdrawal problems from alcohol or drugs like shaking, vomiting, trouble sitting still or sleeping, or that you used alcohol or drugs to stop being sick or avoid withdrawal problems?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q147. When was the last time that...**you used alcohol or drugs in larger amounts, more often or for longer than you meant to?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q148. When was the last time that...**you were unable to cut down or stop using alcohol or drugs?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q149. When was the last time that...**you spent a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (including being high or sick)?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q150. When was the last time that...**your use of alcohol or drugs caused you to give up, reduce or have problems at important activities at work, school, home or social events?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q151. When was the last time that...**you kept using alcohol or drugs even after you knew it was causing medical, psychological or emotional problems?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q152. How old were you the first time you got drunk or used any drugs? — —

- —
- 97 Don't know
 - 98 Refuse to answer
 - 99 Not applicable

If Q141 is less than 2, then skip to instruction before Q170.

READ: Using CARD B:

Earlier you mentioned that within the past year you kept using a substance even though you knew it was keeping you from meeting your responsibilities at work, school, or home. Can you tell me which substances caused you to not meet your responsibilities?

[Listen for responses and then code each item appropriately OR read each item and code.]

If Q41 is less than 2, then skip to instruction before Q154.

Q153. [kept from meeting responsibilities]...**Alcohol? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q48 is less than 2, then skip to instruction before Q155.

Q154. [kept from meeting responsibilities]...**Marijuana? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q52 is less than 2, then skip to instruction before Q156.

Q155. [kept from meeting responsibilities]...**Cocaine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q56 is less than 2, then skip to instruction before Q157.

Q156. [kept from meeting responsibilities]...**Crack? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q60 is less than 2, then skip to instruction before Q158.

Q157. [kept from meeting responsibilities]...**Hallucinogens? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q64 is less than 2, then skip to instruction before Q159.

Q158. [kept from meeting responsibilities]...**Methamphetamine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q68 is less than 2, then skip to instruction before Q160.

Q159. [kept from meeting responsibilities]...**Ecstasy? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q72 is less than 2, then skip to instruction before Q161.

Q160. [kept from meeting responsibilities]...**Poppers? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q76 is less than 2, then skip to instruction before Q162.

Q161. [kept from meeting responsibilities]...**Prescription sedatives (tranquilizers, Xanax) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q80 is less than 2, then skip to instruction before Q163.

Q162. [kept from meeting responsibilities]... **Prescription stimulants (Ritalin, Adderall) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q84 is less than 2, then skip to instruction before Q164.

Q163. [kept from meeting responsibilities]... **Prescription opiates (Vicodin, OxyContin, Percocet) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q88 is less than 2, then skip to instruction before Q165.

Q164. [kept from meeting responsibilities]... **Ketamine (Special K)? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q92 is less than 2, then skip to instruction before Q166.

Q165. [kept from meeting responsibilities]... **GHB? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q96 is less than 2, then skip to instruction before Q167.

Q166. [kept from meeting responsibilities]... **Heroin? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q100 is less than 2, then skip to instruction before Q168.

Q167. [kept from meeting responsibilities]... **Steroids? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q105 is less than 2, then skip to instruction before Q169.

Q168. [kept from meeting responsibilities]... **Prescription Antipsychotics or Antidepressants? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q110 is less than 2, then skip to instruction before Q170.

Q169. [kept from meeting responsibilities]... **Any other substance (DXM, Nitrous Oxide, any other)? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q142 is less than 2, then skip to instruction before Q187.

READ: Using CARD B:

Earlier you mentioned that within the past year you used alcohol or drugs when you were driving a car or in an unsafe situation. Can you tell me which substances you have used in these situations?

[Listen for responses and then code each item appropriately OR read each item and code.]

If Q41 is less than 2, then skip to instruction before Q171.

Q170. [used in unsafe situations]...**Alcohol? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q48 is less than 2, then skip to instruction before Q172.

Q171. [used in an unsafe situation]...**Marijuana? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q52 is less than 2, then skip to instruction before Q173.

Q172. [used in an unsafe situation]...**Cocaine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q56 is less than 2, then skip to instruction before Q174.

Q173. [used in an unsafe situation]...**Crack? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q60 is less than 2, then skip to instruction before Q175.

Q174. [used in an unsafe situation]...**Hallucinogens? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q64 is less than 2, then skip to instruction before Q176.

Q175. [used in an unsafe situation]...**Methamphetamine? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q68 is less than 2, then skip to instruction before Q177.

Q176. [used in an unsafe situation]...**Ecstasy? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q72 is less than 2, then skip to instruction before Q178.

Q177. [used in an unsafe situation]...**Poppers? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q76 is less than 2, then skip to instruction before Q179.

Q178. [used in an unsafe situation]... **Prescription sedatives (tranquilizers, Xanax) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q80 is less than 2, then skip to instruction before Q180.

Q179. [used in an unsafe situation]... **Prescription stimulants (Ritalin, Adderall) ? About when did that happen?** (Choose one)

- 00 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q84 is less than 2, then skip to instruction before Q181.

Q180. [used in an unsafe situation]... **Prescription opiates (Vicodin, OxyContin, Percocet) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q88 is less than 2, then skip to instruction before Q182.

Q181. [used in an unsafe situation]... **Ketamine (Special K)? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q92 is less than 2, then skip to instruction before Q183.

Q182. [used in an unsafe situation]... **GHB? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q96 is less than 2, then skip to instruction before Q184.

Q183. [used in an unsafe situation]... **Heroin? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q100 is less than 2, then skip to instruction before Q185.

Q184. [used in an unsafe situation]... **Steroids? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q105 is less than 2, then skip to instruction before Q186.

Q185. [used in an unsafe situation]... **Prescription Antipsychotics or Antidepressants? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q110 is less than 2, then skip to instruction before Q187.

Q186. [used in an unsafe situation]... **Any other substance (DXM, Nitrous Oxide, any other)? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q143 is less than 2, then skip to instruction before Q204.

READ: Using CARD B:

Earlier you mentioned that within the past year your use of alcohol or drugs caused you to have repeated problems with the law. Can you tell me which substances caused you to have these problems?

[Listen for responses and then code each item appropriately OR read each item and code.]

If Q41 is less than 2, then skip to instruction before Q188.

Q187. [caused you to have repeated problems with the law]...**Alcohol? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q48 is less than 2, then skip to instruction before Q189.

Q188. [caused you to have repeated problems with the law]...**Marijuana? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q52 is less than 2, then skip to instruction before Q190.

Q189. [caused you to have repeated problems with the law]...**Cocaine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q56 is less than 2, then skip to instruction before Q191.

Q190. [caused you to have repeated problems with the law]...**Crack? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q60 is less than 2, then skip to instruction before Q192.

Q191. [caused you to have repeated problems with the law]...**Hallucinogens? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q64 is less than 2, then skip to instruction before Q193.

Q192. [caused you to have repeated problems with the law]...**Methamphetamine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q68 is less than 2, then skip to instruction before Q194.

Q193. [caused you to have repeated problems with the law]...**Ecstasy? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q72 is less than 2, then skip to instruction before Q195.

Q194. [caused you to have repeated problems with the law]...**Poppers? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q76 is less than 2, then skip to instruction before Q196.

Q195. [caused you to have repeated problems with the law]...**Prescription sedatives (tranquilizers, Xanax) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q80 is less than 2, then skip to instruction before Q197.

Q196. [caused you to have repeated problems with the law]... **Prescription stimulants (Ritalin, Adderall) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q84 is less than 2, then skip to instruction before Q198.

Q197. [caused you to have repeated problems with the law]... **Prescription opiates (Vicodin, OxyContin, Percocet) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q88 is less than 2, then skip to instruction before Q199.

Q198. [caused you to have repeated problems with the law]... **Ketamine (Special K)? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q92 is less than 2, then skip to instruction before Q200.

Q199. [caused you to have repeated problems with the law]... **GHB? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q96 is less than 2, then skip to instruction before Q201.

Q200. [caused you to have repeated problems with the law]... **Heroin? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q100 is less than 2, then skip to instruction before Q202.

Q201. [caused you to have repeated problems with the law]... **Steroids? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q105 is less than 2, then skip to instruction before Q203.

Q202. [caused you to have repeated problems with the law]... **Prescription Antipsychotics or Antidepressants? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q110 is less than 2, then skip to instruction before Q204.

Q203. [caused you to have repeated problems with the law]... **Any other substance (DXM, Nitrous Oxide, any other)? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q144 is less than 2, then skip to instruction before Q221.

READ: Using CARD B:

Earlier you mentioned that within the past year your use of alcohol or drugs caused you to have social problems like leading to fights or getting you into trouble with other people. Can you tell me which substances caused you to have social problems?

[Listen for responses and then code each item appropriately OR read each item and code.]

If Q41 is less than 2, then skip to instruction before Q205.

Q204. [caused you to have social problems like fights]...**Alcohol? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q48 is less than 2, then skip to instruction before Q206.

Q205. [caused you to have social problems like fights]...**Marijuana? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q52 is less than 2, then skip to instruction before Q207.

Q206. [caused you to have social problems like fights]...**Cocaine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q56 is less than 2, then skip to instruction before Q208.

Q207. [caused you to have social problems like fights]...**Crack? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q60 is less than 2, then skip to instruction before Q209.

Q208. [caused you to have social problems like fights]...**Hallucinogens? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q64 is less than 2, then skip to instruction before Q210.

Q209. [caused you to have social problems like fights]...**Methamphetamine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q68 is less than 2, then skip to instruction before Q211.

Q210. [caused you to have social problems like fights]...**Ecstasy? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q72 is less than 2, then skip to instruction before Q212.

Q211. [caused you to have social problems like fights]...**Poppers? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q76 is less than 2, then skip to instruction before Q213.

Q212. [caused you to have social problems like fights]...**Prescription sedatives (tranquilizers, Xanax) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q80 is less than 2, then skip to instruction before Q214.

Q213. [caused you to have social problems like fights]... **Prescription stimulants (Ritalin, Adderall) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q84 is less than 2, then skip to instruction before Q215.

Q214. [caused you to have social problems like fights]... **Prescription opiates (Vicodin, OxyContin, Percocet) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q88 is less than 2, then skip to instruction before Q216.

Q215. [caused you to have social problems like fights]... **Ketamine (Special K)? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q92 is less than 2, then skip to instruction before Q217.

Q216. [caused you to have social problems like fights]... **GHB? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q96 is less than 2, then skip to instruction before Q218.

Q217. [caused you to have social problems like fights]... **Heroin? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q100 is less than 2, then skip to instruction before Q219.

Q218. [caused you to have social problems like fights]... **Steroids? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q105 is less than 2, then skip to instruction before Q220.

Q219. [caused you to have social problems like fights]... **Prescription Antipsychotics or Antidepressants? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q110 is less than 2, then skip to instruction before Q221.

Q220. [caused you to have social problems like fights]... **Any other substance (DXM, Nitrous Oxide, any other)? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q145 is less than 2, then skip to instruction before Q238.

READ: Using CARD B:

Earlier you mentioned that within the past year you needed more alcohol or drugs to get the same high or that the same amount did not get you as high as it used to. Can you tell me which substances you needed more of to get high?

[Listen for responses and then code each item appropriately OR read each item and code.]

If Q41 is less than 2, then skip to instruction before Q222.

Q221. [needed more of to get the same high]...**Alcohol? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q48 is less than 2, then skip to instruction before Q223.

Q222. [needed more of to get the same high]...**Marijuana? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q52 is less than 2, then skip to instruction before Q224.

Q223. [needed more of to get the same high]...**Cocaine? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q56 is less than 2, then skip to instruction before Q225.

Q224. [needed more of to get the same high]...**Crack? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q60 is less than 2, then skip to instruction before Q226.

Q225. [needed more of to get the same high]...**Hallucinogens? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q64 is less than 2, then skip to instruction before Q227.

Q226. [needed more of to get the same high]...**Methamphetamine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q68 is less than 2, then skip to instruction before Q228.

Q227. [needed more of to get the same high]...**Ecstasy? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q72 is less than 2, then skip to instruction before Q229.

Q228. [needed more of to get the same high]...**Poppers? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q76 is less than 2, then skip to instruction before Q230.

Q229. [needed more of to get the same high]...**Prescription sedatives (tranquilizers, Xanax)
? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q80 is less than 2, then skip to instruction before Q231.

Q230. [needed more of to get the same high]... **Prescription stimulants (Ritalin, Adderall) ?**
About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q84 is less than 2, then skip to instruction before Q232.

Q231. [needed more of to get the same high]... **Prescription opiates (Vicodin, OxyContin, Percocet) ? About when did that happen? (Choose one)**

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q88 is less than 2, then skip to instruction before Q233.

Q232. [needed more of to get the same high]... **Ketamine (Special K)? About when did that happen? (Choose one)**

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q92 is less than 2, then skip to instruction before Q234.

Q233. [needed more of to get the same high]... **GHB? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q96 is less than 2, then skip to instruction before Q235.

Q234. [needed more of to get the same high]... **Heroin? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q100 is less than 2, then skip to instruction before Q236.

Q235. [needed more of to get the same high]... **Steroids? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q105 is less than 2, then skip to instruction before Q237.

Q236. [needed more of to get the same high]... **Prescription Antipsychotics or Antidepressants? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q110 is less than 2, then skip to instruction before Q238.

Q237. [needed more of to get the same high]... **Any other substance (DXM, Nitrous Oxide, any other)? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q146 is less than 2, then skip to instruction before Q255.

READ: Using CARD B:

Earlier you mentioned that within the past year you had withdrawal problems from alcohol or drugs like shaking, vomiting, trouble sitting still or sleeping or that you used alcohol or drugs to stop being sick or avoid withdrawal problems. Can you tell me which substances you had withdrawal problems from?

[Listen for responses and then code each item appropriately OR read each item and code.]

If Q41 is less than 2, then skip to instruction before Q239.

Q238. [had withdrawal problems]...**Alcohol? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q48 is less than 2, then skip to instruction before Q240.

Q239. [had withdrawal problems]...**Marijuana? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q52 is less than 2, then skip to instruction before Q241.

Q240. [had withdrawal problems]...**Cocaine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q56 is less than 2, then skip to instruction before Q242.

Q241. [had withdrawal problems]...**Crack? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q60 is less than 2, then skip to instruction before Q243.

Q242. [had withdrawal problems]...**Hallucinogens? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q64 is less than 2, then skip to instruction before Q244.

Q243. [had withdrawal problems]...**Methamphetamine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q68 is less than 2, then skip to instruction before Q245.

Q244. [had withdrawal problems]...**Ecstasy? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q72 is less than 2, then skip to instruction before Q246.

Q245. [had withdrawal problems]...**Poppers? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q76 is equal to 0, then skip to instruction before Q247.

Q246. [had withdrawal problems]...**Prescription sedatives (tranquilizers, Xanax) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q80 is less than 2, then skip to instruction before Q248.

Q247. [had withdrawal problems]... **Prescription stimulants (Ritalin, Adderall) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q84 is less than 2, then skip to instruction before Q249.

Q248. [had withdrawal problems]... **Prescription opiates (Vicodin, OxyContin, Percocet) ?**
About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q88 is less than 2, then skip to instruction before Q250.

Q249. [had withdrawal problems]... **Ketamine (Special K)? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q92 is less than 2, then skip to instruction before Q251.

Q250. [had withdrawal problems]... **GHB? About when did that happen? (Choose one)**

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q96 is less than 2, then skip to instruction before Q252.

Q251. [had withdrawal problems]... **Heroin? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q100 is less than 2, then skip to instruction before Q253.

Q252. [had withdrawal problems]... **Steroids? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q105 is less than 2, then skip to instruction before Q254.

Q253. [had withdrawal problems]... **Prescription Antipsychotics or Antidepressants? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q110 is less than 2, then skip to instruction before Q255.

Q254. [had withdrawal problems]... **Any other substance (DXM, Nitrous Oxide, any other)?**
About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q147 is less than 2, then skip to instruction before Q272.

READ: Using CARD B:

Earlier you mentioned that within the past year you used alcohol or drugs in larger amounts, more often or for a longer time than you meant to. Can you tell me which substances you used more of or for longer than you meant to?

[Listen for responses and then code each item appropriately OR read each item and code.]

If Q41 is less than 2, then skip to instruction before Q256.

Q255. [used in larger amounts, more often or for a longer time than you meant to]...**Alcohol?**
About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q48 is less than 2, then skip to instruction before Q257.

Q256. [used in larger amounts, more often or for a longer time than you meant to]...**Marijuana?**
About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q52 is less than 2, then skip to instruction before Q258.

Q257. [used in larger amounts, more often or for a longer time than you meant to]...**Cocaine?**
About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q56 is less than 2, then skip to instruction before Q259.

Q258. [used in larger amounts, more often or for a longer time than you meant to]...**Crack?**
About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q60 is less than 2, then skip to instruction before Q260.

Q259. [used in larger amounts, more often or for a longer time than you meant to]...**Hallucinogens? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q64 is less than 2, then skip to instruction before Q261.

Q260. [used in larger amounts, more often or for a longer time than you meant to]...**Methamphetamine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q68 is less than 2, then skip to instruction before Q262.

Q261. [used in larger amounts, more often or for a longer time than you meant to]...**Ecstasy?**
About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q72 is less than 2, then skip to instruction before Q263.

Q262. [used in larger amounts, more often or for a longer time than you meant to]...**Poppers?**
About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q76 is less than 2, then skip to instruction before Q264.

Q263. [used in larger amounts, more often or for a longer time than you meant to]...**Prescription sedatives (tranquilizers, Xanax) ? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q80 is less than 2, then skip to instruction before Q265.

Q264. [used in larger amounts, more often or for a longer time than you meant to]...
Prescription stimulants (Ritalin, Adderall) ? About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q84 is less than 2, then skip to instruction before Q266.

Q265. [used in larger amounts, more often or for a longer time than you meant to]...
Prescription opiates (Vicodin, OxyContin, Percocet) ? About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q88 is less than 2, then skip to instruction before Q267.

Q266. [used in larger amounts, more often or for a longer time than you meant to]... **Ketamine (Special K)? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q92 is less than 2, then skip to instruction before Q268.

Q267. [used in larger amounts, more often or for a longer time than you meant to]... **GHB?**
About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q96 is less than 2, then skip to instruction before Q269.

Q268. [used in larger amounts, more often or for a longer time than you meant to]... **Heroin?**
About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q100 is less than 2, then skip to instruction before Q270.

Q269. [used in larger amounts, more often or for a longer time than you meant to]... **Steroids?**
About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q105 is less than 2, then skip to instruction before Q271.

Q270. [used in larger amounts, more often or for a longer time than you meant to]...
Prescription Antipsychotics or Antidepressants? About when did that happen?
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q110 is less than 2, then skip to instruction before Q272.

Q271. [used in larger amounts, more often or for a longer time than you meant to]... **Any other substance (DXM, Nitrous Oxide, any other)? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q148 is less than 2, then skip to instruction before Q289.

READ: Using CARD B:

Earlier you mentioned that within the past year you were unable to cut down or stop using drugs or alcohol. Can you tell me which substances you could not cut down on or stop?

[Listen for responses and then code each item appropriately OR read each item and code.]

If Q41 is less than 2, then skip to instruction before Q273.

Q272. [unable to cut down or stop]...**Alcohol? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q48 is less than 2, then skip to instruction before Q274.

Q273. [unable to cut down or stop]...**Marijuana? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q52 is less than 2, then skip to instruction before Q275.

Q274. [unable to cut down or stop]...**Cocaine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q56 is less than 2, then skip to instruction before Q276.

Q275. [unable to cut down or stop]...**Crack? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q60 is less than 2, then skip to instruction before Q277.

Q276. [unable to cut down or stop]...**Hallucinogens? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q64 is less than 2, then skip to instruction before Q278.

Q277. [unable to cut down or stop]...**Methamphetamine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q68 is less than 2, then skip to instruction before Q279.

Q278. [unable to cut down or stop]...**Ecstasy? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q72 is less than 2, then skip to instruction before Q280.

Q279. [unable to cut down or stop]...**Poppers? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q76 is less than 2, then skip to instruction before Q281.

Q280. [unable to cut down or stop]...**Prescription sedatives (tranquilizers, Xanax) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q80 is less than 2, then skip to instruction before Q282.

Q281. [unable to cut down or stop]... **Prescription stimulants (Ritalin, Adderall) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q84 is less than 2, then skip to instruction before Q283.

Q282. [unable to cut down or stop]... **Prescription opiates (Vicodin, OxyContin, Percocet) ?**
About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q88 is less than 2, then skip to instruction before Q284.

Q283. [unable to cut down or stop]... **Ketamine (Special K)? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q92 is less than 2, then skip to instruction before Q285.

Q284. [unable to cut down or stop]... **GHB? About when did that happen? (Choose one)**

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q96 is less than 2, then skip to instruction before Q286.

Q285. [unable to cut down or stop]... **Heroin? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q100 is less than 2, then skip to instruction before Q287.

Q286. [unable to cut down or stop]... **Steroids? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q105 is less than 2, then skip to instruction before Q288.

Q287. [unable to cut down or stop]... **Prescription Antipsychotics or Antidepressants? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q110 is less than 2, then skip to instruction before Q289.

Q288. [unable to cut down or stop]... **Any other substance (DXM, Nitrous Oxide, any other)?**
About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q149 is less than 2, then skip to instruction before Q306.

READ: Using CARD B:

Earlier you mentioned that within the past year you spent a lot of time either getting, using or feeling the effects of drugs or alcohol (like being high or sick). Can you tell me which substances you spent a lot of time getting or using?

[Listen for responses and then code each item appropriately OR read each item and code.]

If Q41 is less than 2, then skip to instruction before Q290.

Q289. [spent a lot of time getting, using or feeling the effects]...**Alcohol? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q48 is less than 2, then skip to instruction before Q291.

Q290. [spent a lot of time getting, using or feeling the effects]...**Marijuana? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q52 is less than 2, then skip to instruction before Q292.

Q291. [spent a lot of time getting, using or feeling the effects]...**Cocaine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q56 is less than 2, then skip to instruction before Q293.

Q292. [spent a lot of time getting, using or feeling the effects]...**Crack? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q60 is less than 2, then skip to instruction before Q294.

Q293. [spent a lot of time getting, using or feeling the effects]...**Hallucinogens? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q64 is less than 2, then skip to instruction before Q295.

Q294. [spent a lot of time getting, using or feeling the effects]...**Methamphetamine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q68 is less than 2, then skip to instruction before Q296.

Q295. [spent a lot of time getting, using or feeling the effects]...**Ecstasy? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q72 is less than 2, then skip to instruction before Q297.

Q296. [spent a lot of time getting, using or feeling the effects]...**Poppers? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q76 is less than 2, then skip to instruction before Q298.

Q297. [spent a lot of time getting, using or feeling the effects]...**Prescription sedatives (tranquilizers, Xanax) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q80 is less than 2, then skip to instruction before Q299.

Q298. [spent a lot of time getting, using or feeling the effects]... **Prescription stimulants (Ritalin, Adderall) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q84 is less than 2, then skip to instruction before Q300.

Q299. [spent a lot of time getting, using or feeling the effects]... **Prescription opiates (Vicodin, OxyContin, Percocet) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q88 is less than 2, then skip to instruction before Q301.

Q300. [spent a lot of time getting, using or feeling the effects]... **Ketamine (Special K)? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q92 is less than 2, then skip to instruction before Q302.

Q301. [spent a lot of time getting, using or feeling the effects]... **GHB? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q96 is less than 2, then skip to instruction before Q303.

Q302. [spent a lot of time getting, using or feeling the effects]... **Heroin? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q100 is less than 2, then skip to instruction before Q304.

Q303. [spent a lot of time getting, using or feeling the effects]... **Steroids? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q105 is less than 2, then skip to instruction before Q305.

Q304. [spent a lot of time getting, using or feeling the effects]... **Prescription Antipsychotics or Antidepressants? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q110 is less than 2, then skip to instruction before Q306.

Q305. [spent a lot of time getting, using or feeling the effects]... **Any other substance (DXM, Nitrous Oxide, any other)? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q150 is less than 2, then skip to instruction before Q323.

READ: Using CARD B:

Earlier you mentioned that within the past year your use of alcohol or drugs caused you to give up, reduce, or have problems at important activities at work, school, home or social events. Can you tell me which substances caused you to give up important activities?

[Listen for responses and then code each item appropriately OR read each item and code.]

If Q41 is less than 2, then skip to instruction before Q307.

Q306. [caused to give up important activities]...**Alcohol? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q48 is less than 2, then skip to instruction before Q308.

Q307. [caused to give up important activities]...**Marijuana? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q52 is less than 2, then skip to instruction before Q309.

Q308. [caused to give up important activities]...**Cocaine? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q56 is less than 2, then skip to instruction before Q310.

Q309. [caused to give up important activities]...**Crack? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q60 is less than 2, then skip to instruction before Q311.

Q310. [caused to give up important activities]...**Hallucinogens? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q64 is less than 2, then skip to instruction before Q312.

Q311. [caused to give up important activities]...**Methamphetamine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q68 is less than 2, then skip to instruction before Q313.

Q312. [caused to give up important activities]...**Ecstasy? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q72 is less than 2, then skip to instruction before Q314.

Q313. [caused to give up important activities]...**Poppers? About when did that happen?**
(Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q76 is less than 2, then skip to instruction before Q315.

Q314. [caused to give up important activities]...**Prescription sedatives (tranquilizers, Xanax)
? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q80 is less than 2, then skip to instruction before Q316.

Q315. [caused to give up important activities]... **Prescription stimulants (Ritalin, Adderall) ?**
About when did that happen? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q84 is less than 2, then skip to instruction before Q317.

Q316. [caused to give up important activities]... **Prescription opiates (Vicodin, OxyContin, Percocet) ?** **About when did that happen? (Choose one)**

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q88 is less than 2, then skip to instruction before Q318.

Q317. [caused to give up important activities]... **Ketamine (Special K)?** **About when did that happen? (Choose one)**

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q92 is less than 2, then skip to instruction before Q319.

Q318. [caused to give up important activities]... **GHB? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q96 is less than 2, then skip to instruction before Q320.

Q319. [caused to give up important activities]... **Heroin? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q100 is less than 2, then skip to instruction before Q321.

Q320. [caused to give up important activities]... **Steroids? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q105 is less than 2, then skip to instruction before Q322.

Q321. [caused to give up important activities]... **Prescription Antipsychotics or Antidepressants? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q110 is less than 2, then skip to instruction before Q323.

Q322. [caused to give up important activities]... **Any other substance (DXM, Nitrous Oxide, any other)? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q151 is less than 2, then skip to Q340.

READ: Using CARD B:

Earlier you mentioned that within the past year you kept using alcohol or drugs after you knew it was causing medical, psychological, or emotional problems. Can you tell me which substances you kept using despite medical, psychological or emotional problems?

[Listen for responses and then code each item appropriately OR read each item and code.]

If Q41 is less than 2, then skip to instruction before Q324.

Q323. [caused or added to medical, psychological or emotional problems]...**Alcohol? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q48 is less than 2, then skip to instruction before Q325.

Q324. [caused or added to medical, psychological or emotional problems]...**Marijuana? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q52 is less than 2, then skip to instruction before Q326.

Q325. [caused or added to medical, psychological or emotional problems]...**Cocaine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q56 is less than 2, then skip to instruction before Q327.

Q326. [caused or added to medical, psychological or emotional problems]...**Crack? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q60 is less than 2, then skip to instruction before Q328.

Q327. [caused or added to medical, psychological or emotional problems]...**Hallucinogens? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q64 is less than 2, then skip to instruction before Q329.

Q328. [caused or added to medical, psychological or emotional problems]...**Methamphetamine? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q68 is less than 2, then skip to instruction before Q330.

Q329. [caused or added to medical, psychological or emotional problems]...**Ecstasy? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q72 is less than 2, then skip to instruction before Q331.

Q330. [caused or added to medical, psychological or emotional problems]...**Poppers? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q76 is less than 2, then skip to instruction before Q332.

Q331. [caused or added to medical, psychological or emotional problems]...**Prescription sedatives (tranquilizers, Xanax) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q80 is less than 2, then skip to instruction before Q333.

Q332. [caused or added to medical, psychological or emotional problems]... **Prescription stimulants (Ritalin, Adderall) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q84 is less than 2, then skip to instruction before Q334.

Q333. [caused or added to medical, psychological or emotional problems]... **Prescription opiates (Vicodin, OxyContin, Percocet) ? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q88 is less than 2, then skip to instruction before Q335.

Q334. [caused or added to medical, psychological or emotional problems]... **Ketamine (Special K)? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q92 is less than 2, then skip to instruction before Q336.

Q335. [caused or added to medical, psychological or emotional problems]... **GHB? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q96 is less than 2, then skip to instruction before Q337.

Q336. [caused or added to medical, psychological or emotional problems]... **Heroin? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q100 is less than 2, then skip to instruction before Q338.

Q337. [caused or added to medical, psychological or emotional problems]... **Steroids? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q105 is less than 2, then skip to instruction before Q339.

Q338. [caused or added to medical, psychological or emotional problems]... **Prescription Antipsychotics or Antidepressants? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q110 is less than 2, then skip to Q340.

Q339. [caused or added to medical, psychological or emotional problems]... **Any other substance (DXM, Nitrous Oxide, any other)? About when did that happen?** (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Within the past 90 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q340. **Using Card C:** How soon, if at all, do you need help or more help with your current alcohol or drug situation? (Choose one)

- 0 Do not need any help
- 1 Getting the help I need already
- 2 More than 3 months from now
- 3 In the next 3 months
- 4 Right away
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

COPE Scale

READ: Please USE CARD D for the following questions. These items deal with ways you've been coping with the stress in your life. Obviously, different people deal with things in different ways. We want to know to what extent you've been doing what the item says: how much or how frequently. Try to rate each item separately in your mind from the others. Make your answers as true for you as you can.

Q341. CARD D:
I've been using alcohol or other drugs to make myself feel better. *[coping with stress]*

- 1 Not at all
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q342. CARD D:
I've been getting emotional support from others. *[coping with stress]*

- 1 Not at all
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q343. CARD D:
I've been giving up trying to cope. *[coping with stress]*

- 1 Not at all
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q344. CARD D:
I've been trying to take action to make the situation better. *[coping with stress]*

- 1 Not at all
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

- Q345. CARD D:
I've been saying to myself, "this isn't real." [*coping with stress*]
- 1 Not at all
 - 2 A little
 - 3 Moderately
 - 4 A lot / Very much
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q346. CARD D:
I've been getting help and advice from other people. [*coping with stress*] 1 Not at all
- 1 Not at all
 - 2 A little
 - 3 Moderately
 - 4 A lot / Very much
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q347. CARD D:
I've been looking for something good in what is happening. [*coping with stress*] 1
- 1 Not at all
 - 2 A little
 - 3 Moderately
 - 4 A lot / Very much
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q348. CARD D:
I've been criticizing myself. [*coping with stress*]
- 1 Not at all
 - 2 A little
 - 3 Moderately
 - 4 A lot / Very much
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable

Q349. CARD D:

I've been using sex to make myself feel better. [*coping with stress*]

- 1 Not at all
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q350. CARD D:

I've been learning to live with it. [*coping with stress*]

- 1 Not at all
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q351. CARD D:

I've been thinking hard about what steps to take. [*coping with stress*]

- 1 Not at all
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Physical Health

READ: The next questions are about your physical health and how you have been feeling physically.

Q352. During the past 12 months, would you say your health in general was....excellent, very good, good, fair, or poor? (Choose one)

- 0 Excellent
- 1 Very good
- 2 Good
- 3 Fair
- 4 Poor
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q353. **Using Card A:** When was the last time (if ever) that you were bothered by health or medical problems or that they kept you from meeting your responsibilities at work, school, or home? (Please include asthma or allergies) (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q353 is less than 3, then skip to Q359.

Q354. **Please answer the following questions using number of days.**

During the past 90 days, on how many days were you bothered by any health or medical problems?

- — 00 zero **Skip to Q359**
- 97 Don't know
- 98 Refuse to answer
- 99 Not applicable **Skip to Q359**

Q355. During the past 90 days, on how many days have medical problems kept you from meeting your responsibilities at work, school, or home?

- — 97 Don't know
- 98 Refuse to answer
- 99 Not applicable

Q356. What is the problem you have been having? (1 of 3)

Q357. What is the problem you have been having? (2 of 3) *If none, click Not Applicable*

If missing **Skip to Q359**

Q358. What is the problem you have been having? (3 of 3) *If none, click Not Applicable*

Q359. **Using Card C:** How soon, if at all, do you need help or more help with your current physical health? (Choose one)

- 0 Do not need any help
- 1 Getting the help I need already
- 2 More than 3 months from now
- 3 In the next 3 months
- 4 Right away
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Risk Behaviors and Disease Prevention

READ: Next we would like to ask you a few very personal questions about behaviors that may have put you at risk or reduced your risk for getting or transmitting infectious diseases. Please remember that all of your answers are strictly confidential. The first questions are about the use of a needle to inject you with drugs. Do not include injections of prescribed medications other than steroids. Please include if you were injected by someone else.

Q360. **Using Card A:** When was the last time (if ever) that you used a needle to inject drugs including steroids (not including prescribed medications like for diabetes)? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q360 is less than 1, then skip to Q373.

Q361. What substances have you ever injected? [first substance] (Choose one)

- 01 Alcohol
- 02 Cocaine
- 03 Cocaine mixed with Heroin
- 04 Hallucinogens
- 05 Methamphetamine
- 06 Ecstasy
- 07 Non-prescribed Rx sedatives
- 08 Non-prescribed Rx stimulants
- 09 Non-prescribed Rx pain killers
- 10 Heroin
- 11 Steroids or HGH
- 12 Other
- 97 Don't Know
- 98 Refuse to Answer
- 99 Not Applicable

If Q361 is less than 12 or Q361 is equal to 99, then skip to Q363.

Q362. Please describe "Other" injected substance:

Q363. **Any others?** (2nd substance injected)) *If none, click Not Applicable* (Choose one)

- 01 Alcohol
- 02 Cocaine
- 03 Cocaine mixed with Heroin
- 04 Hallucinogens
- 05 Methamphetamine
- 06 Ecstasy
- 07 Non-prescribed Rx sedatives
- 08 Non-prescribed Rx stimulants
- 09 Non-prescribed Rx pain killers
- 10 Heroin
- 11 Steroids or HGH
- 12 Other
- 97 Don't Know
- 98 Refuse to Answer
- 99 Not Applicable

If Q363 is less than 12 or Q363 is equal to 99, then skip to instruction before Q365.

Q364. Please describe "Other" injected substance:

If Q363 is equal to 99, then skip to Q369.

Q365. **Any others?** (3rd substance injected) *If none, click Not Applicable* (Choose one)

- 01 Alcohol
- 02 Cocaine
- 03 Cocaine mixed with Heroin
- 04 Hallucinogens
- 05 Methamphetamine
- 06 Ecstasy
- 07 Non-prescribed Rx sedatives
- 08 Non-prescribed Rx stimulants
- 09 Non-prescribed Rx pain killers
- 10 Heroin
- 11 Steroids or HGH
- 12 Other
- 97 Don't Know
- 98 Refuse to Answer
- 99 Not Applicable

If Q365 is less than 12 or Q365 is equal to 99, then skip to instruction before Q367.

Q366. Please describe "Other" injected substance:

If Q365 is equal to 99, then skip to Q369.

Q367. **Any others?** (4th substance injected) *If none, click Not Applicable* (Choose one)

- 01 Alcohol
- 02 Cocaine
- 03 Cocaine mixed with Heroin
- 04 Hallucinogens
- 05 Methamphetamine
- 06 Ecstasy
- 07 Non-prescribed Rx sedatives
- 08 Non-prescribed Rx stimulants
- 09 Non-prescribed Rx pain killers
- 10 Heroin
- 11 Steroids or HGH
- 12 Other
- 97 Don't Know
- 98 Refuse to Answer
- 99 Not Applicable

If Q367 is less than 12 or Q367 is equal to 99, then skip to Q369.

Q368. Please describe "Other" injected substance:

- Q369. Have you ever...**used a needle that you knew or suspected that someone else had used before?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q370. Have you ever...**used someone else's rinse water, cooker, or cotton after they did?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q371. Have you ever...**let someone else use a needle after you used it?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q372. Have you ever...**allowed someone else to inject you with drugs?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q373. Have you ever had a blood transfusion or been a recipient of any blood products such as during surgery?
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q374. Have you ever been exposed to blood through a needle stick in an occupational or work setting such as while working in a lab or a hospital?
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable

HIV disclosure scale

READ: For the following questions, please USE CARD E to indicate how strongly you agree or disagree.

Q375. CARD E:

I have a responsibility to ask my sex partners about their HIV status

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q376. CARD E:

I have a responsibility to let my sex partners know my HIV status

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q377. CARD E:

Many men who think they are negative are actually HIV positive.

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q378. CARD E:

HIV is a community problem; we all should protect each other.

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

- Q379. CARD E:
My sex partners have a responsibility to ask me about my HIV status.
- 1 Strongly Disagree
 - 2 Somewhat Disagree
 - 3 Somewhat Agree
 - 4 Strongly Agree
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable

- Q380. CARD E:
My sex partners have a responsibility to let me know about their HIV status
- 2 Somewhat Disagree
 - 3 Somewhat Agree
 - 4 Strongly Agree
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable

Sex Questions

READ: The next questions are about having sex. When we refer to sex it includes vaginal, oral and anal sex with anyone.

OPTIONAL: Vaginal sex is when a man puts his penis into a woman's vagina. Oral sex is when one person puts his or her mouth on to the other person's penis or vagina. Anal sex is when a man puts his penis into another person's anus.

- Q381. Please answer the next questions using yes or no.
In the past 12 months, did you...**have sex while you or your sex partner was high on alcohol or drugs?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q382. In the past 12 months, did you...**have sex with someone who was an injection drug user?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable

Q383. In the past 12 months, did you...**trade sex to get drugs, gifts or money?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q384. In the past 12 months, did you...**use drugs, gifts, or money to purchase or get sex?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q385. In the past 12 months, did you...**have sex with a female?**

- 1 Yes
- 0 No **Skip to Q387**
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q387**

Q386. During the past 12 months, how many sexual partners did you have who were female?

- — —
- 997 Don't Know
- 998 Refuse to Answer
- 999 Not Applicable

Q387. **Q381.** How many male anal sex partners have you had in the past 3 months? [*Copy answer to bottom of cheat sheet*]

- — — —
- 9997 Don't Know
- 9998 Refuse to Answer
- 9999 Not Applicable

Q388. Have you had a primary partner at any time in the past 90 days? (By primary, we mean a relationship with a man where you feel committed to him above anyone else AND where you have had sex together.)

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q388 is equal to 0, then skip to instruction before Q400.

Q389. Is this now your primary partner?

- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q389 is equal to 1, then skip to Q391.

Q390. Were you in a monogamous relationship with that partner for more than 6 months prior to ending the relationship?

- 1 Yes **Skip to instruction before Q400**
- 0 No **Skip to instruction before Q400**
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to instruction before Q400**

Q391. How long has this been your "primary relationship"? [Note: Convert all time into months. If less than one month, round up.]

- — —
- 997 Don't Know
- 998 Refuse to Answer
- 999 Not Applicable

Q392. Have you had oral or anal sex with him at any time in the past 3 months? 1
Yes

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q393. Which of the following best describes how you and your primary partner deal with sex? [READ choices] (Choose one)

- 0 You don't have sex with other people, and you are not sure about your partner
- 1 You have sex with other people, and you are not sure about your partner
- 2 You both have sex with other people
- 3 Only you have sex with other people
- 4 Only your partner has sex with other people
- 5 Neither of you has sex with other people
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

READ: For the following questions, here are some commonly used terms. When we say "insertive anal sex" we mean when you put your penis in your partner's anus or you were a "top." When we say "receptive anal sex" we mean when your partner put his penis in your anus or you were a "bottom." When we ask about sex "without a condom" we mean penetration without a condom for even part of the time. [Clarify if respondent seems confused or unsure]

If Q392 is equal to 0, then skip to instruction before Q400.

READ: Please answer the next questions regarding your sexual activity in the past 3 months with your **CURRENT** primary partner only.

Q394. [Sex with primary partner]
In the past 3 months, how many **TIMES** did you receive oral sex from your partner?

- — —
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Q395. [Sex with primary partner]
In the past 3 months...how many **TIMES** did you give oral sex to your partner?

- — —
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Q396. [Sex with primary partner]
In the past 3 months...how many **TIMES** did you have insertive anal sex (you were a top)?

- — —
000 zero **Skip to Q398**
997 Don't Know
998 Refuse to Answer
999 Not Applicable **Skip to Q398**

Q397. [Sex with primary partner]
In the past 3 months...of the [**Response to Q396**] times you had insertive anal sex, how many **TIMES** was it without a condom (even part of the time)?

- — —
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Q398. [Sex with primary partner]
In the past 3 months...how many **TIMES** did you have receptive anal sex (you were a bottom)?

- — —
- | | | |
|-----|------------------|--|
| 000 | zero | Skip to instruction before Q400 |
| 997 | Don't Know | |
| 998 | Refuse to Answer | |
| 999 | Not Applicable | Skip to instruction before Q400 |

Q399. [Sex with primary partner]
In the past 3 months...of the [Response to Q398] times you had receptive anal sex, how many **TIMES** was it without a condom (even part of the time)?

- — —
- | | |
|-----|------------------|
| 997 | Don't Know |
| 998 | Refuse to Answer |
| 999 | Not Applicable |

Non-primary insertive oral sex (receiving)

READ: Please answer the next questions regarding your sexual activity in the past 3 months with all sex partners **NOT INCLUDING** your current primary partner, if you have one, **OR** a partner that you were in a monogamous relationship with for more than 6 months prior to the relationship ending.

Interviewer STOP: Ask the questions using the Sex Risk Worksheet, then enter the answers in the appropriate order.

Q400. **Q394.** [Sex with non-primary partner]
In the past 3 months, from how many different MEN did you receive oral sex?

- — —
- | | |
|-----|------------------|
| 997 | Don't Know |
| 998 | Refuse to Answer |
| 999 | Not Applicable |

Q401. **Q395.** [Sex with non-primary partner]
In the past 3 months...how many **TIMES** did you receive oral sex from a man?

- — —
- | | |
|-----|------------------|
| 997 | Don't Know |
| 998 | Refuse to Answer |
| 999 | Not Applicable |

Non-primary receptive oral sex (giving)

Q402. **Q396.** *[Sex with non-primary partner]*
In the past 3 months, to how many different **MEN** did you **give** oral sex? ___ ___ ___

- ___ ___ ___
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Q403. **Q397.** *[Sex with non-primary partner]*
In the past 3 months...how many **TIMES** did you **give** oral sex to a man?

- ___ ___ ___
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Non-primary insertive anal sex

Q404. **Q398.** *[Sex with non-primary partner]*
In the past 3 months, with how many different **MEN** did you have **insertive** anal sex (you were a top)?

- ___ ___ ___
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Q405. **Q399.** *[Sex with non-primary partner]*
...of the times you had **insertive** anal sex, how many **TIMES** was it with a man that you knew to be HIV **positive**?

- ___ ___ ___
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Q406. **Q400.** *[Sex with non-primary partner]*
...of the times you had **insertive** anal sex, how many **TIMES** was it with a man that you knew to be HIV **negative**?

- ___ ___ ___
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Q407. **Q401.** *[Sex with non-primary partner]*
...of the times you had **insertive** anal sex, how many **TIMES** was it with a man that you **did not know** his status?

— — —
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Not Applicable

Q408. **Q402.** *[Sex with non-primary partner]*
In the past 3 months...how many **TIMES in total** did you have **insertive** anal sex?
([Response to Q405] + [Response to Q406] + [Response to Q407])

— — —
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Q409. **Q403.** *[Sex with non-primary partner]*
Of the **[Response to Q404]** men that you had **insertive** anal sex with, how many different **MEN** was it **without** a condom (for even part of the time)?

— — —
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Q410. **Q404.** *[Sex with non-primary partner]*
...of the **[Response to Q405]** times that you had **insertive** anal sex with a man you knew to be HIV **positive**, how many **TIMES** was it **without** a condom?

— — —
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Q411. **Q405.** *[Sex with non-primary partner]*
...of the **[Response to Q406]** times that you had **insertive** anal sex with a man you knew to be HIV **negative**, how many **TIMES** was it **without** a condom?

— — —
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Q412. **Q406.** *[Sex with non-primary partner]*
...of the **[Response to Q407]** times that you had **insertive** anal sex with a man that you **did not know** his status, how many **TIMES** was it **without** a condom?

— — —
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Q413. **Q407.** *[Sex with non-primary partner]*
...of the **[Response to Q408]** times you had **insertive** anal sex, how many **TIMES in total** was it **without** a condom (for even part of the time)? ([Response to Q410] + [Response to Q411] + [Response to Q412])

— — —
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Non-primary receptive anal sex

Q414. **Q408.** *[Sex with non-primary partner]*
In the past 3 months, with how many different **MEN** did you have **receptive** anal sex (you were a bottom)?

— — —
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Q415. **Q409.** *[Sex with non-primary partner]*
...of the times you had **receptive** anal sex, how many **TIMES** was it with a man that you knew to be HIV **positive**?

— — —
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Q416. **Q410.** *[Sex with non-primary partner]*
...of the times you had **receptive** anal sex, how many **TIMES** was it with a man that you knew to be HIV **negative**?

— — —
997 Don't Know
998 Refuse to Answer
999 Not Applicable

Q417. **Q411.** *[Sex with non-primary partner]*
...of the times you had **receptive** anal sex, how many **TIMES** was it with a man that you **did not know** his status?

— — —
997 Don't Know
998 Refuse to Answer
999 Not Applicable

- Q418. **Q412.** *[Sex with non-primary partner]*
 In the past 3 months...how many **TIMES in total** did you have **receptive** anal sex?
 ([Response to Q415] + [Response to Q416] + [Response to Q417])
- — —
 997 Don't Know
 998 Refuse to Answer
 999 Not Applicable
- Q419. **Q413.** *[Sex with non-primary partner]*
 Of the **[Response to Q414]** men that you had **receptive** anal sex with, how many
 different **MEN** was it **without** a condom (for even part of the time)?
- — —
 997 Don't Know
 998 Refuse to Answer
 999 Not Applicable
- Q420. **Q414.** *[Sex with non-primary partner]*
 ...of the **[Response to Q415]** times that you had **receptive** anal sex with a man you
 knew to be HIV **positive**, how many **TIMES** was it **without** a condom?
- — —
 997 Don't Know
 998 Refuse to Answer
 999 Not Applicable
- Q421. **Q415.** *[Sex with non-primary partner i*
 ...of the **[Response to Q416]** times that you had **receptive** anal sex with a man you
 knew to be HIV **negative**, how many **TIMES** was it **without** a condom?
- — —
 997 Don't Know
 998 Refuse to Answer
 999 Not Applicable
- Q422. **Q416.** *[Sex with non-primary partner]*
 ...of the **[Response to Q417]** times that you had **receptive** anal sex with a man that you
did not know his status, how many **TIMES** was it **without** a condom?
- — —
 997 Don't Know
 998 Refuse to Answer
 999 Not Applicable
- Q423. **Q417.** *[Sex with non-primary partner]*
 ...of the **[Response to Q418]** times you had **receptive** anal sex, how many **TIMES in
 total** was it **without** a condom (for even part of the time)? ([Response to Q420] +
 [Response to Q421] + [Response to Q422])
- — —
 997 Don't Know
 998 Refuse to Answer
 999 Not Applicable

Q424. How often in the last 3 months were you "high" on alcohol or drugs when you were having anal sex with a man? Would you say...Almost all the time? More than half the time? About half the time? Less than half the time? Or Never? (Choose one)

- 0 Never
- 1 Less than half the time
- 2 About half the time
- 3 More than half the time
- 4 Almost all the time
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Sex Escape Questions

READ: Please USE CARD E for the next questions to say how strongly you agree or disagree with the following statements.

Q425. CARD E:

When I am high or drunk, I am more likely to want to have anal sex with a man.

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q426. CARD E:

When I am high or drunk, I am more likely to have sex with people I ordinarily wouldn't have sex with.

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q427. CARD E:
Being drunk or high makes me more comfortable sexually.

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q428. CARD E:
After getting drunk or high, I am more sexually responsive.

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q429. CARD E:
When I am drunk or high, I find it difficult to stay within my sexual limits. 1
Strongly Disagree

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q430. CARD E:
Once I have the chance to have sex, I can't say no even if we don't use condoms.

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q431. CARD E:

When I am drunk or high, I will do anything with almost any guy.

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

STIs

Q432. When was the last time, if ever, you had any of the following diseases or conditions?....**Syphilis?** (Choose one)

- 0 Never **Skip to Q434**
- 1 In the past 12 months
- 2 More than 12 months ago
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q434**

Q433. Did you receive effective treatment? (for Syphilis)

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q434. When was the last time, if ever, you had**any form of Gonorrhea?** (Choose one)

- 0 Never **Skip to Q436**
- 1 In the past 12 months
- 2 More than 12 months ago
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q436**

Q435. Did you receive effective treatment? (for Gonorrhea)

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q436. When was the last time, if ever, you had....**Chlamydia or non-specific urithritis?**
(Choose one)

- 0 Never **Skip to Q438**
- 1 In the past 12 months
- 2 More than 12 months ago
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q438**

Q437. Did you receive effective treatment? (for Chlamydia or urithritis)

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q438. When was the last time, if ever, you had....**Giardia or Shigella?** (Choose one)

- 0 Never **Skip to Q440**
- 1 In the past 12 months
- 2 More than 12 months ago
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q440**

Q439. Did you receive effective treatment? (for Giardia or Shigella)

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q440. When was the last time, if ever, you had....**LGV (Lymphogranuloma venereum)?**
(Choose one)

- 0 Never **Skip to Q442**
- 1 In the past 12 months
- 2 More than 12 months ago
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q442**

Q441. Did you receive effective treatment? (for LGV)

- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q442. When was the last time, if ever, you had....**Hepatitis A?** (Choose one)

- 0 Never **Skip to Q444**
- 1 In the past 12 months
- 2 More than 12 months ago
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q444**

Q443. Did you receive effective treatment? (for Hepatitis A)

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q444. When was the last time, if ever, you had....**Hepatitis B?** (Choose one)

- 0 Never **Skip to Q446**
- 1 In the past 12 months
- 2 More than 12 months ago
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q446**

Q445. What year were you first diagnosed with Hepatitis B?

— — — —

- 9997 Don't Know
- 9998 Refuse to Answer
- 9999 Not Applicable

Q446. When was the last time, if ever, you had....**Hepatitis C?** (Choose one)

- 0 Never **Skip to Q448**
- 1 In the past 12 months
- 2 More than 12 months ago
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q448**

Q447. What year were you first diagnosed with Hepatitis C?

— — — —

- 9997 Don't Know
- 9998 Refuse to Answer
- 9999 Not Applicable

Q448. When was the last time, if ever, you had....**Herpes sores?** (Choose one)

- 0 Never **Skip to Q450**
- 1 In the past 12 months
- 2 More than 12 months ago
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q450**

Q449. What year were you first diagnosed with Herpes?

— — — —

- 9997 Don't Know
- 9998 Refuse to Answer
- 9999 Not Applicable

Q450. When was the last time, if ever, you had....**HPV (genital or anal warts)?** (Choose one)

- 0 Never **Skip to Q452**
- 1 In the past 12 months
- 2 More than 12 months ago
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q452**

Q451. What year were you first diagnosed with HPV?

— — — —

- 9997 Don't Know
- 9998 Refuse to Answer
- 9999 Not Applicable

Q452. Prior to being in this study, have you ever had the test for HIV for which you've received the results ?

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q452 is equal to 0, then skip to Q467.

Q453. What year was your last HIV test for which you received the results?

— — — —

- 9997 Don't Know
- 9998 Refuse to Answer
- 9999 Not Applicable

Q454. What month was your last HIV test for which you received the results? (Choose one)

- 01 January
- 02 February
- 03 March
- 04 April
- 05 May
- 06 June
- 07 July
- 08 August
- 09 September
- 10 October
- 11 November
- 12 December
- 97 Don't Know
- 98 Refuse to Answer
- 99 Not Applicable

If Q389 is equal to 0, then skip to Q456.

Q455. Did you share the results of your previous HIV test with your current primary partner? *If no primary partner, click Not Applicable*

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q456. What was the result of your last previous HIV test? (Choose one)

- 0 Negative
- 1 Indeterminate
- 2 Positive
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q456 is less than 2, then skip to Q467.

Q457. What year did you first learn of your positive test results?

- — — — Don't Know
- 9998 Refuse to Answer
- 9999 Not Applicable

Q458. What month did you first learn of your positive test results? (Choose one)

- 01 January
- 02 February
- 03 March
- 04 April
- 05 May
- 06 June
- 07 July
- 08 August
- 09 September
- 10 October
- 11 November
- 12 December
- 97 Don't Know
- 98 Refuse to Answer
- 99 Not Applicable

Q459. Are you currently receiving medical care and/or counseling for your HIV infection?

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q460. Have you been prescribed medication to treat HIV infection?

- 1 Yes
- 0 No **Skip to Q467**
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q467**

Q461. How many HIV medication pills are you prescribed to take on a normal day?

- — —
- 997 Don't Know
- 998 Refuse to Answer
- 999 Not Applicable

Q462. How many HIV medication pills would you say you have missed from your prescriptions whether accidentally or purposefully in the past 30 days?

- — —
- 9997 Don't Know
- 9998 Refuse to Answer
- 9999 Not Applicable

Q463. Have you ever given away, traded or sold your HIV medication to another person?

- 1 Yes
- 0 No **Skip to Q467**
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q467**

Q464. What were the reasons why you traded your HIV medications?

Q465. Were there any other reasons why you traded your HIV medications? [Please record] *If none, click Not Applicable*

If missing **Skip to Q467**

Q466. Were there any other reasons why you traded your HIV medications? [Please record] *If none, click Not Applicable*

Q467. How many people close to you do you know who are HIV positive?

-
- 997 Don't Know
- 998 Refuse to Answer
- 999 Not Applicable

If Q389 is equal to 0, then skip to instruction before Q472.

Q468. Has your current primary partner ever been tested for HIV? *If no primary partner, click Not Applicable*

- 1 Yes
- 0 No **Skip to instruction before Q472**
- 7 Don't Know **Skip to instruction before Q472**
- 8 Refuse to Answer **Skip to instruction before Q472**
- 9 Not Applicable **Skip to instruction before Q472**

Q469. What year was his most recent test?

-
- 997 Don't Know
- 998 Refuse to Answer
- 999 Not Applicable

Q470. What month was his most recent test? (Choose one)

- 01 January
- 02 February
- 03 March
- 04 April
- 05 May
- 06 June
- 07 July
- 08 August
- 09 September
- 10 October
- 11 November
- 12 December
- 97 Don't Know
- 98 Refuse to Answer
- 99 Not Applicable

Q471. What was his most recent result? (Choose one)

- 0 Reported Negative
- 1 Reported Indeterminate
- 2 Reported Positive
- 3 Did not share results
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q456 is equal to 2, then skip to instruction before Q474.

Q472. Which of the following best describes how likely it is that you are infected with HIV today?
Would you say...No chance of it? Unlikely? About 50/50? or Very likely? (Choose one)

- 0 No Chance of it
- 1 Unlikely
- 2 About 50/50
- 3 Very Likely
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q473. Which of the following best describes how likely it is that you will have HIV infection at some time in the future? Would you say...No chance of it? Unlikely? About 50/50? or Very likely? (Choose one)

- 0 No Chance of it
- 1 Unlikely
- 2 About 50/50
- 3 Very Likely
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Sex Sensation Seeking Scale

READ: Please USE CARD F for the following questions to tell me how much like you each of the following statements are.

Q474. CARD F:
I like wild "uninhibited" sexual encounters.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q475. CARD F:
The physical sensations are the most important thing about having sex.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q476. CARD F:
I enjoy the sensation of sex without a condom.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q477. CARD F:
My sexual partners probably think I am a risk taker.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q478. CARD F:
When it comes to sex, physical attraction is more important to me than how well I know the person.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q479. CARD F:
I have said things that were not exactly true to get a person to have sex with me.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q480. CARD F:
I am interested in trying out new sexual experiences.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q481. CARD F:
I feel like exploring my sexuality.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q482. CARD F:
I like to have new and exciting sexual experiences and sensations.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Sexual Compulsivity Scale

Q483. CARD F:
My sexual appetite has gotten in the way of my relationships.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q484. CARD F:

My sexual thoughts and behaviors are causing problems in my life.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q485. CARD F:

My desires to have sex have disrupted my daily life.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q486. CARD F:

I sometimes fail to meet my commitments and responsibilities because of my sexual behaviors.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q487. CARD F:

I sometimes get so horny I could lose control.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q488. CARD F:
I feel that my sexual thoughts and feelings are stronger than I am.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q489. CARD F:
I have to struggle to control my sexual thoughts and behavior.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q490. CARD F:
I think about sex more than I would like to.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q491. CARD F:
It has been difficult for me to find sex partners who desire having sex as much as I want to.

- 1 Not at all like me
- 2 Somewhat not like me
- 3 Somewhat like me
- 4 Very much like me
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

PORNOGRAPHIC OR SEXUALLY EXPLICIT MATERIALS AND MASTURBATION QUESTIONS

Q492. How many days in the past 90 days have you watched pornographic films or viewed other sexually explicit materials?

- — — —
9997 Don't Know
9998 Refuse to Answer
9999 Not Applicable

Q493. How many times in the past 90 days did you masturbate?

- — — —
9997 Don't Know
9998 Refuse to Answer
9999 Not Applicable

Mental and Emotional Health

READ: The interview is now half completed. We are going to start a new line of questioning regarding mental health. This is a great spot to take a break or stop for just a minute to refocus. Would you like to take a break at this time?

Interviewer: Make sure client is focused and ready to continue.

READ: The next questions are about common nerve, mental or psychological problems that many people have. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities or they make you feel like you cannot go on. Please answer the following questions using yes or no.

[Use Significant Problems card]

Q494. During the past 12 months, have you had significant problems with... **headaches, faintness, dizziness, tingling, numbness, sweating or hot or cold spells?**

- 1 Yes
0 No
7 Don't Know
8 Refuse to Answer
9 Not Applicable

Q495. During the past 12 months, have you had significant problems with... **sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day?**

- 1 Yes
0 No
7 Don't Know
8 Refuse to Answer
9 Not Applicable

- Q496. During the past 12 months, have you had significant problems with... **pain or heavy feeling in your heart, chest, lower back, arms, legs or other muscles (not related to known physical health problems)?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q497. During the past 12 months, have you had significant problems with... **nausea, feeling weak, shortness of breath or lump in throat?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q498. During the past 12 months, have you had significant problems with... **feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q499. During the past 12 months, have you had significant problems with... **remembering, concentrating, making decisions, or having your mind go blank?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q500. During the past 12 months, have you had significant problems with... **feeling very shy, self-conscious or uneasy about what people thought or were saying about you?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable

Q501. During the past 12 months, have you had significant problems with... **thoughts that other people did not understand you or appreciate your situation?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q502. During the past 12 months, have you had significant problems with... **feeling easily annoyed, irritated, or having trouble controlling your temper?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q503. During the past 12 months, have you had significant problems with... **feeling tired, having no energy or like you could not get things done?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q504. During the past 12 months, have you had significant problems with... **losing interest or pleasure in work, school, friends, sex or other things you cared about?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q505. During the past 12 months, have you had significant problems with... **losing or gaining 10 or more pounds when you were not trying to?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q506. During the past 12 months, have you had significant problems with... **moving and talking much slower than usual?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q507. During the past 12 months, have you had significant problems with... **feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q508. During the past 12 months, have you had significant problems with... **having to repeat an action over and over or having thoughts that kept running over in your mind?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q509. During the past 12 months, have you had significant problems with... **trembling, having your heart race, or feeling so restless that you could not sit still?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q510. During the past 12 months, have you had significant problems with... **getting into a lot of arguments and feeling the urge to shout, throw things, beat, injure or harm someone?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q511. During the past 12 months, have you had significant problems with... **feeling very afraid of open spaces, leaving your home, having to travel or being in a crowd?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q512. During the past 12 months, have you had significant problems with... **avoiding the dark, being alone, elevators or other things because they frightened you?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q513. During the past 12 months, have you had significant problems with... **thoughts that other people were taking advantage of you, not giving you enough credit or causing you problems?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q514. During the past 12 months, have you had significant problems with... **thoughts that someone was watching you, following you or out to get you?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q515. During the past 12 months, have you had significant problems with... **seeing or hearing things that no one else could see or hear, or feeling that someone else could read or control your thoughts?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q516. During the past 12 months, have you had significant problems with... **thoughts that you should be punished for thinking about sex or other things too much?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q517. During the past 12 months, have you had significant problems with... **having a lot of tension or muscle aches because you were worried?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q518. During the past 12 months, have you had significant problems with... **being unable or finding it difficult to control your worries?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

READ: The next questions are about the different kinds of nerve, mental, or psychological problems just mentioned.

Q519. **Using CARD A:** When was the last time (if ever) you had any significant nerve, mental or psychological problems (including those things we just talked about)? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q519 is less than 3, then skip to Q527.

Q520. Please answer the next questions using days:

During the past 90 days, on how many days were you bothered by any nerve, mental, or psychological problems?

- — Don't Know
- 97 Refuse to Answer
- 99 Not Applicable

Q521. During the past 90 days, on how many days did these problems keep you from meeting your responsibilities at work, school or home, or make you feel like you cannot go on?

- — Don't Know
- 97 Refuse to Answer
- 99 Not Applicable

Q522. The next questions are about whether and how these problems have interacted with your drug and alcohol use.

Do some or all of these psychological problems...**go away when you use drugs or alcohol?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q523. Do some or all of these psychological problems...**get worse when or after you have been using drugs or alcohol?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q524. Do some or all of these psychological problems...**only happen when or after you have been using drugs or alcohol?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q525. Do some or all of these psychological problems...**happen even when you have not been using drugs or alcohol?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q526. How old were you when you first started having these kinds of psychological problems?

- — Don't Know
- 97 Refuse to Answer
- 99 Not Applicable

Q527. Please **USE CARD A**: When was the last time (if ever) your life was disturbed by memories of things from the past that you did, saw or had happen to you? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q527 is less than 2, then skip to instruction before Q542.

Q528. Please answer the next questions using yes or no: During the past 12 months, have the following situations happened to you? **When something reminded you of the past, you became very distressed and upset?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q529. During the past 12 months ... **You had nightmares about things in your past that really happened?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q530. During the past 12 months ... **When you thought of things you have done, you wished you were dead?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q531. During the past 12 months ... **It seemed as if you have no feelings?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q532. During the past 12 months ... **Your dreams at night were so real that you woke up in a cold sweat and forced yourself to stay awake?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q533. During the past 12 months ... **You felt like you could not go on?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q534. During the past 12 months ... **You were frightened by your urges?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q535. During the past 12 months ... **Sometimes you used alcohol or other drugs to help yourself sleep or forget about things that happened in the past?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q536. During the past 12 months ... **You lost your cool and exploded over minor, everyday things?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q537. During the past 12 months ... **You were afraid to go to sleep at night?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q538. During the past 12 months ... **You had a hard time expressing your feelings, even to the people you cared about?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q539. During the past 12 months ... **You felt guilty about things that happened because you felt like you should have done something to prevent them?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q540. During the past 12 months, have you had any of the previous problems for three or more months?

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q541. During the past 90 days, on how many days have you been disturbed by memories of things from the past that you did , saw, or had happen to you?

- —
- 97 Don't Know
- 98 Refuse to Answer
- 99 Not Applicable

READ: The next questions are about treatment for mental, emotional, behavioral, or psychological problems. This includes taking a medication like Prozac, Paxil, Zoloft or any other antidepressants that a doctor may have given you for a mental health condition such as depression. Do not count treatment that was only for substance use or physical health problems.

Q542. Has a doctor, nurse or counselor ever told you that you have a mental, emotional or psychological problem (like depression or anxiety) or told you the name of a particular condition you have or had?

- 1 Yes
- 0 No **Skip to Q562**
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q562**

READ: If yes, please describe. [Interviewer: Mark yes to all of the following conditions that the participant mentions]

- Q543. Ever told that you have or had...**Alcohol or drug dependence?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q544. Ever told that you have or had...**Attention-deficit/hyperactivity disorder (ADHD)?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q545. Ever told that you have or had...**Antisocial personality disorder?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q546. Ever told that you have or had...**Anxiety or phobia disorder?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q547. Ever told that you have or had...**Bi-polar disorder or manic depression?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q548. Ever told that you have or had...**Borderline personality?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable

- Q549. Ever told that you have or had...**Conduct disorder?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q550. Ever told that you have or had...**Depression?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q551. Ever told that you have or had...**Mental retardation, developmental or other communication disorder?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q552. Ever told that you have or had...**Oppositional defiant disorder?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q553. Ever told that you have or had...**Pathological gambling?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q554. Ever told that you have or had...**Post or acute traumatic stress disorder (PTSD)?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable

Q555. Ever told that you have or had...**Somatoform, pain, sleep, eating or body disorder?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q556. Ever told that you have or had...**Other cognitive disorder (like delirium, dementia, amnesia)?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q557. Ever told that you have or had...**Other mental breakdown, nerves or stress?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q558. Ever told that you have or had...**Other personality disorder (like avoidant, dependent, histrionic, narcissistic, obsessive-compulsive, paranoid, schizoid or schizotypal)?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q559. Ever told that you have or had...**Schizophrenia or psychotic disorder?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q560. Ever told that you have or had...**Any other mental, emotional or psychological problem not mentioned?**

- 1 Yes
- 0 No **Skip to Q562**
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q562**

Q561. Please describe (mental condition not previously mentioned)

Q562. How many times in your life have you...**been treated in an emergency room for mental, emotional, behavioral or psychological problems?**

- — —
- 997 Don't Know
 - 998 Refuse to Answer
 - 999 Not Applicable

Q563. How many times in your life have you...**been admitted overnight to a hospital for mental, emotional, behavioral or psychological problems?**

- — —
- 997 Don't Know
 - 998 Refuse to Answer
 - 999 Not Applicable

Q564. Are you currently taking prescribed medication for mental, emotional, behavioral or psychological problems?

- 1 Yes
- 0 No **Skip to Q566**
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q566**

Q565. Please describe (medication taken for psychological problems)

Q566. **Using Card C:** How soon, if at all, do you need help or more help with your current mental, emotional or psychological problems? (Choose one)

- 0 Do not need any help
- 1 Getting the help I need already
- 2 More than 3 months from now
- 3 In the next 3 months
- 4 Right away
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

UCLA LONLINESS SCALE

READ: The next few questions are about how you feel about your relationships with other people. Please USE CARD G to tell me how often you feel this way for each item.

Q567. CARD G:

How often do you feel that you lack companionship?

- 1 Never
- 2 Rarely
- 3 Sometimes
- 4 Always
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q568. CARD G:

How often do you feel that you have a lot in common with the people around you?

- 1 Never
- 2 Rarely
- 3 Sometimes
- 4 Always
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q569. CARD G:

How often do you feel close to people?

- 1 Never
- 2 Rarely
- 3 Sometimes
- 4 Always
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q570. CARD G:

How often do you feel left out?

- 1 Never
- 2 Rarely
- 3 Sometimes
- 4 Always
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q571. CARD G:
How often do you feel that your relationships with others are not meaningful?

- 1 Never
- 2 Rarely
- 3 Sometimes
- 4 Always
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q572. CARD G:
How often do you feel that no one really knows you well?

- 1 Never
- 2 Rarely
- 3 Sometimes
- 4 Always
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q573. CARD G:
How often do you feel isolated from others?

- 1 Never
- 2 Rarely
- 3 Sometimes
- 4 Always
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q574. CARD G:
How often do you feel that there are people who really understand you?

- 1 Never
- 2 Rarely
- 3 Sometimes
- 4 Always
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

- Q575. CARD G:
How often do you feel that people are around you but not with you?
- 1 Never
 - 2 Rarely
 - 3 Sometimes
 - 4 Always
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable

- Q576. CARD G:
How often do you feel that there are people you can talk to?
- 1 Never
 - 2 Rarely
 - 3 Sometimes
 - 4 Always
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable

- Q577. CARD G:
How often do you feel that there are people you can turn to?
- 1 Never
 - 2 Rarely
 - 3 Sometimes
 - 4 Always
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable

Personal Mastery Scale

READ: Please USE CARD E for the next several questions to indicate how strongly you agree or disagree with these statements about yourself.

- Q578. CARD E:
There is really no way I can solve some of the problems I have.
- 1 Strongly Disagree
 - 2 Somewhat Disagree
 - 3 Somewhat Agree
 - 4 Strongly Agree
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable

Q579. CARD E:
Sometimes I feel that I am being pushed around in my life.

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q580. CARD E:
I have little control over the things that happen to me.

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q581. CARD E:
I can do just about anything I really set my mind to.

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Applicable

Q582. CARD E:
I often feel helpless in dealing with problems of my life.

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q583. CARD E:
What happens to me in the future mostly depends on me.

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q584. CARD E:
There is little I can do to change many of the important things in my life.

- 1 Strongly Disagree
- 2 Somewhat Disagree
- 3 Somewhat Agree
- 4 Strongly Agree
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Coping Self Efficacy Scale

READ: Please USE CARD H for the next set of questions.

When things aren't going well for you, or when you're having problems, how confident or certain are you that you can do the following?

Q585. CARD H:
How confident or certain are you that you can...**Break an upsetting problem down into smaller parts?**

- 01 1-Cannot do at all
- 02 2
- 03 3
- 04 4
- 05 5-Moderately certain can do
- 06 6
- 07 7
- 08 8
- 09 9
- 10 10-Certain can do
- 97 Don't Know
- 98 Refuse to Answer
- 99 Not Applicable

Q586. CARD H:

How confident or certain are you that you can...**Sort out what can be changed and what cannot be changed?**

- | | |
|----|-----------------------------|
| 01 | 1-Cannot do at all |
| 02 | 2 |
| 03 | 3 |
| 04 | 4 |
| 05 | 5-Moderately certain can do |
| 06 | 6 |
| 07 | 7 |
| 08 | 8 |
| 09 | 9 |
| 10 | 10-Certain can do |
| 97 | Don't Know |
| 98 | Refuse to Answer |
| 99 | Not Applicable |

Q587. CARD H:

How confident or certain are you that you can...**Make a plan of action and follow it when confronted with a problem?**

- | | |
|----|-----------------------------|
| 01 | 1-Cannot do at all |
| 02 | 2 |
| 03 | 3 |
| 04 | 4 |
| 05 | 5-Moderately certain can do |
| 06 | 6 |
| 07 | 7 |
| 08 | 8 |
| 09 | 9 |
| 10 | 10-Certain can do |
| 97 | Don't Know |
| 98 | Refuse to Answer |
| 99 | Not Applicable |

Q588. CARD H:

How confident or certain are you that you can...**Leave options open when things get stressful?**

- | | |
|----|-----------------------------|
| 01 | 1-Cannot do at all |
| 02 | 2 |
| 03 | 3 |
| 04 | 4 |
| 05 | 5-Moderately certain can do |
| 06 | 6 |
| 07 | 7 |
| 08 | 8 |
| 09 | 9 |
| 10 | 10-Certain can do |
| 97 | Don't Know |
| 98 | Refuse to Answer |
| 99 | Not Applicable |

Q589. CARD H:

How confident or certain are you that you can...**Think about one part of the problem at a time?**

- | | |
|----|-----------------------------|
| 01 | 1-Cannot do at all |
| 02 | 2 |
| 03 | 3 |
| 04 | 4 |
| 05 | 5-Moderately certain can do |
| 06 | 6 |
| 07 | 7 |
| 08 | 8 |
| 09 | 9 |
| 10 | 10-Certain can do |
| 97 | Don't Know |
| 98 | Refuse to Answer |
| 99 | Not Applicable |

Q590. CARD H:

How confident or certain are you that you can...**Find solutions to your most difficult problems?**

- | | |
|----|-----------------------------|
| 01 | 1-Cannot do at all |
| 02 | 2 |
| 03 | 3 |
| 04 | 4 |
| 05 | 5-Moderately certain can do |
| 06 | 6 |
| 07 | 7 |
| 08 | 8 |
| 09 | 9 |
| 10 | 10-Certain can do |
| 97 | Don't Know |
| 98 | Refuse to Answer |
| 99 | Not Applicable |

Q591. CARD H:

How confident or certain are you that you can...**Make unpleasant thoughts go away?**

- | | |
|----|-----------------------------|
| 01 | 1-Cannot do at all |
| 02 | 2 |
| 03 | 3 |
| 04 | 4 |
| 05 | 5-Moderately certain can do |
| 06 | 6 |
| 07 | 7 |
| 08 | 8 |
| 09 | 9 |
| 10 | 10-Certain can do |
| 97 | Don't Know |
| 98 | Refuse to Answer |
| 99 | Not Applicable |

Q592. CARD H:

How confident or certain are you that you can...**Take your mind off unpleasant thoughts?**

- | | |
|----|-----------------------------|
| 01 | 1-Cannot do at all |
| 02 | 2 |
| 03 | 3 |
| 04 | 4 |
| 05 | 5-Moderately certain can do |
| 06 | 6 |
| 07 | 7 |
| 08 | 8 |
| 09 | 9 |
| 10 | 10-Certain can do |
| 97 | Don't Know |
| 98 | Refuse to Answer |
| 99 | Not Applicable |

Q593. CARD H:

How confident or certain are you that you can...**Stop yourself from being upset by unpleasant thoughts?**

- | | |
|----|-----------------------------|
| 01 | 1-Cannot do at all |
| 02 | 2 |
| 03 | 3 |
| 04 | 4 |
| 05 | 5-Moderately certain can do |
| 06 | 6 |
| 07 | 7 |
| 08 | 8 |
| 09 | 9 |
| 10 | 10-Certain can do |
| 97 | Don't Know |
| 98 | Refuse to Answer |
| 99 | Not Applicable |

Q594. CARD H:

How confident or certain are you that you can...**Keep from feeling sad?**

- | | |
|----|-----------------------------|
| 01 | 1-Cannot do at all |
| 02 | 2 |
| 03 | 3 |
| 04 | 4 |
| 05 | 5-Moderately certain can do |
| 06 | 6 |
| 07 | 7 |
| 08 | 8 |
| 09 | 9 |
| 10 | 10-Certain can do |
| 97 | Don't Know |
| 98 | Refuse to Answer |
| 99 | Not Applicable |

Q595. CARD H:

How confident or certain are you that you can...**Get friends to help you with the things you need?**

- | | |
|----|-----------------------------|
| 01 | 1-Cannot do at all |
| 02 | 2 |
| 03 | 3 |
| 04 | 4 |
| 05 | 5-Moderately certain can do |
| 06 | 6 |
| 07 | 7 |
| 08 | 8 |
| 09 | 9 |
| 10 | 10-Certain can do |
| 97 | Don't Know |
| 98 | Refuse to Answer |
| 99 | Not Applicable |

Q596. CARD H:

How confident or certain are you that you can...**Get emotional support from friends and family?**

- | | |
|----|-----------------------------|
| 01 | 1-Cannot do at all |
| 02 | 2 |
| 03 | 3 |
| 04 | 4 |
| 05 | 5-Moderately certain can do |
| 06 | 6 |
| 07 | 7 |
| 08 | 8 |
| 09 | 9 |
| 10 | 10-Certain can do |
| 97 | Don't Know |
| 98 | Refuse to Answer |
| 99 | Not Applicable |

Q597. CARD H:

How confident or certain are you that you can...**Make new friends?**

- | | |
|----|-----------------------------|
| 01 | 1-Cannot do at all |
| 02 | 2 |
| 03 | 3 |
| 04 | 4 |
| 05 | 5-Moderately certain can do |
| 06 | 6 |
| 07 | 7 |
| 08 | 8 |
| 09 | 9 |
| 10 | 10-Certain can do |
| 97 | Don't Know |
| 98 | Refuse to Answer |
| 99 | Not Applicable |

Experience of Shame Scale

READ: Please USE CARD D for the next set of questions.

Everybody at times can feel embarrassed, self-conscious or ashamed. These questions are about such feelings if they have have occurred at any time in the past year.

Q598. CARD D:

In the past year...**Have you felt ashamed of the sort of person you are?**

- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q599. CARD D:

In the past year...**Have you worried about what other people think of the sort of person you are?**

- 1 Not at all
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q600. CARD D:

In the past year...**Have you tried to conceal from others the sort of person you are?**

- 1 Not at all
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q601. CARD D:

In the past year...**Have you felt ashamed of your ability to do things?**

- 1 Not at all
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q602. CARD D:
In the past year...**Have you worried about what other people think of your ability to do things?**

- 1 Not at all
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q603. CARD D:
In the past year...**Have you avoided people because of your inability to do things?**

- 1 Not at all
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q604. CARD D:
In the past year...**Do you feel ashamed when you do something wrong?**

- 1 Not at all
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q605. CARD D:
In the past year...**Have you worried about what other people think of you when you do something wrong?**

- 1 Not at all
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q606. CARD D:

In the past year...**Have you tried to cover up or conceal things you felt ashamed of having done?**

1 Not at all

2 A little

3 Moderately

4 A lot / Very much

7 Don't Know

8 Refuse to Answer

9 Not Applicable

Q607. CARD D:

In the past year...**Have you felt ashamed when you failed at something which was important to you?**

1 Not at all

2 A little

3 Moderately

4 A lot / Very much

7 Don't Know

8 Refuse to Answer

9 Not Applicable

Q608. CARD D:

In the past year...**Have you worried about what other people think of you when you fail?**

1 Not at all

2 A little

3 Moderately

4 A lot / Very much

7 Don't Know

8 Refuse to Answer

9 Not Applicable

Q609. CARD D:

In the past year...**Have you avoided people who have seen you fail?**

1 Not at all

2 A little

3 Moderately

4 A lot / Very much

7 Don't Know

8 Refuse to Answer

9 Not Applicable

Q610. CARD D:

In the past year...**Have you felt ashamed of your body or any part of it?**

1 Not at all

- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q611. CARD D:

In the past year...**Have you worried about what other people think of your appearance?**

- 1 Not at all
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q612. CARD D:

In the past year...**Have you avoided looking at yourself in the mirror?**

- 1 Not at all
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q613. CARD D:

In the past year...**Have you wanted to hide or conceal your body or any part of it?**

- 1 Not at 1
- 2 A little
- 3 Moderately
- 4 A lot / Very much
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Environment and Living Situation

READ: The next set of questions are about places where you spend most of your time and the people you spend your time with. First we would like to ask you some questions about where you live.

Q614. **Using CARD A:** When was the last time (if ever) that you considered yourself to be homeless OR had to stay with someone else in order to avoid being homeless? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q615. Can you continue to stay where you are now?

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q616. During the past 3 months, have you lived with anyone other than yourself?

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q616 is equal to 0, then skip to Q623.

Q617. Who have you lived with? [Allow client to respond. Mark each of the following that apply]

Have you lived with...**A spouse or significant other?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q618. Have you lived with...**Parents?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q619. Have you lived with...**Other relatives?**

- 1
- 0
- 7
- 8
- 9

Q620. Have you lived with...**Other adult roommates?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q621. Have you lived with...**Anyone else we didn't mention?**

- 1 Yes
- 0 No **Skip to Q623**
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable **Skip to Q623**

Q622. Please describe **Other** living arrangement:

Q623. During the past 3 months, how many people would you say you spend most of your free time with or hang out with?

-
- 997 Don't Know
- 998 Refuse to Answer
- 999 Not Applicable

If Q623 is equal to 0, then skip to instruction before Q630.

- Q624. **USING CARD I:** Of the people you have regularly socialized with or hung out with, would you say that none, a few, some, most or all of them...**were employed or in school or training full-time?** (Choose one)
- 0 All
 - 1 Most
 - 2 Some
 - 3 A few
 - 4 None
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q625. Of the people you have regularly socialized with or hung out with, how many would you say...**were involved in illegal activity other than drug use?** (Choose one)
- 0 None
 - 1 A few
 - 2 Some
 - 3 Most
 - 4 All
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q626. Of the people you have regularly socialized with or hung out with, how many would you say...**weekly got drunk or had 5 or more drinks in a day?** (Choose one)
- 0 None
 - 1 A few
 - 2 Some
 - 3 Most
 - 4 All
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q627. Of the people you have regularly socialized with or hung out with, how many would you say...**used any drugs during the past 90 days?** (Choose one)
- 0 None
 - 1 A few
 - 2 Some
 - 3 Most
 - 4 All
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable

Q628. Of the people you have regularly socialized with or hung out with, how many would you say...**shout, argue, and fight most weeks?** (Choose one)

- 0 None
- 1 A few
- 2 Some
- 3 Most
- 4 All
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q629. Of the people you have regularly socialized with or hung out with, how many would you say...**have ever been in drug or alcohol treatment?** (Choose one)

- 0 All
- 1 Most
- 2 Some
- 3 A few
- 4 None
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Administer the Access to Social Capital worksheet:

READ: The following questions ask about people in your environment who provide you with help or support. Each question has two parts.

1). For each question, list the individuals (using their initials) of all the people you know, excluding yourself, whom you can count on for help or support for the item. In some cases, there may be no one, in other cases many. Please feel free to leave boxes empty and do not list more than 9 individuals for each item.

2). For the second part of each question, please circle how satisfied you are with the overall support available to you for each item.

Collect Access to Social Capital worksheet. Make sure that all of the questions are completely answered before returning to the interview. Enter the answers from worksheet after the completion of the interview.

READ: No matter how hard people try, they sometimes have conflicts or disagreements. Next is a list of various ways people try to settle their differences. The first set of questions is about what you may have done.

Q630. **USING CARD A:** When was the last time (if ever) that during an argument with someone else, you swore, cursed, threatened them, threw something, or pushed or hit them in any way? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q630 is less than 2, then skip to instruction before Q641.

Q631. Please answer the next questions using yes or no.
During the past 12 months, did you have a disagreement in which you did the following things?...**Discussed it calmly and settled the disagreement rather than argue?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q632. During the past 12 months, did you have a disagreement in which you ...**Left the room or area rather than argue?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q633. During the past 12 months, did you have a disagreement in which you ...**Insulted, swore or cursed at someone?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q634. During the past 12 months, did you have a disagreement in which you ...**Threatened to hit or throw something at another person?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q635. During the past 12 months, did you have a disagreement in which you ...**Pushed, grabbed, kicked, bit, or hit someone?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q636. During the past 12 months, did you have a disagreement in which you ...**Hit or tried to hit anyone with an object?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q637. During the past 12 months, did you have a disagreement in which you ...**Beat up someone?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q638. During the past 12 months, did you have a disagreement in which you ...**Threatened anyone with a knife or a gun?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q639. During the past 12 months, did you have a disagreement in which you ...**Actually used a knife or a gun on another person?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q640. During the past 90 days, on how many days did you have an argument with someone else in which you swore, cursed, threatened them, threw something, or pushed or hit them in any way?

- — Don't Know
- 97 Refuse to Answer
- 99 Not Applicable

READ: The next questions are about things that other people may have done to you. Please continue to answer the next questions using yes or no.

Q641. Has anyone ever done any of the following things to you?...**Attacked you with a gun, knife, stick, bottle or other weapon?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q642. Has anyone ever done any of the following things to you?...**Hurt you by striking or beating you to the point where you had bruises, cuts, broken bones or otherwise physically abused you?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q643. Has anyone ever done any of the following things to you?...**Pressured or forced you to participate in sexual acts against your will, including your regular sexual partner, a family member or friend?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q644. Has anyone ever done any of the following things to you?...**Abused you emotionally, that is did or said things to make you feel very bad about yourself or your life?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q645. [Interviewer: Were any of the previous abuse criteria selected?]

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q645 is equal to 0, then skip to Q656.

Q646. About how old were you the first time any of these things happened to you?

- —
- 97 Don't Know
- 98 Refuse to Answer
- 99 Not Applicable

Q647. [Interviewer: Was the age at first abuse under age 18?]

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q648. Did any of the previous things happen...**several times or over a long period of time?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q649. Did any of the previous things happen...**with more than one person involved in hurting you?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q650. Did any of the previous things happen...**where one or more of the people involved was a family member, a close family friend, partner, professional or someone else you had trusted?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q651. Did any of the previous things happen...**where you were afraid for your life or that you might be seriously injured?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q652. Did any of the previous things happen...**and result in oral, vaginal, or anal sex?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q653. Did any of the previous things happen...**and people you told did not believe or help you?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q654. **USING CARD A:** When was the last time that you were attacked with a weapon, beaten, sexually or emotionally abused? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q654 is less than 3, then skip to Q656.

Q655. During the past 90 days, on how many days were you attacked with a weapon, beaten, sexually abused or emotionally abused?

- — Don't Know
- 97 Refuse to Answer
- 99 Not Applicable

Q656. Are you currently worried that someone might...**attack you with a gun, knife, stick, bottle or other weapon?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q657. Are you currently worried that someone might...**hurt you by striking or beating or otherwise physically abuse you?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q658. Are you currently worried that someone might...**pressure or force you to participate in sexual acts against your will?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q659. Are you currently worried that someone might...**abuse you emotionally?** 1
Yes

- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q660. Please continue using yes or no for the following questions.
Are you satisfied with...**where you are living?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q661. Are you satisfied with...**your family relationships?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q662. Are you satisfied with...**your friendships?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q663. Are you satisfied with...**your sexual and/or intimate relationships?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q664. Are you satisfied with...**your school and/or work situations?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q665. Are you satisfied with...**how you spend your free time?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q666. Are you satisfied with...**the extent to which you are coping with or getting help with your problems?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q667. **Using Card C:** How soon, if at all, do you need help or more help with your current environment or living situation? (Choose one)

- 0 Do not need any help
- 1 Getting the help I need already
- 2 More than 3 months from now
- 3 In the next 3 months
- 4 Right away
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Legal

READ: This section deals with the legal system and behaviors that may get you into trouble or be against the law. Remember that your answers here are strictly confidential. Please answer the next several questions using number of days.

Q668. During the past 90 days, how many days were you involved in any activities you thought might get you into trouble or be against the law (besides traffic violations and drug use)?

- —
- 97 Don't Know
 - 98 Refuse to Answer
 - 99 Not Applicable

If Q668 is equal to 0, then skip to Q672.

Q669. On how many of these days were you involved in these activities (you thought might get you into trouble or be against the law)...**in order to support yourself financially?**

- —
- 97 Don't Know
 - 98 Refuse to Answer
 - 99 Not Applicable

Q670. On how many of these days were you involved in these activities (you thought might get you into trouble or be against the law)...**in order to obtain drugs or alcohol?**

- —
- 97 Don't Know
 - 98 Refuse to Answer
 - 99 Not Applicable

Q671. On how many of these days were you involved in these activities (you thought might get you into trouble or be against the law)...**while you were high or drunk?**

- —
- 97 Don't Know
 - 98 Refuse to Answer
 - 99 Not Applicable

Q672. In your lifetime, about how many times have you been arrested, charged with a crime and booked? (Please include all the times this happened, even if you were then released or the charges were dropped.)

- — —
- 997 Don't Know
 - 998 Refuse to Answer
 - 999 Not Applicable

If Q672 is equal to 0, then skip to instruction before Q698.

READ: For which of the following offenses have you ever been arrested and charged with?

[If less than 5 arrests were reported, allow client to circle the responses USING CARD J, then mark 'yes' to each of the items mentioned. If 5 or more arrests were reported, read and mark each item.]

Q673. Have you ever been arrested and charged with.....**Vandalism or property destruction?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q674. Have you ever been arrested and charged with...**Receiving, possessing or selling stolen goods?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q675. Have you ever been arrested and charged with...**Passing bad checks, forgery or fraud?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q676. Have you ever been arrested and charged with...**Shoplifting?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q677. Have you ever been arrested and charged with...**Larceny or theft?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q678. Have you ever been arrested and charged with...**Burglary or breaking and entering?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q679. Have you ever been arrested and charged with...**Motor vehicle theft?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q680. Have you ever been arrested and charged with...**Robbery?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q681. Have you ever been arrested and charged with...**Simple assault or battery?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q682. Have you ever been arrested and charged with...**Aggravated assault?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q683. Have you ever been arrested and charged with...**Forcible Rape?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q684. Have you ever been arrested and charged with...**Murder, homicide, or non-negligent manslaughter?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q685. Have you ever been arrested and charged with...**Arson?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q686. Have you ever been arrested and charged with...**Driving under the influence (DUI)?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q687. Have you ever been arrested and charged with...**Drunkness or other liquor law violations?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q688. Have you ever been arrested and charged with...**Possession of drugs or drug paraphernalia?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q689. Have you ever been arrested and charged with...**Dealing, distribution or sale of drugs?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q690. Have you ever been arrested and charged with...**Prostitution, pimping or commercialized sex?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q691. Have you ever been arrested and charged with...**Probation or parole violations?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q692. Have you ever been arrested and charged with...**Driving offenses (including driving without a license or with a suspended license)?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q693. Have you ever been arrested and charged with...**Illegal gambling?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q694. Have you ever been arrested and charged with...**Any other offenses including public nudity, sex or lewdness, gang involvement or activity, graffiti, disturbing the peace, disorderly conduct or domestic violence?**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

If Q694 is equal to 0, then skip to Q696.

Q695. Please describe (other offenses):

Q696. How many times were you convicted or adjudicated?

- 997 Don't Know
- 998 Refuse to Answer
- 999 Not Applicable

Q697. **USING CARD A:** When was the last time that you were arrested, charged with a crime and booked? (Choose one)

- 0 Never
- 1 More than 12 months ago
- 2 Between 4 to 12 months ago
- 3 Between 1 to 3 months ago
- 4 Between 1 to 4 weeks ago
- 5 Within the past 7 days
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

READ: The next questions are about school, work, and money.

Q698. What is the last grade or year that you completed in school? [Note: 12 for HS diploma or GED, 14 for AA, 16 for BA/BS and 17 or higher for grad school or more than 4 years in college]

- —
- 97 Don't Know
 - 98 Refuse to Answer
 - 99 Not Applicable

Q699. **Using CARD K:** Which one of the following statements best describes your present work or school situation? [If more than one applies, select the one engaged in most often] (Choose one)

- 01 Working full-time, 35+ hours a week
- 02 Working part-time, <35 hours a week
- 03 Working and going to school
- 04 Unemployed or laid off and looking for work
- 05 Unemployed or laid off and NOT looking for work
- 06 In school or training only
- 07 Too disabled for work
- 08 Some other work situation
- 97 Don't Know
- 98 Refuse to Answer
- 99 Not Applicable

If Q699 is less than 7, then skip to Q701.

Q700. Please describe your situation: (Either disability or Other work situation)

Q701. How long have you been in this situation? [YEARS: If answer is a year or more, enter value. If less than a year, enter zero and continue.]

- —
97 Don't Know
98 Refuse to Answer
99 Not Applicable

If Q701 is greater than 0, then skip to Q705.

Q702. How many **months** have you been in this situation? [If less than a month, enter zero and continue]

- —
97 Don't Know
98 Refuse to Answer
99 Not Applicable

If Q702 is greater than 0, then skip to Q705.

Q703. How many **weeks** have you been in this situation? [If less than a week, enter zero and continue]

- —
97 Don't Know
98 Refuse to Answer
99 Not Applicable

If Q703 is greater than 0, then skip to Q705.

Q704. How many **days** you been in this situation?

- —
97 Don't Know
98 Refuse to Answer
99 Not Applicable

Q705. In a typical week in the past 3 months, how many hours per week, if any, did you work at a paid job or business?

- —
97 Don't Know
98 Refuse to Answer
99 Not Applicable

Q706. Please answer the next questions using yes or no.
During the past 12 months, have you...**run out of money for food or transportation?**

- 1 Yes
0 No
7 Don't Know
8 Refuse to Answer
9 Not Applicable

- Q707. During the past 12 months, have you...**run out of money for housing?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q708. During the past 12 months, have you...**been 120 days or more behind on a bill?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q709. During the past 12 months, have you...**had to borrow money from a family member or close friend for food, rent or utilities?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q710. During the past 12 months, have you...**had to use a food bank, soup kitchen or emergency shelter?**
- 1 Yes
 - 0 No
 - 7 Don't Know
 - 8 Refuse to Answer
 - 9 Not Applicable
- Q711. During the past 90 days, on how many days have you had any money problems including not having enough for food or housing?
- — Don't Know
 - 97 Refuse to Answer
 - 99 Not Applicable

Q712. **USING CARD L:** What is your primary source of income? (Choose one)

- 00 None
- 01 Wages or salary from legitimate job or business
- 02 SSI or SSDI (Supplemental Social Security)
- 03 Other public assistance (state or local welfare)
- 04 Interests, dividends, rent, royalties, or inheritance
- 05 Income from partner or spouse, family or friends
- 06 Hustling, dealing or other illegal activities
- 07 Unemployment compensation
- 08 Some other source
- 97 Don't Know
- 98 Refuse to Answer
- 99 Not Applicable

If Q712 is less than 8, then skip to Q714.

Q713. Please describe (Other source of income)

Q714. **USING CARD M:** Considering all sources of your income, how much money did you make altogether in the last 12 months? Please answer with the code letter from the card. (Choose one)

- 01 \$0 - \$9,999
- 02 \$10,000 - \$19,999
- 03 \$20,000 - \$29,999
- 04 \$30,000 - \$39,999
- 05 \$40,000 - \$49,999
- 06 \$50,000 - \$59,999
- 07 \$60,000 - \$69,999
- 08 \$70,000 - \$79,999
- 09 \$80,000+
- 97 Don't Know
- 98 Refuse to Answer
- 99 Not Applicable

Q715. Please answer the following questions in dollar amounts.
During the past 90 days, how much did you spend, on average, on alcohol, per month?

-
- 9997 Don't Know
 - 9998 Refuse to Answer
 - 9999 Not Applicable

Q716. During the past 90 days, how much did you spend, on average, on drugs, per month?

- — — —
- 9997 Don't Know
 - 9998 Refuse to Answer
 - 9999 Not Applicable

Q717. **Using Card C:** How soon, if at all, do you need help or more help with your work or financial situation? (Choose one)

- 0 Do not need any help
- 1 Getting the help I need already
- 2 More than 3 months from now
- 3 In the next 3 months
- 4 Right away
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

READ: Thank you! This completes the interview questions for today.

Q718. Interviewer: How many minutes worth of breaks did you take?

- —
- 97 Don't Know
 - 98 Refuse to Answer
 - 99 Not Applicable

Random Assignment

Now, please enter information regarding random assignment into the study

Q719. Envelope number

- 997 Don't Know
- 998 Refuse to Answer
- 999 Not Applicable

Q720. Study arm (Choose one)

- 2 Control condition (RESPECT)
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Access to Social Capital

Please enter in the data collected on the ACCESS TO SOCIAL CAPITAL worksheet that the client filled out.

Q721. Number of people listed for: 1) Whom can you really count on to help you get a new job?

— —
97 Don't Know
98 Refuse to Answer
99 Not Applicable

Q722. Overall satisfaction of support for: 1) Whom can you really count on to help you get a new job?

0 Very dissatisfied

1 1
2 2
3 3
4 4
5 Very satisfied
7 Don't Know
8 Refuse to Answer
9 Not Applicable

Q723. Number of people listed for: 2) Whom can you really count on to lend you \$100?

— —
97 Don't Know
98 Refuse to Answer
99 Not Applicable

Q724. Overall satisfaction of support for: 2) Whom can you really count on to lend you \$100?

0 Very dissatisfied
1 1
2 2
3 3
4 4
5 Very satisfied
7 Don't Know
8 Refuse to Answer
9 Not Applicable

Q725. Number of people listed for: 3) Whom can you really count on to let you live with them if you lost housing?

— —
97 Don't Know
98 Refuse to Answer
99 Not Applicable

Q726. Overall satisfaction of support for: 3) Whom can you really count on to let you live with them if you lost your housing?

- 0 Very dissatisfied
- 1 1
- 2 2
- 3 3
- 4 4
- 5 Very satisfied
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q727. Number of people listed for: 4) Whom can you really count on to bail you out of jail?

- —
- 97 Don't Know
- 98 Refuse to Answer
- 99 Not Applicable

Q728. Overall satisfaction of support for: 4) Whom can you really count on to bail you out of jail?

- 0 Very dissatisfied
- 1 1
- 2 2
- 3 3
- 4 4
- 5 Very satisfied
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q729. Number of people listed for: 5) Whom can you really count on to help you if you had a health crisis?

- —
- 97 Don't Know
- 98 Refuse to Answer
- 99 Not Applicable

Q730. Overall satisfaction of support for: 5) Whom can you really count on to help you if you had a health crisis?

- 0 Very dissatisfied
- 1 1
- 2 2
- 3 3
- 4 4
- 5 Very satisfied
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Please document the following aspects regarding how the interview was administered. If there are more detailed comments, please be sure to summarize them in the additional comments section below.

Q731. Was there any evidence that the person could not place himself in place or time or, in general, any evidence of cognitive impairment or dementia? (Choose one)

- 0 No/none
- 1 Minimal
- 2 Moderate
- 3 Major
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q732. Was there any evidence of the following observed participant behaviors?...**Depressed or withdrawn**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q733. Was there any evidence of the following observed participant behaviors?...**Violent or hostile**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q734. Was there any evidence of the following observed participant behaviors?...**Anxious or nervous**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q735. Was there any evidence of the following observed participant behaviors?...**Bored or impatient**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q736. Was there any evidence of the following observed participant behaviors?...**Intoxicated or high**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q737. Was there any evidence of the following observed participant behaviors?...**In withdrawal**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q738. Was there any evidence of the following observed participant behaviors?...**Distracted**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q739. Was there any evidence of the following observed participant behaviors?...**Cooperative**

- 1 Yes
- 0 No
- 7 Don't Know
- 8 Refuse to Answer
- 9 Not Applicable

Q740. Do you have any additional comments about the administration of the assessment or things that should be considered in interpreting this assessment? **Comment 1**

If missing **Skip to end of**

questionnaire

Q741. Do you have any additional comments about the administration of the assessment or things that should be considered in interpreting this assessment? **Comment 2** *If none, click Not Applicable*

If missing **Skip to end of**

questionnaire

Q742. Do you have any additional comments about the administration of the assessment or things that should be considered in interpreting this assessment? **Comment 3** *If none, click Not Applicable*

The end. Please continue and **SAVE** the interview.

APPENDIX B: SEMI-STRUCTURED QUALITATIVE INTERVIEW GUIDE

I. Introduction/Establish Rapport

Introduce myself as the interviewer. Describe the purpose of the session, the expected duration (approximately 90 minutes), and what is hoped to be achieved in the interview.

- Explain the human subjects protections and obtained informed consent from the respondent.
- Tell the respondent he will be compensated \$50 for his time and travel.
- Remind the respondent of the dates of study enrollment and completion.

II. Brief History and Environment Discussion

The purpose of this section is to gather information about the respondent's life prior to study enrollment. The goal is to understand the respondent's experience with structural violence (e.g. unequal access to health care or education), and how this environment was related to syndemic health and social disparities.

Suggested open-ended questions:

- How long have you lived in Miami?

(If respondent migrated from somewhere else, consider asking, "When did you move here? Why did you move here? Where did you grow up?" What was the relocating process like?)
- What was it like growing up in your neighborhood?
- Tell me a little bit about your family? School? Sports? Church? Activities?
- What kinds of things were most challenging growing up there? Stigma? Homophobia? Crime? Victimization? Poverty? Access to health care?
- Tell me about the best parts about growing up there.
- Tell me a little bit about your educational background. Did you go to school in Miami? Where? Did you graduate from high school or college? Did you like school? Why or why not? In what ways did school benefit you? In what ways did school not meet your needs?

- Tell me a little bit about what you do for work. How long have you worked there? What did you do before that? Do you like what you do? If not, what would you like to be doing instead?

III. Self-perception of Syndemic Health and Social Disparities

Ask the respondent to describe what life was like when he enrolled in the study with an emphasis on syndemic health and social disparities and their environmental causes.

Suggested open-ended questions:

- What are some challenges that you were facing?

Probes:

- Substance use (which drugs, quantity, contexts)
- Relationships (friends, family, sexual)
- Health and wellness (mental health, physical health, access to care)
- Stigma or homophobia
- Victimization
- What did you do that made those challenges get worse? Better?
- What aspects of yourself made those challenges get worse? Better?
- How did your relationships impact your situation?
- What aspects of things around you (e.g. school, neighborhood, community, family) made these challenges worse? What made them better?

IV. General changes since the Project ROOM study participation

- What changes have you experienced in your life since you began participating in the Project ROOM study until your study participation ended? Probes:

- new or changed social relationships, friendships, group participation, etc.
- employment, volunteerism, involvement in sports or church
- health and wellness
- new goals and/or steps to achieving them
- coping with problems, stress management (including support groups, substance abuse treatment)

- Housing, neighborhood, who you've lived with, or other living situation.

- Can you talk a bit about why and how these changes happened?
- What has the process been like in going through these changes?
- What impact has it had on your life?

V. Changes in substance use since the Project ROOM study participation

- What changes have you experienced in your drug or alcohol use since you began participating in the Project ROOM study until your study participation ended? Probes:
 - setting
 - people
 - patterns of use (fluctuations in amount; type of substance)
- Can you talk a bit about why and how these changes happened?
- What has the process been like in going through these changes?
- What impact has it had on your life?
- What has happened since the study ended?

VI. Changes in sexual behavior since the Project ROOM study participation

- What changes have you experienced in your drug or alcohol use since you began participating in the Project ROOM study until your study participation ended? Probes:
 - partners
 - protection or safer sex behaviors
 - HIV testing
- Can you talk a bit about why and how these changes happened?
- What has the process been like in going through these changes?
- What impact has it had on your life?
- What has happened since the study ended?

VII. Assessment of Assets and Resources

The purpose of this section is to have the respondent identify and discuss any challenges faced during his life and how he overcame it. Ask additional questions to get the respondent identify internal assets he used or developed through the process. In addition, the respondent may also identify external assets or resources.

Suggested open-ended questions:

- Can you tell about any challenges you have faced (or are currently facing) in your and how you managed to overcome it?
- What did you do when you faced this difficulty in your life? What caused you to act this way?
- What other things helped? (Here ask the respondent to identify other resources outside of himself such as a supportive friend, savings account, education, job, etc.)
- What could have you done differently? What barriers did you face?
- What outside resources were available to you in that time of challenge?
 - Church
 - Community or support group
 - Friend or family member
- How easy is it to access these resources if you wanted to?
 - Transportation
 - Cost
 - Social stigma
 - Culturally relevant

VIII. Respondent Goals and Actions

Review the list of respondent goals he completed during the Project ROOM study.

- What assets or resources helped you achieve these goals?
- What were you not able to achieve and why not?
- What (if anything) are you presently doing to overcome these challenges?

- What would you like to do to achieve these goals (or if applicable, make new goals)?
- Who have you talked to about your goals or actions, like a friend/ family member/pastor, etc?

IX. Self-perception of Resilience

End the interview with a discussion of what it means to be resilient.

- How do you describe people who grow up well here despite the many problems they face?
- What do you do when you face difficulties in your life?
- What does being healthy mean to you?
- What do you and others you know do, to keep healthy, mentally, physically, emotionally, spiritually?

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