# Chapter 11
# Understanding the Developmental and Psychosocial Needs of HIV Positive Gay Adolescent Males

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This chapter explores core developmental and psychosocial needs of gay adolescent males who are living with the human immunodeficiency virus (HIV). Adolescence represents a period of significant transition for youth who are experimenting with changing roles and responsibilities, exploring their ethnic, gender, and sexual identities, and negotiating sexual and romantic relationships (Bauermeister et al., 2010; Hussen, Harper et al., 2015; Rosario, Schrimshaw, & Hunter, 2010; Steinberg & Morris, 2001). During the developmental processes of adolescence, HIV positive gay adolescent males also experience challenges related to managing disclosure based on their sexuality and HIV status (Hightow-Weidman et al., 2013; Jeffries et al., 2015; Tharinger & Wells, 2000), and the corresponding stigma and mental health sequelae often associated with negative peer and family reactions to such disclosures (D'Augelli, Grossman, & Starks, 2006; Herek, 2002; Lam, Naar-King, & Wright, 2007; Marshal et al., 2011; Rosario, Schrimshaw, & Hunter, 2012). HIV positive gay male youth may be negotiating these challenges while they strive for academic success, which is important to their future life trajectories (Bradley & Greene, 2013; Bruce et al., 2012). Consequently, HIV positive gay adolescent males experience fundamental psychosocial needs that are not adequately understood or attended to holistically by many current HIV prevention and service delivery programs (Harper et al., 2013; Kingdon et al., 2013). It is critical that we better understand and create supportive services that address these key challenges, which, in turn, will help to raise health awareness, enhance coping skills, and improve

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secondary HIV prevention for gay adolescent males living with HIV and AIDS (Bouris et al., 2013; Hussen, Chahroudi et al., 2015).

This chapter first focuses on the increasing HIV infection rates among young gay males and examines pertinent research on core issues faced by HIV-infected youth, including experiences of HIV-related stigma, family and peer relationships, mental health and substance use challenges, and psychosocial needs (e.g., basic resources such as food and shelter). While there is a larger body of research on gay youth and HIV positive adult males, less emphasis has been placed on HIV positive gay adolescent males. Thus, this chapter will draw from these related literatures and relevant empirical studies on HIV positive gay adolescent males to highlight the developmental challenges, psychosocial needs, and service delivery needs of HIV positive gay adolescent males. We will also discuss key current federal and educational policies related to protection, service provision, and treatment for this population. We begin with a review of research on the shifting demographics of HIV, which highlights the importance of focusing on HIV positive adolescent gay males.

## Shifting Demographics Within the Context of HIV

Several distinct epidemics (e.g., gay men, injection drug users, hemophiliacs, and women) have emerged over the last 35 years in the United States, each impacting a specific subpopulation, which has been shaped by unique sets of predictors and prevention challenges (Amaro & Raj, 2000; Elford & Hart, 2003; Evatt, 2006; Karon, Fleming, Steketee, & De Cock, 2001; Lusher & Brownstein, 2007; Murrill et al., 2002; Pulerwitz, Amaro, Jong, Gortmaker, & Rudd, 2002). Historically, response to the HIV/AIDS epidemic focused on adult gay populations, since this group experienced the highest AIDS mortality. From the outset, the HIV epidemic tapped into a moral preoccupation that painted some people as "innocent" (e.g., hemophiliacs and children) and others as "culpable" due to their engagement in socially undesirable behaviors, such as same-sex sexuality and drug use (Mawar, Sahay, Pandit, & Mahajan, 2005; Schellenberg, Keil, & Bem, 1995). These discriminatory beliefs significantly shaped early governmental response (or non-response) to the development of HIV prevention and treatment policy in the USA (Shilts, 1988). The void in early governmental response in the HIV/AIDS epidemic also stimulated a powerful social movement within Lesbian, Gay, Bisexual, and Transgender (LGBT) communities that aimed not only to spur the government into action but also to bring a greater legitimacy to LGBT people and communities as whole, worthy, and important members of our society. Thirty-five years later, while men who have sex with men (MSM), particularly men of color, continue to bear the greatest burden of HIV/AIDS infection, the demographics of the epidemic show a gradual shift away from some populations (e.g., hemophiliacs, children infected at birth) to communities of color, young adults, and adolescents (CDC, 2015, 2016). Not surprisingly, the public and private perception of those infected with HIV continues to have a pivotal role in shaping federal and state responses to the HIV epidemic in the USA.

Currently, estimates suggest more than 1.2 million people are living with HIV in the USA (CDC, 2015). In 2015, gay men and other MSM continue to be disproportionately impacted, accounting for 67% of new HIV infections (CDC, 2015) while only comprising between 2 and 4% of the overall population (CDC, 2015; Gates, 2011). Adolescents and young adults (aged 13–24) are especially vulnerable to HIV, representing 22% of new infections in 2014 (CDC, 2015). Furthermore, Black and Latino youth are even more disproportionately impacted by HIV, accounting for 55% and 23%, respectively, of new infections among young gay males in 2014 (CDC, 2015). However, it is important to note that when statistics report on "gay youth" it is not always clear what populations fall under that broad umbrella. For example, some statistics may include gay identified youth, while others may consider MSM who do not identify as gay. In other instances, bisexual, queer, or questioning youth may be included. Nevertheless, while rates of new HIV infections have decreased or remained relatively stable among most groups (including adult gay men), new infections continue to rise among adolescent gay males, in general, and young Black gay males specifically (CDC, 2015; IOM, 2011). In fact, young Black gay males are twice as likely as other groups to be diagnosed with HIV, and both Black and Latino adolescents are more likely to become infected with HIV at younger ages than White adolescents (CDC, 2008; IOM, 2011). These factors provide evidence that the epidemic continues to disproportionately affect disenfranchised populations (e.g., communities of color and LGBT communities), mirroring other health disparities such as cancer, heart disease, and diabetes (Smedley, Stith, & Nelson, 2003).

## The National HIV/AIDS Strategy

The existence of a federal HIV/AIDS policy not only sets the agenda for prevention, intervention, and service delivery, but also serves as a powerful tool for shaping how society views and responds to HIV positive individuals. The National HIV/AIDS Strategy, enacted by President Obama in 2010, identifies three primary objectives: to reduce HIV infections, increase access to care and treatment for HIV-infected individuals, and reduce HIV-related health disparities, inequities, and stigma (White House Office of National AIDS Policy, 2010). Certainly, the "on-the-ground" impact of the National HIV/AIDS Strategy once fully implemented will have some positive impact on lessening the developmental challenges for HIV positive adolescent males. However, the unfolding of this policy will take time in the midst of fiscal challenges, complex bureaucracies, and changing political landscapes. At the current moment, important adolescent developmental challenges remain.

Despite the growing rate of HIV among young gay males and a national strategy that specifically calls for more research and services directed towards populations at greatest risk, HIV positive gay male adolescents have received limited attention in the extant literature. The data from these studies was derived from diverse samples with regard to age, gender, and sexual orientation, and across a wide range of

infection routes, including perinatal infection. The data was also collected at a time when HIV treatment was more limited, less HIV information was provided in schools and within broader communities, and overt HIV stigma was more socially accepted.

## Adolescent Development

Adolescence is a transitional time of navigation and exploration when adolescents seek ways of becoming more autonomous while also trying to maintain security through and connectedness with supportive networks such as family and school (Spear & Kulbok, 2004). Adolescence is characterized by major changes (and potential conflict) in family and peer relationships (Lynch, Lerner, & Leventhal, 2013; Spear & Kulbok, 2004; Tillfors, Persson, Willén, & Burk, 2012); identity development, formation, and crisis (Marcia, 1980); pressures of school achievement (Lynch et al., 2013); and issues of sexuality, dating, and intimacy (Tolman & McClelland, 2011). HIV positive gay adolescent males, while experiencing these developmental processes, also have unique challenges, including recognizing and understanding their same-sex sexual attraction, learning to navigate intimate same-sex relationships, making decisions about sexual identity and HIV-related disclosure, and managing both positive and negative reactions to their disclosures to family, friends, and peers (Bauermeister et al., 2010; Hussen, Harper et al., 2015; Rosario et al., 2012; Tharinger & Wells, 2000). In the next few sections, we discuss how stigma and discrimination related to sexual minority and HIV status may influence psychosocial functioning.

## LGBT Sexualities and HIV: Multiple Stigmas and Challenges

Young gay males (and other sexual minority youth) face multiple challenges, including increased risks of bullying (Austin, 2012; Roberts, Rosario, Slopen, Calzo, & Austin, 2013; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011), homelessness (Corliss, Goodenow, Nichols, & Austin, 2011), substance use (Ott et al., 2013), violence (Friedman et al., 2011), incarceration, poorer school achievement (Pearson, Muller, & Wilkinson, 2007), mental health distress (e.g., depression) (Galliher, Rostosky, & Hughes, 2004; Roberts et al., 2013), and suicidal ideation (Marshal et al., 2011). These challenges are often embedded in societal stigma, discrimination, and negative treatment by others associated with their sexual identities (Wilson et al., 2010). Moreover, an HIV positive diagnosis may serve to exacerbate the more fundamental challenges experienced by young gay males. These sexuality-based and HIV-related stigmas stem from multiple macro- and microlevel sources, including family, schools, peers, religious institutions, and community organizations, and are influenced by social and community norms regarding sexuality (Bird & Voisin, 2013;

Campbell & Deacon, 2006; Cohen, 1999; Herek, 2004; Parker & Aggleton, 2003). However, examining the impact of sexuality-based stigma and discrimination on youth and the general impact of HIV-related stigma on adults with HIV may help to illuminate the potential challenges faced by HIV positive gay male adolescents.

## Stigma and Discrimination Based on Sexual Minority Status

There has been substantial progress in terms of LGBTQ rights and the reduction of sexuality-based discrimination. Some of these developments have included the 2015 Supreme Court ruling in *Obergefell v. Hodges* that same-sex marriage is a constitutionally protected right, lifting of the ban on lesbian and gay US service members, the first endorsement of same-sex marriage by a sitting U.S. president, the rise of gay-straight alliances within school systems, and greater public awareness campaigns supporting young LGBTQ individuals (e.g., the "It Gets Better Campaign"). However, these advancements have been tempered by persistent negative beliefs about LGBTQ people as observed with the continued resistance to not only same-sex marriage but also to equal rights for and anti-discrimination laws protecting LGBTQ individuals (especially within highly religious and more rural communities).

Many gay youth are exposed to environmental contexts that discount their sexuality and demand silence around issues of sexual identity. This expected silence is often learned by observing how openly LGBTQ individuals are discussed and/or treated by others. Therefore, LGBTQ youth experience a sense of "otherness" around which there is a social expectation of secrecy. Additionally, some African American and Latino youth may experience increased stigma or hostility with regard to being gay or bisexual given strong familial and community norms against homosexuality in some communities of color (Lam et al., 2007). This adds more complexity and highlights the ways that multiple factors intersect to increase stress and challenge positive coping. For instance, Agronick et al. (2004) found that young Latino MSM (aged 15–25) who identified as bisexual were more likely than those individuals who identified as gay to engage in insertive condomless anal intercourse, have more than one male sex partner in the preceding 3 months, and use drugs or alcohol during their last sex act with a male partner. The researchers theorized that many Latino YMSM who primarily have sex with men might identify as bisexual due to internalized homophobia, based out of cultural and familial norms, which strongly sanction against homosexuality (Agronick et al., 2004).

In a recent qualitative study of 20 Black gay adolescents, several participants reported internal conflicts related to their identity given that immediate family members loved and accepted them, but that their sexuality or related issues were not discussed and that the topic was often ignored (Voisin & Bird, 2012). In one instance, a participant indicated that when he disclosed his sexual orientation and HIV positive status to his mother, it was made clear that he was still her son but the topic would be discussed once and never again. Participants reported that despite

feeling loved by immediate family members, homophobia on the part of some family members and "their Black community," coupled with the need to avoid stigma, prevented discussions about sexuality and sexual health from taking place on a regular basis. For some respondents, societal racism and the anticipation of racism from White gay communities resulted in heightened feelings of hyper-vigilance, which led to apathy about adhering to HIV prevention messages (Voisin & Bird, 2012). In such cases, young gay males of color are challenged by the intersection of racism and racially specific norms against homosexuality, and, in the case of HIV positive youth, HIV-related stigma, and discrimination.

The need to keep emerging same-sex sexual feelings and identity secret can interfere with the connectedness LGBT youth have with family and friends and can result in increased isolation, shame, and internalized stigma and homophobia, interfering with self-confidence and feelings of self-worth (Tharinger & Wells, 2000). Moreover, it removes pathways to many of the protective social relationships that are so important to positive functioning during adolescence (Tharinger & Wells, 2000). Furthermore, this continued isolation from family and peers for LGBT youth may facilitate the search for intimate and social relationships outside of familiar social networks and, thereby, expose adolescents to increased sexual and health risks (Bird, LaSala, Hidalgo, Kuhns, & Garofalo, 2017). This may be especially true in the absence of comprehensive sex education that specifically addresses the potential risks for young gay and bisexual men.

## HIV-Related Stigma and Discrimination

HIV-related stigma is based on the perception of HIV as a discrediting attribute that marks the individual as different, less desirable, and more dangerous than those who are not HIV positive (Herek, 2002). While it may be true that overt HIV-related stigma has declined somewhat over time (Flicker et al., 2005), it remains a critical issue for HIV positive youth for whom this sense of secrecy may be exacerbated (Galindo, 2013). Issues of sexuality and disease may become intertwined in ways that deepen shame and create emotional distance from family and supportive networks (Bird, LaSala et al., 2017; Lam et al., 2007). Different populations (e.g., age, race, and ethnicity, gender) experience different amounts and types of HIV-related stigma. However, evidence suggests that HIV positive adolescents widely encounter HIV-related stigma through lived negative experiences, which compound their fear of breaking the silence around their HIV positive status (Flicker et al., 2005).

While gay adolescent males represent a growing proportion of those living with HIV and AIDS, there has been limited research on their experiences of HIV-related stigma (Dowshen, Binns, & Garofalo, 2009). One study of an ethnically diverse sample of young people aged 16–24 in Chicago found associations between HIV stigma and psychological distress, lower self-esteem, and loneliness. Levels of stigma did not vary significantly based on race, age, or gender identity. Additionally, adolescent gay males in this study reported levels of HIV-related stigma comparable

to other HIV positive populations in previous studies (Dowshen et al., 2009). Stigma has also been identified as a significant factor driving nonadherence to HIV medication regimens for gay adolescents (Rao, Kekwaletswe, Hosek, Martinez, & Rodriguez, 2007). Given the increased risk for stigma and discrimination that HIV positive adolescent males are likely to experience, it is not surprising that these youth are confronted with multiple psychosocial challenges.

## Navigating Romantic Relationship, Family Dynamics, and Academic Success

In the following sections, we discuss family and peer dynamics and academic policy and achievement as major domains that influence positive youth outcomes and upward trajectories.

## Romantic Relationships

As gay youth navigate dating and sexual exploration during adolescence, they may unknowingly place themselves or their partners at risk of HIV. A high proportion of HIV positive gay youths do not know their HIV status, and therefore may engage in sexual risk behavior that could transmit HIV to their romantic partners (Halkitis et al., 2011; Mustanski, Newcomb, Du Bois, Garcia, & Grov, 2011). If HIV positive gay adolescents who are unaware of their HIV status perceive themselves as unlikely to have HIV, they may engage in more sexual risk-taking activity, such as having condomless anal intercourse, thereby placing their partners at risk (Halkitis et al., 2013). Similarly, HIV negative youth may assume that young romantic partners are HIV negative and thereby be willing to engage in sexual risk (Mustanski et al., 2011).

One way that gay adolescents often locate potential romantic or sexual partners is through the Internet (Garofalo, Herrick, Mustanski, & Donenberg, 2007). Studies suggest that the Internet has influenced the practice of sexual risk-taking behaviors, such as condomless anal intercourse or condom misuse, with sexual partners (Garofalo, Mustanski, Johnson, & Emerson, 2010). Additionally, some gay adolescents report having older gay male sexual partners (Rind, 2001), who may be more likely to be HIV positive (Garofalo et al., 2010). While qualitative studies with young, HIV positive gay and bisexual males have indicated that older gay men can be a source of support for gay youths (Bruce, Harper, & ATN, 2011), romantic relationships with older gay men may also heighten gay adolescents' risk of HIV exposure (Bird, LaSala et al., 2017).

Gay adolescents are faced with myriad complexities as they enter their life phase of romantic and sexual exploration, which they often must negotiate on their own in

the absence of peer or family support. If an adolescent is aware of their HIV positive status, this presents the additional challenge of negotiating disclosure to romantic or sexual partners—a task that requires a high level of social efficacy (Bird, Eversman, & Voisin, 2017) from youth who may already be struggling to manage various demands on their psychological and emotional resources.

## Family and Peer Dynamics: Sexuality Disclosure

Due to traditional societal norms against LGBT sexualities, gay youth often face challenges related to disclosing their sexuality to and dealing with negative reactions to that disclosure from parents, family members, and friends. Furthermore, for gay adolescents, an HIV diagnosis may be perceived as providing evidence of their being gay or bisexual and the choice to disclose an HIV positive status means also disclosing their sexual identity. Therefore, the adolescent must contend with a double-disclosure to family and friends and, potentially, double stigmatization and potential "blame" for their HIV infection. A number of gay youth face parental rejection, including exposure to violence from family members and being forced to leave home due to the sexual minority disclosure (Bird, LaSala et al., 2017; Tharinger & Wells, 2000). A recent study of young HIV positive youth, aged 17–24, across four cities indicated that few of the participants reported having the support of their families as they came to terms with their sexual orientation (Bruce et al., 2011). This is especially problematic since parental rejection has been associated with negative outcomes. For example, Ryan, Huebner, Diaz, and Sanchez (2009) in a study of 224 White and Latino participants found that adolescents who had experienced family rejection on the basis of their sexual orientation were 3.4 times more likely to have engaged in condomless anal intercourse, thereby increasing their risk of contracting or transmitting HIV. This finding corroborates with a growing body of research that indicates that adolescents who lack family support may be more likely to engage in unprotected sex that places them at increased HIV risk; they are also less likely to have supportive family networks to help them come to terms with an HIV positive diagnosis (Bird, LaSala et al., 2017).

## Family and Peer Dynamics: HIV Disclosure

HIV disclosure is also a primary issue with which young, HIV positive gay adolescent males must contend. This includes having to make decisions about to whom one discloses, why one might decide to disclose, and what potential reactions may occur (Bird & Voisin, 2013; Brown, Lourie, & Pao, 2000). The need to manage such sensitive and potentially stigmatizing health information can have a profound impact on relationships with family, friends, and others with or without actual disclosure. Experiences with heterosexism and HIV-related stigma during adolescence,

when young gay males are coming to terms with their sexual identity, may influence HIV positive youth to remain silent about their HIV status (Flicker et al., 2005). They may also choose to keep their HIV status and/or sexuality secret in order maintain peer approval (Lam et al., 2007). Ultimately, this secrecy can result in increased social isolation and decreased access to resources. On the other hand, HIV disclosure carries the potential for negative consequences, as well, and may result in social ostracism from supportive communities and peer networks (Bird & Voisin, 2013; Hightow-Weidman et al., 2013) and potential rejection from families (Bird & Voisin, 2013), especially since an HIV disclosure may result in a broader disclosure about sexuality and sexual identity.

Few studies have specifically examined HIV disclosure outcomes among gay youth. However, based on resiliency research with other populations, we posit several factors that are likely to matter. Individual-level factors include positive intellectual functioning; the ability to form secure attachments with others; having a sociable and appealing disposition; having high levels of self-efficacy, self-confidence, and self-esteem; being goal-orientated; and feeling hopeful about the future (Tharinger & Wells, 2000). Additionally, having strong and close family relationships, being connected to extended supportive networks, and having positive school-based relationships have been shown to enhance coping for adolescents, which may make disclosure more likely. However, heterosexism and sexuality-based stigmatization and discrimination often stand as significant barriers between HIV positive gay adolescents and typical sources of support, such as family, friends, teachers or other school officials, and community or religious organizations.

Even in the case where a gay adolescent male does not "come out" to family, he may experience feelings of rejection based on how family members talk about or treat other gay and lesbian individuals (Tharinger & Wells, 2000). In the absence of parental support, Bruce et al. (2011) found that most participants spoke of feelings of loneliness and isolation. In their survey of 54 HIV positive gay adolescents and emerging adults, aged 17–24, participants were asked to describe risks and resiliencies associated with being a gay youth and many spoke of leaving home to find other males "like them," in gay communities (p. 371). Because many of these young gay males felt unsupported by their families and had moved to larger cities on their own, participants who recounted experimentation with drugs and sex often lacked a supportive network or parental guidance to help them navigate the health risks (Bruce et al., 2011). However, other participants spoke of the supportive networks or alternative families provided by others in gay communities, frequently comprised of older gay men who played a mentoring role to adolescent and emerging adult gay males. The interviews revealed that the young gay men who had left home were susceptible to a variety of risks: some reported feeling vulnerable to peer influences due to feelings of identity confusion, and others reported that deeper emotional needs led them to seek out multiple sexual partners. On the other hand, many participants reported resiliencies associated with their migration to gay communities, including feelings of increased self-reliance, strength borne out of overcoming adversity, and an open-mindedness that allowed them to encounter a rich variety of people and experiences (Bruce et al., 2011).

Furthermore, not all families reject or ill-treat their LGBTQ children, and families can provide an important protective role for LGBTQ youth by providing social support, acceptance, and security (Bouris et al., 2010). The degree and resolution of family conflict, when it occurs, is often dependent on the strength of the family relationships prior to disclosure (Tharinger & Wells, 2000), and several studies have found that young gay male participants report valuing family relationships and their families of origin (McDowell & Serovich, 2007; Serovich & Grafsky, 2011). Therefore, looking for ways to strengthen family dynamics, communication, attachment, and coping strategies has the benefit of helping families overcome negative beliefs and feelings related to sexual minorities and LGBTQ children. Furthermore, this strengthening of families could serve as a primary coping mechanism for HIV positive youth (Bird, LaSala et al., 2017; Kalichman, DiMarco, Austin, Luke, & Di-Fonzo, 2003; Serovich & Grafsky, 2011) and increase positive outcomes, such as increased adherence to HIV treatment (Murphy, Roberts, Marelich, & Hoffman, 2000).

## Academic Policy and School Success

It is widely known that school achievement is associated with important future accomplishments and upward social mobility. Daily stigmatization, discrimination, or exposure to a hostile academic environment can interfere with the learning process and school achievement. Furthermore, fear about negative treatment can lead to decreased involvement in school activities and the maintenance of smaller social networks, which can increase isolation and limit access to social support and resources (Tharinger & Wells, 2000). Adolescent gay males often encounter entrenched antigay stigma and discrimination within their school settings (Solorio, Swendeman, & Rotheram-Borus, 2003), and sometimes this discrimination is institutionalized in the policies and behaviors of the school administration (Bruce et al., 2011). Additional studies have indicated that children and adolescents whose HIV status is disclosed in a school setting often face stigma and discrimination on account of their HIV status, with some children even being denied school entry (Weiner, Battles, & Heilman, 2000). Therefore, young HIV positive gay males are at risk of discrimination based on their sexual orientation and HIV status.

Regardless of the fact that HIV positive children and adolescents are vulnerable to verbal assault and discrimination in school settings, research on HIV school policies has largely focused on HIV prevention policies. In response to the potential for HIV-related stigmatization and discrimination within school systems, various organizations have created position statements for protecting HIV positive students in schools, which have often derived from federal laws. For example, the American Academy of Pediatrics (AAP) offers six recommendations: (1) that all HIV positive children and youth have equal access to high quality educational experiences; (2) that special education services be provided as needed; (3) that there be accommodation of medical needs within the school setting; (4) that continuity of education be

uninterrupted by HIV management; (5) that confidentiality of HIV status be maintained; and (6) that there be coordination between the pediatrician/medical home provider and school when appropriate (AAP, 2000).

In addition to the AAP, the American Civil Liberties Union (ACLU), American Psychiatric Association (APA), American Nursing Association (ANA), and the Center for HIV Law and Policy have all released policy statements regarding the protection of HIV positive youth within schools. For example, the ACLU's AIDS Project released a report entitled "HIV & Civil Rights" (Lange, 2003), which outlines the rights of HIV positive persons to privacy and confidentiality, nondiscrimination, and accurate sexual and prevention education in schools. The ANA released "Recommendations for the School Nurse in Addressing HIV/AIDS with Adolescents" in 1996, which recommended that school nurses integrate HIV/AIDS education into their schools' health programs; take leadership in educating fellow school personnel and community members on HIV/AIDS; advocate to protect the rights of students with HIV/AIDS; and connect them and their families with community supportive resources (Uris, 1996). In its 2009 "Position Statement on HIV and Adolescents," the APA charged that HIV status should be disclosed on a "need-to-know" basis within school settings, as outlined within the framework of the law and stated that HIV positive students should not be restricted from participation in school activities (APA, 2009).

Finally, the Center for HIV Law and Policy developed the Teen SENSE (Sexual health and Education Now in State Environments) initiative to ensure that HIV positive adolescents in state custody have access to "comprehensive, scientifically accurate, LGBT-inclusive sexual health care services and education" (The Center for HIV Law & Policy, n.d.). Teen SENSE offers a federal and state legal framework that protects these rights for HIV positive adolescents, as well as model guidelines for nonjudgmental and LGBTQ-inclusive health care, education, and professional development/staff training of personnel who work with HIV positive youth in foster care and juvenile justice facilities. HIV positive students' rights are also explicitly protected by several federal laws. For example, the Rehabilitation Act of 1973, Section 504, pertains to children or adolescents with health care needs who do not require special education classes. It requires that public schools permit these students to attend regular classes and accommodate students with special support such as medical or psychological services if necessary (AAP, 2000).

Additionally, the Supreme Court's 1998 ruling in *Bragdon v. Abbott* determined that people with HIV or AIDS are protected under the Americans with Disabilities Act (ADA), as are persons who are discriminated against because they are regarded as being HIV positive, and persons who face discrimination because they have a relationship with someone who is HIV positive. The ADA prohibits state and local governments from discriminating against people with HIV, including public school systems (U.S. Department of Justice, n.d.). Finally, the Individuals with Disabilities Education Act (IDEA) applies to children and adolescents ages 3–21 with disabilities or medical concerns (including HIV/AIDS) that require special accommodation in a school setting. IDEA guarantees access to schooling and supportive services for eligible children. Schools are required to prepare an Individualized Education

Program (IEP) for each eligible child that outlines a plan to ensure that their disability or medical condition does not interfere with their education (AAP, 2000).

Various states also provide policy guidelines to assist local school districts in developing policies that protect the rights of HIV positive students. Often these guidelines include an HIV/AIDS primer to educate administrators, teachers, and families, and a host of policy recommendations, including HIV/AIDS prevention education; safeguarding students through infection control, privacy and confidentiality, and nondiscrimination; ensuring student access to communicable disease reporting and physical and psychological health services; protecting the rights of HIV positive students to participate in athletics and other student programs; and communicating policies to families. Wisconsin's School HIV/AIDS Policy Tool Kit acknowledges that "communities typically focus on the safety of children that do not have HIV infection," but suggests that "[I]n addition, messages can be developed to inform the community that policies are in place to protect the rights of all students and staff, including those infected and affected by HIV" (Cox, 2003, p. 67).

However, there is some question about the extent to which these policy guidelines are actually implemented at the local level. For example, a content analysis of HIV-related school policy in 79 school systems in North Carolina found that school boards largely failed to provide detailed HIV-related policies (Fair, Garner-Edwards, & McLees-Lane, 2005) such as the ones recommended by the state's Healthy Schools Initiative, funded by the Departments of Public Instruction and Health and Human Services. Furthermore, North Carolina passed a law in 2016 (House Bill 2) barring local ordinances protecting LGBT populations, which will likely have a negative impact on LGBTQ and HIV-infected youth in schools (House Bill 2, 2016).

A 2008 study by the CDC analyzed survey data from the 2006 School Health Profiles for public secondary schools (grades 6–12) in 36 states and 13 large urban school districts and found that approximately half of all secondary schools reported having a policy to protect the rights of staff and students infected with HIV or AIDS (CDC, 2008). The median percentage of schools with such a policy in place decreased from 71.9% in 1996 to 52.9% in 2006 among states and from 86.2 to 49.2% among school districts, when comparing results from the same 21 states and eight school districts that participated in both the 1996 and 2006 School Health Profiles surveys. While this study suffers from response bias due to self-report and non-response, it most likely overestimates the number of schools with policies to protect HIV positive high school students, suggesting that public secondary schools are falling short in providing a safe environment for HIV positive adolescents.

There are also policies that have the potential to infringe on the confidentiality of HIV positive youth. For example, a South Carolina law requires the Department of Health and Environmental Control (DHEC) to report the identities of students who are HIV positive to public school administrators (DeGroat, 2009). Besides challenging what other states have interpreted as a students' right to privacy and confidentiality, the law also potentially discourages students from getting HIV tested, in spite of the fact that the CDC recommends regular testing as an effective component of HIV prevention programs (Branson et al., 2006). Additionally, the law potentially increases the potential for HIV-related stigma and discrimination if their HIV status is shared (DeGroat, 2009).

Furthermore, in spite of legal protections for HIV positive students, various states and local governments have enacted policies that curtail the rights of HIV positive young people, leaving them vulnerable to stigmatization and substandard education quality. Whether or not the laws are enforced, the threat remains that HIV positive students may be denied equal rights within a school setting under the laws. Alabama, California, Georgia, Indiana, Louisiana, Missouri, Oklahoma, Oregon, and South Carolina have laws that devolve authority to local school boards to determine whether HIV positive students can be excluded from public school. A handful of other states do not explicitly mention HIV but permit school boards to prevent students with infectious diseases from attending school if they are deemed a health risk (National Association of State Boards of Education [NASBE], 2012). These policies exist despite the fact that the American Academy of Pediatrics asserts that HIV positive children should not be excluded from school or isolated within the school setting (AAP, 2000). Many of these states have contradictory policies—within the same state there may be one policy that grants schools the authority to suspend students due to their HIV status, and another policy that makes it compulsory to protect HIV positive students' rights to privacy, confidentiality, and accommodation within schools (NASBE, 2012).

## Mental Health Concerns

Although there is a growing body of literature on the effects of sexual minority stigma and discrimination on the mental health functioning of LGBTQ youth, there has been a dearth of research exploring the unique mental health concerns experienced by young, HIV positive gay males. However, based on research involving gay youth and clinical observations, we can posit that HIV positive gay adolescent males are at an increased risk for significant mental health concerns. Given the presence of both HIV-related and sexuality-based stigma and discrimination, it is not surprising that HIV positive gay adolescents are at elevated risks of experiencing psychological distress, including decreased self-esteem (Tharinger & Wells, 2000); increased thoughts of suicide (Brown et al., 2000; Tharinger & Wells, 2000); and feelings of sadness, depression (Brown et al., 2000; Flicker et al., 2005), anxiety, hopelessness, anger (Brown et al., 2000), and isolation and loneliness (Brown et al., 2000; Flicker et al., 2005; Lam et al., 2007), especially when there is less access to others who are HIV positive (Lam et al., 2007). Furthermore, research suggests that HIV positive adolescents may be more preoccupied with mortality and fears of death (Brown et al., 2000; Flicker et al., 2005) and experience feelings of regret, shame, guilt, fear, humiliation, or anger about the circumstances of their infection (Flicker et al., 2005; Tharinger & Wells, 2000).

Benton (2010), in a review of psychiatric papers on HIV positive adolescents, posits that the rate of psychological distress appeared to be higher for HIV positive youth than HIV negative youth and that there may be a relationship between taking HAART medication and mental health concerns that should be explored in future

research. Furthermore, the Youth Risk Behavior Survey (YRBS) found that the combination of LGB identity and experiencing victimization or bullying at school was associated with increased substance use, mental health problems, suicidality, and sexual risk behavior, compared to heterosexual youth. The mental health consequences of stigma for young gay males can lead to emotional distress, suicide attempts, drug use, and risky sex (Mustanski et al., 2011). Furthermore, Mustanski et al. (2011) found an association between psychological distress, depressive symptoms, and condomless anal intercourse in their urban sample of young gay males (aged 18–30), indicating that mental health concerns among HIV positive young gay men may result in sexual risk for themselves and others. Family rejection or poor familial support (e.g. being harassed by family members for being gay or being kicked out of the home) are likely to drive these negative outcomes (Bird, LaSala et al., 2017; Mustanski et al., 2011).

## Substance Use

Although there is limited research specifically on substance use and HIV positive gay adolescent males, there is some data to suggest that HIV positive youth have higher levels of substance use than their HIV negative peers (Naar-King, Wright et al., 2006; Remafedi, Farrow, & Deisher, 1991). However, it is useful to explore the literature on substance use for young gay males in general, as an indicator of use among HIV positive adolescent gay males. A review of epidemiology, risk and protective factors, and interventions among young gay males found that, in comparison with their heterosexual counterparts (Brewster & Tillman, 2012; Traube, Schrager, Holloway, Weiss, & Kipke, 2012) as well as with older gay men (Salomon et al., 2009), young gay males are more likely to use a variety of different substances, including alcohol and illicit drugs, and to engage in heavy substance use. Young gay males along with other sexual minority youth also tend to begin substance use at an earlier age (Corliss et al., 2010) and to increase use more rapidly over time (Marshal, Friedman, Stall, & Thompson, 2009). Although the use of club drugs, such as stimulants and hallucinogens, is high among urban young gay men regardless of race (Mustanski et al., 2011), White young gay males are more likely than Blacks and Latinos to use club drugs (Halkitis & Palamar, 2008) notably MDMA (ecstasy) (Klitzman, Greenberg, Pollack, & Dolezal, 2002). Several studies have highlighted the correlation between club drug use and engaging in risky sexual behavior (Drumright, Patterson, & Strathdee, 2006; Garofalo, Mustanski, McKirnan, Herrick, & Donenberg, 2007; Steuve et al., 2002), which likely increases the spread of HIV and other STIs among urban young gay males. Fewer studies have examined the use of marijuana among young gay males, but findings generally show a correlation between marijuana use and sexual risk (Bryan, Schmiege, & Magnan, 2012; Outlaw et al., 2011). While there is also a correlation between alcohol and sexual risk

taking, the nature of that correlation is inconsistent and merits further study (Newcomb, Clerkin, & Mustanski, 2011). Despite these correlations, the association between young gay males' drug and alcohol use and sexual risk depends on several situational variables, including partner type (primary vs. casual) and sexual role (insertive vs. receptive in anal sex) (Mustanski et al., 2011).

For many young gay males, drug and alcohol use has become a part of their sexual identity (Bruce & Harper, 2011). Urban gay culture has traditionally included drug and alcohol use, and therefore marginalized young gay males seeking to integrate into gay communities often adopt these behaviors. Several studies have found that young gay males who reported a history of forced sex were more likely to use drugs, and those with more serious levels of drug use were also more likely to report a history of having run away (Thiede et al., 2003).

## Sexual Risk

Studies show that young, HIV positive gay males continue to engage in sexual risk taking—including sex with more casual sexual partners, using condoms less frequently and having survival sex more often, than their HIV negative peers (Hein & Dell, 1995; Naar-King, Wright et al., 2006; Rotheram-Borus et al., 1997). One study of 231 HIV positive gay and bisexual adolescents found that participants were younger than 15 years on average when they first had anal sex, and that their first sexual partner was generally more than 10 years older (average age 28 years) (Solorio et al., 2003, p. 86). Additionally some studies have noted a correlation between sex work, particularly street-based sex work, risky sexual behavior, and HIV. In these circumstances, young gay sex workers may lack the appropriate skills to negotiate condom use with clients, or may choose to avoid using condoms for additional money or to avoid conflicts with clients (Mustanski et al., 2011).

Some studies of adolescent and emerging adult gay and bisexual males have found that differences in HIV prevalence among various racial/ethnic groups could not be attributed to risky sexual behaviors (Garofalo et al., 2010; Solorio et al., 2003). One particular study that looked at sexual risk taking among a sample of 273 Black, Latino, and White HIV positive gay and bisexual young males found that among all three racial/ethnic groups, HIV was positively correlated with having older sexual partners, commercial sex, and sex with partners they met on the Internet (Garofalo et al., 2010). Studies have also shown that young, HIV positive gay males may generally have more difficulty negotiating safer sex or discussing HIV with sexual partners, especially within longer-term relationships (Bird, LaSala et al., 2017; Mustanski et al., 2011). These findings have implications for both the individual's health and for public health, as these risky sexual behaviors increase the possibility of transmission to others (Flicker et al., 2005; Naar-King, Wright et al., 2006).

## Substance Use and Sexual Risk Behaviors

To some extent, it is not uncommon for adolescents to experiment with drugs or engage in sexual activity or some degree of risky sex (i.e., intercourse with condoms), as a normal part of adolescent development and experimentation with new social roles and scripts (Voisin & Bird, 2012). However, gay HIV positive adolescent males may engage in higher rates of risky sex compared to their heterosexual counterparts. Researchers have theorized that health disparities among adolescents and emerging adult MSM are co-occurring and mutually reinforcing (Bruce et al., 2011). This theory of "syndemic production" of health disparities among MSM youth and emerging adults suggests that high rates of drug use, depression, and HIV infection are intertwined, and result from social marginalization. This is consistent with a minority stress model inferred from several sociological and social psychological theories (e.g., critical race theory, social stigma, stress theories) and may partly explain why gay adolescent males may engage in higher rates of drug and sexual risks behaviors. In addition, it may also partially explain why these young males persist in these risk behaviors after becoming infected. According to this theory, gay youth are isolated from social structures, norms, and institutions because of their sexual minority status (Mustanski, Garofalo, Herrick, & Donenberg, 2007). Given their marginalized status, gay adolescent males are subjected to greater societal stressors because dominant culture and social structures do not typically reflect or respond to the individual's needs or realities (Meyer, 2003), which may influence drug and sexual risks.

## Implications for Treatment and Intervention

Given the developmental and psychosocial needs of HIV positive gay adolescent males discussed earlier, we offer several treatment and intervention considerations. These recommendations are partly informed by the challenges addressed earlier in this chapter.

## Addressing Developmental Factors Associated with Change

According to the Information-Motivation-Behavioral (IMB) model of behavior change, the pathway to creating effective behavior change is to provide information about how HIV is transmitted, raise awareness about an individual's personal vulnerability to infection, teach safer sex skills, and engender the self-efficacy to use those skills (Fisher & Fisher, 2002). In the case of young, HIV positive gay males, providing information about how HIV is transmitted and raising awareness about vulnerability is essential but not sufficient for changing sexual risk-taking behavior

(Brown et al., 2000). It is equally important to attend to adolescent-specific factors, such as cognitive immaturity, exploratory learning behavior, and impulsivity (Brooks-Gunn, Boyer, & Hein, 1988; Brown, DiClemente, & Reynolds, 1991; Brown et al., 2000; Emans, Brown, Davis, Felice, & Hein, 1991; Irwin, Igra, Eyre, & Millstein, 1997), and seek to increase empathy and a sense of responsibility so that adolescents can better understand how their actions may impact the health and lives of their sexual partners (Brown et al., 2000).

## Access to Health Care and HIV Treatment

Access and adherence to HIV treatment is also a critical issue for young, HIV positive gay males as adolescents have unique treatment needs and preferences for health care services (O'Byrne & Watts, 2014). Appropriate adherence to HIV treatment is essential to improving the long-term health of young positive men and reducing secondary transmission. Research shows that HIV positive adolescents often experience problems obtaining adequate health care services, medication, and social services (Bell et al., 2003; Brown et al., 2000; Rotheram-Borus, O'Keefe, Kracker, & Foo, 2000). Prior research has also shown that many HIV positive adolescents did not receive age-specific HIV-related services (Hein & Dell, 1995), which poses implications for the provision of HIV care (Bouris et al., 2013).

Gay HIV positive adolescent males may also have unique barriers to accessing health care services and treatment (Flicker et al., 2004). First, they are a more hidden population often disenfranchised from larger social systems and more covert about their risk behaviors and sexual identities (Bell et al., 2003). Because of this, they may be harder to identify and enroll into needed medical and social services. Secondly, many of these youth may not have access to insurance or primary care services, and those who do have access are likely covered by their parents' insurance plans. This may present a double barrier for young gay males who are at risk of having to both disclose their HIV status and their sexuality and sexual behavior to parents or other caregivers in order to access health care.

Effective adherence is critical not only to the individual's health but also to public health, given recent findings that viral suppression through proper treatment adherence has the added benefit of reducing the transmissibility of HIV (referred to as "Treatment as Prevention"). For adults, poor adherence to HIV treatment has been linked to lower self-efficacy, the lack of social support, and psychological distress. Naar-King, Templin et al. (2006) found in a sample of HIV positive youth that the rate of adherence was not sufficient for effectively managing the disease, and that both self-efficacy and psychological distress were associated with lower adherence. While lack of social support was not directly related to lower adherence, it was associated with lower self-efficacy (Naar-King, Templin et al., 2006) and Radcliffe, Tanney, and Rudy (2006) found that the experience of trauma among HIV positive adolescents and young adults might adversely affect adherence to HIV treatment. Moreover, Benton (2010), in a review of the literature concerning mental

health issues affecting HIV positive children and adolescents, noted several studies that indicate the negative impact of mental health concerns, such as depression, on adherence. Given these barriers to access and challenges to adherence, it is important to design social service programs that help to identify HIV positive youth, increase social support, and decrease psychological distress in an effort to increase the effectiveness of treatment.

## Positive Coping

Despite the fact that adolescents and young adults are disproportionately affected by the HIV epidemic, there is still limited research on the unique influences that HIV infection has on the lives of HIV positive adolescents, or the ways that they learn to cope with the disease (Brown et al., 2000). Gay adolescents living with HIV experience a variety of complications, and their ability to cope with an HIV diagnosis and the ongoing aspects of the disease is influenced by the specific psychological stressors, personality factors, and access to social support of each individual. Poor coping skills are associated with a number of negative factors, including maladjustment to HIV infection, lower fighting spirit, hopelessness, fatalism and a preoccupation with mortality, anger, and the feeling of having loss of control over life events (Brown et al., 2000). These considerations, in turn, can have a deleterious impact on an individual's relationships with family and friends, academic achievement, and risk-taking behaviors. Conversely, positive psychological coping has been associated with feelings of empowerment, and beliefs about HIV presenting an opportunity to reevaluate life goals and make positive changes that enhance relationships and health (Flicker et al., 2005).

How young, HIV positive gay males learn to respond and adapt to HIV infection is critical to their success as a basis to not only remain healthy, but also to mitigate the risk of transmitting HIV to intimate partners. Building strong social support networks with parents, family members, close friends, romantic partners, and other HIV positive youth can be an extremely valuable strategy to buffering against some of the potentially negative mental health and psychosocial challenges of being HIV positive (Flicker et al., 2005; Lam et al., 2007).

Early intervention is critical to helping navigate these stressors and increasing positive coping skills. Since adolescence is a time when youth set lifelong health and behavioral patterns, providing guidance during this important stage is essential to ensuring more healthy adulthood functioning (Flicker et al., 2004). To accomplish this, an environment that works to mitigate the negative social challenges such as HIV-related and sexuality-based stigma and discrimination is needed. One strategy is to design age-appropriate, confidential, and structured programs within schools and at community-based organizations that provide social support (both around issues of sexuality and HIV infection), enhance coping skills, increase stability (e.g., housing, education, basic needs) (Flicker et al., 2005; Hein & Dell, 1995), and address typical and age-specific adolescent challenges (e.g., impulsivity)

(Brown et al., 2000). These programs need to be multi-pronged, aiming to address the interrelated risk factors faced by HIV positive adolescents by increasing youths' motivation to decrease sexual and drug-using risk behaviors (Hein & Dell, 1995); facilitating the use of protective health behaviors such as starting and maintaining HIV treatment adherence (Naar-King, Wright et al., 2006); and providing supportive services and access to medical care to improve the immediate health and control the progression of HIV for young gay and bisexual men. It is also important that programs be implemented at the school and broader community level to increase empathy around issues of HIV and actively work against discriminatory and stigmatizing messages that isolate and silence young LGBTQ individuals and young people who are HIV infected.

Finding ways to help HIV positive gay adolescents access and stay engaged in care and social services can help provide a stable, socially supported environment and an avenue through which they can address the different psychosocial challenges that may arise throughout adolescence (Bell et al., 2003). Yet, because HIV positive gay youths are a vulnerable, disenfranchised, and often hidden population, identifying who needs access to adequate services and interventions and retaining them in care can be a primary barrier (Bell et al., 2003; Hein & Dell, 1995). Intervening at the moment of testing may be a critical strategy to engage young, HIV positive gay males, and has the potential for shaping future health and risk behaviors. Project Engage is one example of an innovative network support intervention designed to link and keep newly diagnosed HIV positive Black male adolescent engaged in care (Bouris et al., 2013). Currently, we know that HIV treatment is another form of prevention, given that keeping viral loads undetectable can reduce the rates of transmission to sexual partners (Bell et al., 2003).

However, voluntary counseling and immediately referring to treatment may become more difficult as home HIV testing becomes standard and pre- and post-test counseling is de-emphasized in favor of increased speed and access to testing. These technological developments around home testing elevate the importance of embracing the use of new technologies to find HIV positive adolescents, provide supportive communities, and transmit health information. HIV positive youth increasingly feel comfortable with and rely upon the Internet to access a wide variety of resources specific to their needs (Flicker et al., 2004). The Internet appears to be an important tool regardless of socioeconomic status or other demographic factors such as age, gender, and race ethnicity (Flicker et al., 2004). However, while the Internet has proven useful for building supportive communities, it is not currently used as a primary source of information about health or ways to access information on HIV prevention (Voisin, Bird, Shi Shiu, & Kreiger, 2013). Leveraging the Internet to be a tool for advocacy, information seeking, and health promotion for young HIV positive gay and bisexual men may be essential, as it holds potential as a source where HIV positive gay adolescents could anonymously and comfortably access information and support with reduced fear of stigma and discrimination.

Finally, given the significance of education in the lives of all adolescents it is important to address the largely unmet sexual health education needs of gay male youth, especially given that an increasing number of these teens are becoming HIV

infected. A recent qualitative study of Black gay male youth illustrated the shortcomings of HIV education in school settings, with participants indicating that schools were not a significant source of HIV prevention information because sex education classes were primarily focused on pregnancy prevention, not STIs or HIV prevention. As a result, the sex education content received by these participants and their peers was mostly irrelevant to the needs and special challenges of gay youth (Voisin & Bird, 2012). This finding corroborates with prior results that document the inadequacy of school-based sexual health education in addressing the needs of gay youth (Kubicek, Beyer, Weiss, Iverson, & Kipke, 2010). In fact, the exclusion of same sex content in many sexual health curricula may reinforce a sense of alienation and "otherness," which may foster feelings of negative self-regard for some gay male youth and add to minority stress (Voisin et al., 2013).

Comprehensive sex education is critical to destigmatizing gay and HIV positive youth and decreasing rising HIV rates for this vulnerable population. Despite this need, there is a scarcity of LGBTQ-inclusive curricular content and a general lack of political will at the state level to enact such policies. Furthermore, even in school districts that promote HIV education, the curriculum is not often written for adolescents who are already living with HIV. This oversight represents a missed opportunity to provide a hard-to-reach population with health information and social support and dispel misinformation about HIV that leads to fear and stigma. Given this, it is time for the federal government to enact a comprehensive, national sex education policy that provides critical health information for all youth, including those who are gay and HIV positive. Such progressive actions at the federal level would send a strong message of support to gay adolescents living with HIV, affirming a national commitment to their health, inclusion, and well-being.

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## References

Agronick, G., O'Donnell, L., Stueve, A., San Doval, A., Duran, R., & Vargo, S. (2004). Sexual behaviors and risks among bisexually- and gay-identified young Latino men. *AIDS and Behavior*, *8*(2), 185–197.

Amaro, H., & Raj, A. (2000). On the margin: Power and women's HIV risk reduction strategies. *Sex Roles*, *42*(7/8), 723–749.

American Academy of Pediatrics (AAP). (2000). Education of children with human immunodeficiency virus infection. *Pediatrics*, *105*(6), 1358–1360.

American Psychiatric Association (APA). (2009). *Position statement on HIV and adolescents*. Retrieved from https://docs.google.com/viewer?a=v&q=cache:LQaqJz49L0EJ:www.psychiatry.org/File%2520Library/Advocacy%2520and%2520Newsroom/Position%2520Statements/ps2009_HIVadolescents.pdf+&hl=en&gl=us&pid=bl&srcid=ADGEESieyitZX9O_we7B7FJe8WJsqnQkhuyFl9RwVOEhr349X66I9iL15WfUz_6iwfMhXb79PubDu_5Ft6ycDeuBE4AIIsMS_WNQcKnvuBxWDMUDT3fKmnUIeC0mMp6iKRiKKK_V3w_r&sig=AHIEtbQRf_pZh5SJPUfgh0VNdg6mUqXllA.

Austin, S. B. (2012). Elevated risk of posttraumatic stress in sexual minority youths: Mediation by childhood abuse and gender nonconformity. *American Journal of Public Health*, *102*(8), 1587–1593.

Bauermeister, J. A., Johns, M. M., Sandfort, T. G., Eisenberg, A., Grossman, A. H., & D'Augelli, A. R. (2010). Relationship trajectories and psychological well-being among sexual minority youth. *Journal of Youth and Adolescence*, *39*(10), 1148–1163.

Bell, D., Martinez, J., Botwinick, G., Shaw, K., Walker, L., Dodds, S., & Siciliano, C. (2003). Case finding for HIV-positive youth: A special type of hidden population. *Journal of Adolescent Health*, *33*(2), 10–22.

Benton, T. D. (2010). Psychiatric considerations in children and adolescents with HIV/AIDS. *Child & Adolescent Psychiatric Clinics of North America*, *19*(2), 387–400.

Bird, J. D., Eversman, M., & Voisin, D. R. (2017). "You just can't trust everybody": the impact of sexual risk, partner type and perceived partner trustworthiness on HIV-status disclosure decisions among HIV-positive black gay and bisexual men. Culture, *health & sexuality, 19*(8), 829–843. DOI: 10.1080/13691058.2016.1267408

Bird, J. D. P., LaSala, M., Hidalgo, M., Kuhns, L., & Garofalo, R. (2017). "I had to go to the streets to get love": Pathways from parental rejection to HIV risk among young gay men. *Journal of Homosexuality*, *64*(3), 321–342.

Bird, J. D. P., & Voisin, D. (2013). "You're an open target to be abused": A qualitative study of stigma and HIV self-disclosure among black men who have sex with men. *American Journal of Public Health*, *103*(12), 2193–2199.

Bouris, A., Guilamo-Ramos, V., Pickard, A., Shiu, C., Loosier, P. S., Dittus, P., … Waldmiller, M. J. (2010). A systematic review of parental influences on the health and well-being of lesbian, gay, and bisexual youth: Time for a new public health research and practice agenda. *Journal of Primary Prevention*, *31*(5-6), 273–309.

Bouris, A., Voisin, D., Pilloton, M., Flatt, N., Eavou, R., Hampton, K.,… John A Schneider (2013). Project nGage: Network supported HIV care engagement for younger black men who have sex with men and transgender persons. *Journal of AIDS & Clinical Research, 4*. doi:10.4172/2155-6113.1000236, 04.

Bradley, B. J., & Greene, A. C. (2013). Do health and education agencies in the United States share responsibility for academic achievement and health? A review of 25 years of evidence about the relationship of adolescents' academic achievement and health behaviors. *Journal of Adolescent Health*, *52*, 523–532.

Branson, B., Handsfield, H., Lampe, M., Janssen, R., Taylor, A., Lyss, S., & Clark, J. (2006). Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *Morbidity & Mortality Weekly Report*, *55*, 752–783.

Brewster, K. L., & Tillman, K. H. (2012). Sexual orientation and substance use among adolescents and young adults. *American Journal of Public Health*, *102*(6), 1168–1176.

Brooks-Gunn, J., Boyer, C. B., & Hein, K. (1988). Preventing HIV infection and AIDS in children and adolescents: Behavioral research and intervention strategies. *American Psychologist*, *43*(11), 958–964.

Brown, L. K., DiClemente, R. J., & Reynolds, L. A. (1991). HIV prevention for adolescents: Utility of the health belief model. *AIDS Education and Prevention*, *3*(1), 50–59.

Brown, L. K., Lourie, K. J., & Pao, M. (2000). Children and adolescents living with HIV and AIDS: A review. *Journal of Child Psychology and Psychiatry*, *41*(1), 81–96.

Bruce, D., Harper, G. W., & Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN). (2011). Operating without a safety net: Gay male adolescents and emerging adults' experiences of marginalization and migration, and implications for theory of syndemic production of health disparities. *Health Education & Behavior*, *38*(4), 367–378.

Bruce, D., Harper, G. W., & Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN). (2012). Future life goals of HIV-positive gay and bisexual male emerging adults. *Journal of Adolescent Research*, *27*(4), 449–470.

Bryan, A. D., Schmiege, S. J., & Magnan, R. E. (2012). Marijuana use and risky sexual behavior among high-risk adolescents: Trajectories, risk factors, and event-level relationships. *Developmental Psychology*, *48*(5), 1429–1442.

Campbell, C., & Deacon, H. (2006). Unraveling the contexts of stigma: From internalization to resistance to change. *Journal of Community & Applied Social Psychology*, *16*(6), 411–417.

Centers for Disease Control and Prevention (CDC). (2008). HIV prevention education and HIV-related policies in secondary schools—selected sites, United States, 2006. *MMWR: Morbidity & Mortality Weekly Report*, *57*(30), 822–825.

Centers for Disease Control and Prevention (CDC). (2015). *HIV in the United States: At a glance*. Retrieved from http://www.cdc.gov/hiv/resources/factsheets/PDF/stats_basics_factsheet.pdf.

Centers for Disease Control and Prevention (CDC). (2016). *HIV among youth*. Retrieved from https://www.cdc.gov/hiv/group/age/youth/index.html.

Cohen, C. J. (1999). *The boundaries of blackness: AIDS and the breakdown of black politics*. Chicago, IL: University of Chicago Press.

Corliss, H. L., Goodenow, C. S., Nichols, L., & Austin, S. B. (2011). High burden of homelessness among sexual-minority adolescents: Findings from a representative Massachusetts high school sample. *American Journal of Public Health*, *101*(9), 1683–1689.

Corliss, H. L., Rosario, M., Wypij, D., Wylie, S. A., Frazier, A. L., & Austin, S. B. (2010). Sexual orientation and drug use in a longitudinal cohort study of U.S. adolescents. *Addictive Behaviors*, *35*(5), 517–521.

Cox, N. S. (2003). *School HIV/AIDS policy toolkit*. Madison, WI: Wisconsin Department of Public Instruction.

D'Augelli, A. R., Grossman, A. H., & Starks, M. T. (2006). Childhood gender a typicality, victimization, and PTSD among lesbian, gay, and bisexual youth. *Journal of Interpersonal Violence*, *21*(11), 1462–1482.

DeGroat, D. M. (2009). When students test positive, their privacy fails: The unconstitutionality of South Carolina's HIV/AIDS reporting requirement. *American University Journal of Gender, Social Policy & the Law*, *17*, 751–785.

Dowshen, N., Binns, H., & Garofalo, R. (2009). Experiences of HIV-related stigma among young men who have sex with men. *AIDS Patient Care and STDs*, *23*(5), 371.

Drumright, L. N., Patterson, T. L., & Strathdee, S. A. (2006). Club drugs as causal risk factors for HIV acquisition among men who have sex with men: A review. *Substance Use & Misuse*, *41*(10-12), 1551–1601.

Elford, J., & Hart, G. (2003). If HIV prevention works, why are rates of high-risk sexual behavior increasing among MSM? *AIDS Education and Prevention*, *15*(4), 294–308.

Emans, S. J., Brown, R. T., Davis, A., Felice, M., & Hein, K. (1991). Society for adolescent medicine position paper on reproductive health care for adolescents. *Journal of Adolescent Health*, *12*(8), 649–661.

Evatt, B. L. (2006). The tragic history of AIDS in the hemophilia population, 1982–1984. *Journal of Thrombosis and Haemostasis*, *4*(11), 2295–2301.

Fair, C., Garner-Edwards, D., & McLees-Lane, M. (2005). Assessment of HIV-related school policy in North Carolina. *Journal of HIV/AIDS & Social Services*, *4*(4), 47–63.

Fisher, J. D., & Fisher, W. A. (2002). The information-motivation-behavioral skills model. In R. J. DiClemente, R. A. Crosby, & M. C. Kegler (Eds.), *Emerging theories in health promotion practice and research: Strategies for improving public health* (pp. 40–70). San Francisco: Jossey-Bass.

Flicker, S., Goldberg, E., Read, S., Veinot, T., McClelland, A., Saulnier, P., & Skinner, H. (2004). HIV-positive youth's perspectives on the internet and ehealth. *Journal of Medical Internet Research*, *6*(3), e32.

Flicker, S., Skinner, H., Read, S., Veinot, T., McClelland, A., Saulnier, P., & Goldberg, E. (2005). Falling through the cracks of the big cities: Who is meeting the needs of HIV-positive youth? *Canadian Journal of Public Health*, *96*(4), 308–312.

Friedman, M. S., Marshal, M. P., Guadamuz, T. E., Wei, C., Wong, C. F., Saewyc, E. M., & Stall, R. (2011). A meta-analysis of disparities in childhood sexual abuse, parental physical abuse,

and peer victimization among sexual minority and sexual nonminority individuals. *American Journal of Public Health*, *101*(8), 1481–1494.

Galindo, G. R. (2013). A loss of moral experience: Understanding HIV-related stigma in the New York City house and ball community. *American Journal of Public Health*, *103*(2), 293–299.

Galliher, R. V., Rostosky, S. S., & Hughes, H. K. (2004). School belonging, self-esteem, and depressive symptoms in adolescents: An examination of sex, sexual attraction status, and urbanicity. *Journal of Youth and Adolescence*, *33*(3), 235–245.

Garofalo, R., Herrick, A., Mustanski, B., & Donenberg, G. R. (2007). Tip of the iceberg: Young men who have sex with men, the internet, and HIV risk. *American Journal of Public Health*, *97*, 1113–1117.

Garofalo, R., Mustanski, B., Johnson, A., & Emerson, E. (2010). Exploring factors that underlie racial/ethnic disparities in HIV risk among young men who have sex with men. *Journal of Urban Health*, *87*(2), 318–323.

Garofalo, R., Mustanski, B., McKirnan, D., Herrick, A., & Donenberg, G. (2007). Methamphetamine and young men who have sex with men: Understanding patterns and correlates of use and the association with HIV-related sexual risk. *Archives of Pediatrics & Adolescent Medicine*, *161*(6), 591–596.

Gates, G. J. (2011, April). *How many people are lesbian, gay, bisexual, and transgender?* Retrieved from http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf.

Halkitis, P. N., Brockwell, S., Siconolfi, D. E., Moeller, R. W., Sussman, R. D., Mougues, P. J., … Sweeney, M. M. (2011). Sexual behaviors of adolescent emerging and young adult men who have sex with men ages 13-29 in New York City. *Journal of Acquired Immune Deficiency Syndromes*, *56*, 285–291.

Halkitis, P. N., Kapadia, F., Siconolfi, D. E., Moeller, R. W., Figueroa, R. P., Barton, S. C., & Blachman-Forshay, J. (2013). Individual, psychosocial, and social correlates of unprotected anal intercourse in a new generation of young men who have sex with men in New York City. *American Journal of Public Health*, *103*, 889–895.

Halkitis, P. N., & Palamar, J. J. (2008). Club drug initiation: Multivariate modeling of club drug use initiation among gay and bisexual men. *Substance Use & Misuse*, *43*, 871–879.

Harper, G. W., Fernandez, I. M., Bruce, D., Hosek, S. G., Jacobs, R. J., & Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN). (2013). The role of multiple identities in adherence to medical appointments among gay/bisexual male adolescents living with HIV. *AIDS and Behavior*, *17*(1), 213–223.

Hein, K., & Dell, R. (1995). Comparison of HIV+ and HIV- adolescents: Risks factors and psychosocial determinants. *Pediatrics*, *95*(1), 96–104.

Herek, G. M. (2002). Thinking about AIDS and stigma: A psychologist's perspective. *Journal of Law, Medicine, and Ethics*, *30*, 594–607.

Herek, G. M. (2004). Beyond "homophobia": Thinking about sexual prejudice and stigma in the twenty-first century. *Sexuality Research & Social Policy*, *1*(2), 6–24.

Hightow-Weidman, L. B., Phillips, G., II, Outlaw, A. Y., Wohl, A. R., Fields, S., Hildalgo, J., & LeGrand, S. (2013). Patterns of HIV disclosure and condom use among HIV-infected young racial/ethnic minority men who have sex with men. *AIDS and Behavior*, *17*(1), 360–368.

House Bill 2. (2016). Retrieved from http://www.ncleg.net/sessions/2015e2/bills/house/pdf/h2v4.pdf.

Hussen, S. A., Chahroudi, A., Boylan, A., Camacho-Gonzalez, A. F., Hackett, S., & Chakraborty, R. (2015). Transition of youth living with HIV infection pediatric to adult-centered healthcare: A review of the literature. *Future Virology*, *9*, 921–929.

Hussen, S. A., Harper, G. W., Bauermeister, J. A., Hightow-Weidman, L. B., & Adolescent Medicine Trials Network for HIV/AIDS Interventions. (2015). Psychosocial influences on engagement in care among HIV-positive young black gay/bisexual and other men who have sex with men. *AIDS Patient Care & STDs*, *29*, 77–85.

Institute of Medicine of the National Academies (IOM). (2011). Childhood/adolescence. In *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding* (pp. 141–184). Washington, DC: The National Academies Press.

Irwin, C. E., Igra, V., Eyre, S., & Millstein, S. (1997). Risk-taking behavior in adolescents: The paradigm. *Annals of New York Academy of Sciences*, *817*, 1–35.

Jeffries, W. L., 4th, Townsend, E. S., Gelaude, D. J., Torrone, E. A., Gasiorowicz, M., & Bertolli, J. (2015). HIV stigma experienced by young men who have sex with men (MSM) living with HIV infection. *AIDS Education and Prevention*, *27*, 58–71.

Kalichman, S. C., DiMarco, M., Austin, J., Luke, W., & Di-Fonzo, K. (2003). Stress, social support, and HIV-status disclosure to family and friends among HIV-positive men and women. *Journal of Behavioral Medicine*, *26*, 315–332.

Karon, J., Fleming, P., Steketee, R., & De Cock, K. (2001). HIV in the united states at the turn of the century: An epidemic in transition. *American Journal of Public Health*, *91*(7), 1060–1068.

Kingdon, M. J., Storholm, E. D., Halkitis, P. N., Jones, D. C., Moeller, R. W., Siconolfi, D., & Solomon, T. M. (2013). Targeting HIV prevention messaging to a new generation of gay, bisexual, and other young men who have sex with men. *Journal of Health Communication*, *18*, 325–342.

Klitzman, R. L., Greenberg, J. D., Pollack, L. M., & Dolezal, C. (2002). MDMA ('ecstasy') use, and its association with high risk behaviors, mental health, and other factors among gay/bisexual men in New York city. *Drug and Alcohol Dependence*, *66*, 115–125.

Kubicek, K., Beyer, W. J., Weiss, G., Iverson, E., & Kipke, M. D. (2010). In the dark: Young men's stories of sexual initiation in the absence of relevant sexual health information. *Health Education & Behavior*, *37*(2), 243–263.

Lam, P. K., Naar-King, S., & Wright, K. (2007). Social support and disclosure as predictors of mental health in HIV-positive youth. *AIDS Patient Care and STDs*, *21*(1), 20–29.

Lange, T. (2003). *HIV and civil rights*. New York: ACLU AIDS Project. Retrieved from http://www.aclu.org/pdfs/hivaids/hiv_civilrights.pdf.

Lusher, J. M., & Brownstein, A. P. (2007). HIV and hemophilia. *Journal of Thrombosis and Haemostasis*, *5*(3), 609–610.

Lynch, A. D., Lerner, R. M., & Leventhal, T. (2013). Adolescent academic achievement and school engagement: An examination of the role of school-wide peer culture. *Journal of Youth and Adolescence*, *42*(1), 6–19.

Marcia, J. (1980). Identity in adolescence. In J. Adelson (Ed.), *Handbook of adolescent psychology* (pp. 159–187). Hoboken, NJ: Wiley & Sons.

Marshal, M. P., Dietz, L. J., Friedman, M. S., Stall, R., Smith, H. A., McGinley, J., … Brent, D. A. (2011). Suicidality and depression disparities between sexual minority and heterosexual youth: A meta-analytic review. *Journal of Adolescent Health*, *49*(2), 115–123.

Marshal, M. P., Friedman, M. S., Stall, R., & Thompson, A. L. (2009). Individual trajectories of substance use in lesbian, gay, and bisexual youth and heterosexual youth. *Addiction*, *104*, 974–981.

Mawar, N., Sahay, S., Pandit, A., & Mahajan, U. (2005). The third phase of HIV pandemic: Social consequences of HIV/AIDS stigma & discrimination & future needs. *Indian Journal of Medical Research*, *122*(6), 471–484.

McDowell, T. L., & Serovich, J. M. (2007). The effect of perceived and actual social support on the mental health of HIV+ individuals. *AIDS Care*, *19*, 1223–1229.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674–697.

Murphy, D., Roberts, K., Marelich, W., & Hoffman, D. (2000). Barriers to antiretroviral adherence among HIV-infected adults. *AIDS Patient Care*, *14*, 47–58.

Murrill, C. S., Weeks, H., Castrucci, B. C., Weinstock, H. S., Bell, B. P., Spruill, C., & Gwinn, M. (2002). Age-specific seroprevalence of HIV, hepatitis B virus, and hepatitis C virus infection among injection drug users admitted to drug treatment in 6 US cities. *The American Journal of Public Health*, *92*(3), 385–387.

Mustanski, B., Garofalo, R., Herrick, A., & Donenberg, G. (2007). Psychosocial health problems increase risk for HIV among urban young men who have sex with men: Preliminary evidence of a syndemic in need of attention. *Annals of Behavioral Medicine*, *34*(1), 37–45.

Mustanski, B., Newcomb, M., Du Bois, S., Garcia, S., & Grov, C. (2011). HIV in young men who have sex with men: A review of epidemiology, risk and protective factors, and interventions. *Journal of Sex Research*, *48*(2-3), 218–253.

Naar-King, S., Templin, T., Wright, K., Frey, M., Parsons, J., & Lam, P. (2006). Psychosocial factors and medication adherence in HIV-positive youth. *AIDS Patient Care and STDs*, *20*(1), 44–47.

Naar-King, S., Wright, K., Parsons, J., Frey, M., Templin, T., Lam, P., & Murphy, D. (2006). Healthy choices: Motivational enhancement therapy for health risk behaviors in HIV-positive youth. *AIDS Education & Prevention*, *18*(1), 1–11.

National Association of State Boards of Education (NASBE). (2012). *State school healthy policy database*. Retrieved from http://nasbe.org/healthy_schools/hs/bytopics.php?topicid=5110&catExpand=acdnbtm_catE.

Newcomb, M. E., Clerkin, E. M., & Mustanski, B. (2011). Sensation seeking moderates the effects of alcohol and drug use prior to sex on sexual risk in young men who have sex with men. *AIDS and Behavior*, *15*, 565–575.

O'Byrne, P., & Watts, J. (2014). Include, differentiate and manage: Gay male youth, stigma and healthcare utilization. *Nursing Inquiry*, *21*(1), 20–29. doi:10.1111/nin. 12014

Ott, M. Q., Wypij, D., Corliss, H. L., Rosario, M., Reisner, S. L., Gordon, A. R., & Austin, S. B. (2013). Repeated changes in reported sexual orientation identity linked to substance use behaviors in youth. *Journal of Adolescent Health*, *52*(4), 465–472.

Outlaw, A. Y., Phillips, G., Hightow-Weidman, L. B., Fields, S. D., Hidalgo, J., Halpern-Felsher, B., & Green-Jones, A. (2011). Age of MSM sexual debut and risk factors: Results from a multisite study of racial/ethnic minority YMSM living with HIV. *AIDS Patient Care & STDs*, *25*, S23–S29.

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science & Medicine*, *57*(1), 13–24.

Pearson, J., Muller, C., & Wilkinson, L. (2007). Adolescent same-sex attraction and academic outcomes: The role of school attachment and engagement. *Social Problems*, *54*(4), 523–542.

Pulerwitz, J., Amaro, H., Jong, W. D., Gortmaker, S. L., & Rudd, R. (2002). Relationship power, condom use and HIV risk among women in the USA. *AIDS Care*, *14*(6), 789–800.

Radcliffe, J., Tanney, M., & Rudy, B. J. (2006). Post-traumatic stress and adherence to medical treatment among youth with HIV. *Journal of Adolescent Health*, *38*(2), 110–111.

Rao, D., Kekwaletswe, T., Hosek, S., Martinez, J., & Rodriguez, F. (2007). Stigma and social barriers to medication adherence with urban youth living with HIV. *AIDS Care*, *19*(1), 28–33.

Remafedi, G., Farrow, J. A., & Deisher, R. W. (1991). Risk factors for attempted suicide in gay and bisexual youth. *Pediatrics*, *87*(6), 869–875. Retrieved from http://www.psych.org/advocacy--newsroom/position-statements.

Rind, B. (2001). Gay and bisexual adolescent boys' sexual experiences with men: An empirical examination of psychological correlates in a nonclinical sample. *Archives of Sexual Behavior*, *50(4)*, 345–368.

Roberts, A. L., Rosario, M., Slopen, N., Calzo, J. P., & Austin, S. B. (2013). Childhood gender nonconformity, bullying victimization, and depressive symptoms across adolescence and early adulthood: An 11-year longitudinal study. *Journal of the American Academy of Child and Adolescent Psychiatry*, *52*(2), 143–152.

Rosario, M., Schrimshaw, E. W., & Hunter, J. (2010). Different patterns of sexual identity development over time: Implications for the psychological adjustment of lesbian, gay, and bisexual youths. *Journal of Sex Research*, *48*(1), 3–15.

Rosario, M., Schrimshaw, E. W., & Hunter, J. (2012). Homelessness among lesbian, gay, and bisexual youth: Implications for subsequent internalizing and externalizing symptoms. *Journal of Youth and Adolescence*, *41*(5), 544–560.

Rotheram-Borus, M. J., Murphy, D. A., Coleman, C. L., Kennedy, M., Reid, H. M., Cline, T. R., … Kipke, M. (1997). Risk acts, health care, and medical adherence among HIV+ youths in care over time. *AIDS and Behavior*, *1*(1), 43–52.

Rotheram-Borus, M. J., O'Keefe, Z., Kracker, R., & Foo, H. (2000). Prevention of HIV among adolescents. *Prevention Science*, *1*(1), 15–30.

Russell, S. T., Ryan, C., Toomey, R. B., Diaz, R. M., & Sanchez, J. (2011). Lesbian, gay, bisexual, and transgender adolescent school victimization: Implications for young adult health and adjustment. *Journal of School Health*, *81*(5), 223–230.

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, *123*(1), 346–352.

Salomon, E., Mimiaga, M., Husnik, M., Welles, S., Manseau, M., Montenegro, A., … Mayer, K. (2009). Depressive symptoms, utilization of mental health care, substance use and sexual risk among young men who have sex with men in EXPLORE: Implications for age-specific interventions. *AIDS and Behavior*, *13*(4), 811–821.

Schellenberg, E. G., Keil, J. M., & Bem, S. L. (1995). "innocent victims" of AIDS: Identifying the subtext. *Journal of Applied Social Psychology*, *25*(20), 1790–1800.

Serovich, J. M., & Grafsky, E. L. (2011). Does family matter to HIV-positive men who have sex with men? *Journal of Marital and Family Therapy*, *37*(3), 290–298.

Shilts, R. (1988). *And the band played on: Politics, people, and the AIDS epidemic*. New York, NY: Penguin Books.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: The National Academy of Sciences Press.

Solorio, R., Swendeman, D., & Rotheram-Borus, M. J. (2003). Risk among young gay and bisexual men living with HIV. *AIDS Education and Prevention*, *15*(1_supplement), 80–89.

Spear, H. J., & Kulbok, P. (2004). Autonomy and adolescence: A concept analysis. *Public Health Nursing*, *21*(2), 144–152.

Steinberg, L., & Morris, S. A. (2001). Adolescent development. *Annual Review of Psychology*, *52*, 83–110.

Stueve, A. A., O'Donnell, L. L., Duran, R. R., Doval, A. S., Geier, J. J., & Community Intervention Trial for Youth Study. (2002). Being high and taking sexual risks: Findings from a multisite survey of urban young men who have sex with men. *AIDS Education and Prevention*, *14*, 482–495.

Tharinger, D., & Wells, G. (2000). An attachment perspective on the developmental challenges of gay and lesbian adolescents: The needs for continuity of caregiving from family and schools. *School Psychology Review*, *29*(2), 158–172.

The Center for HIV Law & Policy. (n.d.). *Teen SENSE: Model sexual health education standards for youth in state custody*. Retrieved from http://www.hivlawandpolicy.org/public/initiatives/teensense.

Thiede, H., Valleroy, L., MacKellar, D., Celentano, D., Ford, W., Hagan, H., & Torian, L. (2003). Regional patterns and correlates of substance use among young men who have sex with men in 7 U.S. urban areas. *American Journal of Public Health*, *93*(11), 1915–1921.

Tillfors, M., Persson, S., Willén, M., & Burk, W. J. (2012). Prospective links between social anxiety and adolescent peer relations. *Journal of Adolescence*, *35*(5), 1255–1263.

Tolman, D. L., & McClelland, S. I. (2011). Normative sexuality development in adolescence: A decade in review, 2000–2009. *Journal of Research on Adolescence*, *21*(1), 242–255.

Traube, D. E., Schrager, S. M., Holloway, I. W., Weiss, G., & Kipke, M. D. (2012). *Environmental risk, social cognition, and drug use among young men who have sex with men: Longitudinal effects of minority status on health processes and outcomes*. Drug and Alcohol Dependence. Retrieved from http://www.sciencedirect.com/science/article/pii/S0376871612002244.

U.S. Department of Justice (n.d.). *Questions and answers: The Americans with disabilities act and persons with HIV/AIDS.* Retrieved from http://www.ada.gov/archive/hivqanda.txt.

Uris, P. (1996). *Recommendations for the school health nurse in addressing HIV/AIDS with adolescents. (nurses campaign for public health)*. Washington, DC: American Nurses Association.

Voisin, D., & Bird, D. (2012). "you get more respect," reasons for sex among African American youth. *Journal of Social Service Research*, *38*(3), 392–401.

Voisin, D., Bird, J., Shi Shiu, C., & Kreiger, C. (2013). "It's crazy being a black and gay youth." getting information about HIV prevention: A pilot study. *Journal of Adolescence*, *36*(1), 111–119.

Weiner, L. S., Battles, H. B., & Heilman, N. (2000). Public disclosure of a child's HIV infection: Impact on children and families. *AIDS Patient Care and STDs*, *14*(9), 485–497.

White House Office of National AIDS Policy. (2010). *National HIV/AIDS strategy for the United States*. Retrieved from http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf.

Wilson, B. D., Harper, G. W., Hidalgo, M. A., Jamil, O. B., Torres, R. S., & Fernandez, M. I. (2010). Negotiating dominant masculinity ideology: Strategies used by gay, bisexual and questioning male adolescents. *American Journal of Community Psychology*, *45*(1-2), 169–185.