Chapter 9
Working with Asian American/Pacific Islander Gay Men Living with HIV/AIDS: Promoting Effective and Culturally Appropriate Approaches

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Introduction

Many scholars have contended that research focusing on lesbian, gay, bisexual, transgender, and queer (LGBTQ) issues tends to exclude the experiences of LGBTQ persons of color, particularly LGBTQ Asian Americans and Pacific Islanders (AAPIs) (Chan, 1989, 1992, 1995; Chung & Szymanski, 2006; Nadal, 2010; Nadal & Corpus, 2012). Specifically, while there has been an increase in literature focusing on White gay men, African American gay men, and Latino gay men, there has been a dearth of research concentrating on the experiences of Asian American gay men (Nadal, 2010; Nadal & Corpus, 2012). Furthermore, some scholars have described how studies pertaining to LGBTQ AAPIs and other people of color tend to emphasize the "deficit model" (i.e., focusing primarily on the negative aspects of LGBTQ AAPIs' and other people of color's experiences), instead of focusing on macro-level and sociopolitical experiences that influence LGBTQ mental health, physical health, and behaviors (Akerlund & Chung, 2000). Accordingly, the experiences of AAPI gay men tend to be marginalized in the academic literature in general, resulting in practitioners' and educators' inability to work with this population in effective or culturally competent ways. Second, an overemphasis is placed on the shortcomings or faults of AAPI gay men, often resulting in the pathologizing of their experiences, instead of highlighting the group's strengths and potential for optimal physical and mental health.

The purpose of this chapter is to describe the experiences of AAPI gay men living with HIV/AIDS. First, we will introduce fundamental information about the AAPI

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population, which will be followed by a discussion about the various factors that may impact AAPI gay men's identity development and mental health. Then, we will provide current epidemiological findings involving gay men living with HIV and AIDS, as well as the types of experiences that this community may face in their everyday lives. Finally, we will conclude with recommendations for providing effective and culturally appropriate approaches in working with Asian American/Pacific Islander gay men living with HIV and AIDS.

Who Are Asian Americans and Pacific Islanders?

Before we describe the experiences of AAPI gay men, it is necessary to first understand who is included in the AAPI population. The term "Asian American" refers to persons who have common ancestral roots in Asia and the Pacific Islands, with a similar physical appearance and cultural values. The Asian American racial category comprises of over 40 distinct ethnicities, which may include Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, Hmong, and Cambodian. While Pacific Islanders are separated from Asian Americans in the US Census, they are often lumped into this category when discussing multicultural issues, forming broader racial categorizations such as "Asian/Pacific Islander" (or API), "Asian Americans/Pacific Islanders" (or AAPI), or "Asian Pacific Americans" (or APA).

According to the 2010 US Census, Asian Americans are the fastest growing racial/ethnic minority group in the USA (Hoeffel, Rastogi, Kim, & Shahid, 2012). As a group, Asian Americans have multiplied eightfold from 1.4 million in 1970 to 11.9 million in 2000, and are projected to increase to 20 million by 2020 (Nadal & Sue, 2009). In fact, the Asian population grew faster than any other racial group in the USA between 2000 and 2010, increasing by 43% from 10.2 million to 14.7 million (Hoeffel et al., 2012). Meanwhile, the 2010 Census revealed that the Native Hawaiian and other Pacific Islander populations increased three times faster than the general US population, resulting in a population of 540,000 people (Hixson, Hepler, & Kim, 2012). According to the 2010 US Census, the largest ethnic group within the Asian American population is Chinese American, with 3.7 million individuals in the USA, which is followed by Filipino Americans (3.4 million), Asian Indian (3.1 million), Vietnamese Americans (1.7 million), and Korean Americans (1.7 million). Nearly half of the population lived on the West Coast, while 22% lived in the South, 20% in the Northwest, and 12% in the Midwest (Hoeffel et al., 2012). Asian Americans also contribute greatly to immigration to the USA, accounting for one-third of all arrivals since the 1970s (Nadal & Sue, 2009).

Based on this population data, it is critical to note the heterogeneity of the AAPI community. First, there are hundreds of languages within the AAPI population, including Tagalog, Farsi, Cantonese, Mandarin, Vietnamese, and Japanese. Second, there are over 20 major religions within the Asian American racial group, including Buddhism, Sikhism, Hinduism, Taoism, Confucianism, and Christianity. Third, there are many physical differences between the major Asian subgroups.

For example, while East Asians (e.g., Chinese, Japanese, and Korean) may have a lighter peach skin tone and smaller eyes, Filipino Americans and Southeast Asians (e.g., Vietnamese, Cambodian, Laotian) may have a light to dark brown skin tone, and South Asians (e.g., Asian Indians, Pakistanis) may have a very dark brown skin tone and larger eyes. Because of this heterogeneity and lack of cohesion between Asian countries, it is common for Asian Americans to identify in terms of their ethnicity (e.g., "Indian," "Filipino," "Korean"), instead of the broader racial category of Asian or Asian American (Nadal & Sue, 2009). As a result, some individuals may not be included in AAPI statistics, may purposefully separate themselves from the pan-ethnic AAPI community and associate only with others in their ethnic group. Importantly, research which makes broad generalizations about AAPIs may not reflect the identities and experiences of all people who would fit under the racial umbrella.

Furthermore, it is important to note that because of different historical, religious, and colonial experiences in their home countries, Asian Americans may prescribe to various cultural worldviews and values. Asian and Asian American ethnic groups may have a range of common cultural values (e.g., collectivism, saving face, emphasis on family), while the unique sociohistorical experiences of each Asian ethnic group will influence these values. For instance, because of English colonization on India and Spanish/American colonization on the Philippines, these two ethnic groups may have both similar and unique cultural values than groups like Chinese or Japanese Americans who may be more heavily influenced by Buddhist or Confucian teachings (Nadal, 2011; Nadal & Sue, 2009).

Asian Americans and Gender Roles

In order to understand AAPI gay men, it is first important to understand how gender is generally conceptualized and understood in AAPI cultures. While gender is defined as "a socially constructed identity that is usually determined by one's biological sex (or whether one has male or female reproductive organs" (Nadal, 2013, p. 35), gender roles are "expectations defined within specific societies and cultures about culturally appropriate behaviors, norms, and values for men and women, based on gender" (Nadal, 2013, p. 35). Gender roles are derived from a spectrum of factors, including (a) traditional gender stereotypes; (b) messages about dress and clothing; (c) messages about career choices or family roles; and (d) expectations of personality, traits, interests, or behaviors. Across AAPI ethnic groups, there are some similarities in the ways that gender roles and sexuality are constructed. First, in terms of gender, Asian American families tend to assign men a higher status as compared with women, give older generations an elevated status, and designate the father as the dominant member of the household with unquestioned authority (Tewari & Alvarez, 2009). For example, in some Asian countries, there has been a history of "son preference," in which male babies are considered a prize because they can continue on the family name and legacy, while female babies are considered a

burden because they cannot (Chung, 2007; Mahalingam & Balan, 2008). As a result, boys and men may learn that there is an expectation to continue on the family name and legacy; bring honor to the family; and to be dominant and strong members in their families. When boys and men who do not assume traditional gender roles that are prescribed in their families and communities (e.g., individuals who identify as gay), they may experience gender role conflict, often resulting in varying amounts of psychological distress (Nadal, 2010).

There are also many ways that gender role expectations manifest differently for the various Asian American ethnic groups. For example, some scholars have asserted that Chinese and Chinese American gender roles emphasize the dominance of males and the submissiveness or obedience of women (Chia, Moore, Lam, & Chuang, 1994). Conversely, Filipinos and Filipino Americans tend to have a more complex experience with gender role expectations (Nadal & Corpus, 2012). First, the Philippines advocates for a gender-neutral society, in which women are encouraged to succeed in careers as much as men, and in which women are often the leaders, disciplinarians, and financial decision-makers in the family. In fact, the Philippines was one of the few Asian countries to elect a woman as president. However, as a result of Spanish colonization, Filipino men are still taught to be ultramasculine and Filipina women are taught to be ultrafeminine (Nadal & Corpus, 2012). Accordingly, Filipino and Filipino Americans may learn messages about gender that are both similar and unique to other Asian Americans.

Furthermore, in Asian and Asian American cultures, it is quite common for gender, gender identity, and sexuality to be used interchangeably (Jackson, 1999; Nadal & Corpus, 2012). For instance, in Thailand, there is a strong presence of "ladyboys" or *kathoey* (drag queens, cross-dressers, transgender male-to-female) who are often viewed as sexual objects who work as entertainers or commercial sex workers (Jackson, 1999). As a result, many Thai people (and people of other Asian countries) may assume that all gay men are feminine and identify as transgender women, or both. Perhaps one reason why AAPI men who have sex with men (MSM) may not identify with the terms "gay" or "bisexual" is because they view themselves as masculine and as "real" men, assuming that gay men must behave otherwise.

Asian Americans and Sexual Orientation Identity

Some scholars have described the psychological stressors that AAPI gay men may experience as a result of their intersectional identities (i.e., the intersection of their sexual orientation, racial, ethnic identities). First, many studies support that Asian Americans and other LGBTQ persons of color are often forced and/or expected to choose between their racial/ethnic identity (e.g., Asian American, Cambodian American) and sexual orientation identity (e.g., gay or lesbian). Previous authors have revealed that individuals may desire to identify with both their racial/ethnic and sexual orientation identities, but may struggle because they feel negative repercussions from both of their groups (Chan, 1989, 1992, 1995; Nadal & Corpus, 2012;

Operario, Han, & Choi, 2008). Moreover, many studies have found that it was common for LGBTQ Asian Americans to be the subject of racial stereotyping in general LGBTQ social circles, while enduring homophobia in their ethnic families and communities (Han, 2008; Nadal & Corpus, 2012).

Regarding sexual orientation identity development, there are myriad ways that identity development processes may be different for AAPI gay men. First, while numerous Western/American models of sexual orientation identity development label the "coming out" process as an imperative, developmental stage for gay/bisexual individuals (Nadal, 2010), many LGBTQ people of color (particularly those from immigrant communities) may view coming out (or announcing one's sexual orientation to one's family and friends) as superfluous and unnecessary (Chan, 1989, 1992, 1995; Nadal, 2010; Nadal & Corpus, 2012). Many LGBTQ individuals may not feel the need to officially proclaim their sexual orientation for numerous reasons, including the desire to avoid family conflict or the resentment that heterosexuals do not have to proclaim their sexualities (Nadal, 2010).

For AAPI gay men, there is an array of real or perceived repercussions that may occur if one chooses to "come out" in traditional Western/American ways. Previous research has indicated that many Asian Americans may hide their sexual identities from their families and communities because of the shame that accompanies it (Chan, 1989, 1992, 1995; Nadal & Corpus, 2012; Operario et al., 2008). Shame may impact LGBTQ children who do not want to disgrace or dishonor their family, while also affecting parents of LGBTQ people who fear that they may be blamed for not raising their child heterosexual (Chan, 1992; Operario et al., 2008). Similarly, open disclosure about one's sexual orientation for AAPI gay men may also be viewed as disrespectful because in doing so, one is openly announcing that he is rejecting one's traditional gender roles (Chan, 1992). As a result, many AAPI gay men may maintain a "public self" and a "private self" (Chan, 1995); the public self is one that is revealed to one's family and ethnic community, while the private self is reserved for the individual's personal life and intimate social circles.

Religion may also be a major factor that may prevent many AAPI gay men from accepting their sexual orientation identities. Most Asian countries have had a strong presence of organized religion in their histories and cultures. For example, Hinduism is widespread in India, Buddhism is prevalent in Thailand, Islam is customary in Indonesia, and Christianity is present in Korea (Chung & Singh, 2008). Each of these religions promotes varying levels of negative teachings of homosexuality and bisexuality, which may further result in AAPI gay men resisting their true sexual orientation identities.

Current Findings of AAPI Gay Men Living with HIV/AIDS

Now that we have provided a contextualized scope of some of the core experiences of AAPI gay men's communities, we will now describe how HIV/AIDS has affected AAPI gay men as well as AAPI MSM. At mere surface glance, the epidemiological

profile of HIV/AIDS in the USA indicates a low prevalence in AAPI communities. In 2015, AAPIs had the lowest rates of HIV/AIDS out of all racial minority groups, comprising only 5.5% for every 100,000 cases (Centers for Disease Control and Prevention [CDC], 2017). For Black/African Americans, the rates were 44.3%, rates for people of multiple races were 12.2%, rates for Latino/as were 16.4%, rates for Native Hawaiians/other Pacific Islanders were 14.1%, rates for American Indians/Alaska Natives were 8.8%, and rates for Whites were 5.3% (CDC, 2017). There have been several studies that have found that HIV prevalence estimates among the AAPI MSM population to be quite low. For instance, a CDC (2008a) report on new infections found that only 2% of AAPIs were infected with HIV/AIDS. Studies that included AAPI MSM participants listed HIV prevalence rates for this group as between 6 and 10% (Catania et al., 2001; Nemoto, Iwamoto, Kamitani, Morris, & Sakata, 2011; Raymond & McFarland, 2009). For young AAPI MSM (i.e., individuals between 18 and 29 years old), HIV/AIDS prevalence estimates have been recorded as low as 2.6% (Choi et al., 2004; Do et al., 2005).

Despite this low prevalence, there are many studies that have suggested that HIV/AIDS is still a considerable problem in the AAPI community. First, an analysis from 2001 to 2008 showed that Asian Americans and Pacific Islanders had the highest HIV incidence rates in the nation (at 4.4%), representing the only statistically significant growth among any racial or ethnic group in the same time period; in fact, the HIV incidence rate actually declined for several of the other racial groups (Adih, Campsmith, Williams, Hardnett, & Hughes, 2011). The CDC (2006) found that from 2001 to 2004, AAPIs had the highest estimated annual percentage increase in HIV/AIDS diagnosis rates of all race/ethnicities, particularly for AAPI women (34.5% for males and 68% for females). Two years later, the CDC (2008b) reported that from 2001 to 2006, the largest proportionate increase in HIV/AIDS diagnosis rates (255.6%) was with AAPI MSM aged 13–24 years. More recently, the CDC (2017) reported that while the total number of reported AIDS cases has generally declined over the past 5 years for the White population, it has increased for Asian Americans.

Despite these numbers, AAPIs are still stereotyped as being unaffected by the HIV/AIDS epidemic in comparison to how other communities of color are perceived as being affected by the disease (Sabato & Silverio, 2010). As a result, the funding of HIV/AIDS prevention campaigns, education programs, and research studies for AAPIs has been inadequate. One reason for this lack of advocacy for AAPIs is based on the Model Minority Myth (Sabato & Silverio, 2010). The Model Minority Myth, which contends that Asian Americans are well-educated, successful, and law-abiding citizens in the USA (Nadal & Sue, 2009; Wu, 2003), is problematic for several reasons. First, the myth presumes that every person under the AAPI umbrella is the same; so while there are some parts of the AAPI community that fit the stereotype of the "Model Minority," there are many Asian American subgroups (e.g., Southeast Asians, Filipino Americans, LGBTQ AAPIs) who experience a multitude of health, sociocultural, and educational inequalities that are quite contrary to the myth. Furthermore, the myth perpetuates tensions between AAPIs and other people of color groups. For instance, African Americans are often compared

to AAPIs, being told that they need to "work hard" like the Asian Americans; as a result, racial tensions may arise between the two groups. At the same time, AAPIs may be commended for being the "model" which in turn may create a perceived racial hierarchy and discrimination between Asian Americans and other people of color. Finally, regarding HIV/AIDS and other health-related disparities, the myth often creates the view that because many AAPIs are financially successful and educated that they do not experience health problems (including becoming infected with HIV/AIDS).

One of the main reasons for the low HIV/AIDS prevalence and high incidence relates to the cultural stigma among AAPIs. Because of the shame and silence among AAPI communities, many AAPI individuals may experience a lack of access to HIV testing, education, and prevention services (Sabato & Silverio, 2010). In fact, nearly two-thirds of Asian Americans and over 70% of Pacific Islanders have never tested for HIV, and AAPIs have the lowest HIV testing rates of all races and ethnicities (Schiller, Lucas, Ward, and Peregoy, 2012). Some researchers even estimate that one in three AAPIs who are living with HIV/AIDS is undiagnosed (Campsmith, Rhodes, Hall, & Green, 2010). Cultural factors may influence the lack of HIV testing for both heterosexual and LGBTQ AAPIs; some studies have found that AAPIs may delay testing and treatment for fear of bringing shame to one's self and one's family, as well as being disowned from one's family because of the stigma of HIV/AIDS (Sabato & Silverio, 2010). Based on these sociocultural factors, low HIV testing rates and increasing HIV incidence among AAPIs suggests that the rates of HIV/AIDS in this community are likely to be higher than currently documented.

Some research has also found that when AAPIs have HIV testing, it is usually at a late stage in the disease's progression, often resulting in an AIDS diagnosis (Wong, Nehl, Han et al., 2012). Another study found that many Asian American MSM participants were diagnosed with HIV/AIDS at later stages, because they never were tested for HIV, citing that some of the reasons for avoiding being tested included perceived low risk, fear of results, and fear of needles (Do et al., 2005). Taken together, while AAPIs have low HIV testing rates, when they do get tested, this often results in a more accelerated progression to AIDS, which, in turn, affects their opportunities for treatment and care.

There are many barriers facing AAPI communities that provide reasons for the prevalence of HIV/AIDS. Because of the lack of culturally sensitive and language appropriate media campaigns, outreach material, and trained clinical staff, there is a lack of access to HIV/AIDS prevention, testing, and education services among AAPI communities (Sabato & Silverio, 2010). In addition, many states with considerable AAPI populations have not included Asians or Pacific Islanders in their HIV surveillance reports. For example, according to the CDC (2008b), California only began including AAPIs in their HIV surveillance reports within the past few years. Furthermore, medical professionals who misclassify the race and ethnicity of AAPI patients in medical record intakes contribute to the underreporting of HIV/AIDS of AAPI people (Zaidi et al., 2005). Finally, because HIV researchers tend not to disaggregate AAPI data, there is very little known about AAPI ethnic groups.

Given that there is a vast range of health, educational, and sociocultural disparities that affect different AAPI ethnic groups (Nadal, 2011), there is a potential for ethnic differences with HIV/AIDS experiences that are being neglected or overlooked.

Furthermore, despite the lack of data and underreporting, HIV/AIDS prevention researchers have contended that there is no evidence to suggest that AAPIs are engaging in less risk behaviors (Nemoto et al., 2011; Peterson, Bakeman, & Stokes, 2001). One study revealed that 38% of AAPI MSM participants who self-identified as being HIV positive reported having sex with casual partners under the influence of alcohol, while 62% of the group reported having sex with casual partners under the influence of drugs; findings also showed that approximately two-thirds of them (68%) reported that they did not know their casual partners' HIV status (Nemoto et al., 2011). Another study found 64% of AAPI MSM had multiple sex partners and 47% reported unprotected anal sex in the past 6 months (Choi, et al., 2004). Operario and Hall (2003) also found that 49% of AAPI MSM reported having sex under the influence of substances. Choi et al. (2005) found that within the past 6 months, 32% of API MSM participants reported having sex under the influence of alcohol and 34% had sex while under the influence of drugs. Nemoto, Operario, and Soma (2002) found that Filipino American MSM who used amphetamines were likely to have unprotected sex, were more likely to have sex under the influence of drugs and alcohol and engage in injection drug use, while being less likely to be tested for HIV/AIDS. Operario et al. (2006) found a significant and positive relationship between risky sexual behaviors and substance use. All of these findings are supported by other studies which revealed that AAPI MSM often engage in risky behaviors such as drug use and unprotected sex, which simultaneously often leads to higher exposure to HIV/AIDS (Choi, Han, Hudes, & Kegeles, 2002; McFarland, Chen, Weide, Kohn, & Klausner, 2004; Peterson et al., 2001; Schwarcz et al., 2007).

In addition to risky sexual behaviors, lack of HIV education can also contribute to the spread of the disease. One study found that 85% of AAPI MSM who reported unprotected anal intercourse reported that they were unlikely to contract HIV (Santa Clara County, 2008). Perhaps AAPI gay men believe that they are not susceptible to the disease because they are not educated about HIV risk factors, because HIV/AIDS is not highly visible in their communities, or both.

Finally, a multitude of sociocultural factors may influence the risky sexual behaviors of AAPI MSM. First, because sex is rarely discussed in AAPI families, many AAPI individuals may not learn about the risk factors associated with unprotected sex, as social norms discouraging the discussion of sex are prevalent in many AAPI cultures (Nemoto et al., 2003). For LGBTQ AAPI people, there may not be any opportunities to discuss sex, sexuality, or sexual behaviors, because they do not have any LGBTQ role models, are in the closet, or a number of other reasons. Similarly, sociocultural factors may influence mental health and HIV risk behaviors. Because AAPI MSM may fear being disowned by family or become depressed because they are unable to navigate their LGBTQ identities, they may engage in high HIV risk behavior, deny their potential for risk, and even avoid HIV prevention services at all costs.

Stigma, Discrimination, and Cultural Factors for AAPI Gay Men Living with HIV/AIDS

There are numerous factors that may affect the everyday lives of AAPI gay men living with HIV/AIDS. First, they must live with the stigma and discrimination that all people infected with HIV/AIDS may encounter. Stigma has been found to be a major stressor for individuals living with HIV/AIDS (Swendeman, Rotheram-Borus, Comulada, Weiss, & Ramos, 2006), and stigma has even been found to be a major barrier for HIV prevention (Chesney & Smith, 1999; Wolitski, Pals, Kidder, Courtenay-Quirk, & Holtgrave, 2009). Some researchers have described how gay men living with HIV/AIDS are likely to experience both a "double stigma"—stigma due to their HIV status and stigma due to their gay identity (Chenard, 2007). Because HIV/AIDS is typically stereotyped as being the "gay disease," people tend to blame gay men with HIV/AIDS for their actions, often citing that they deserved to contract the disease (Nadal & Rivera, 2012). Some studies have even supported that members of the general public are more likely to place blame and anger on gay men living with HIV/AIDS than they are with other populations with HIV (Herek & Capitanio, 1999).

For AAPI gay men (and other gay men of color), they may experience a "triple stigma" as a result of their race, sexual identities, HIV status, or some combinations of them all. First, they may experience overt racism, in that they may be the victims of race-based hate crimes, subjected to racial slurs like "chinks," "gooks," or "japs," and denied service because of their race. This group may also be victimized by racial microaggressions, which are defined as subtle or covert behaviors or statements that convey negative slights and insults towards people of color (Sue, Bucceri, Lin, Nadal, & Torino, 2007). For example, people may assume that AAPIs have limited English proficiency, may categorize them as model minorities, or treat them as perpetual foreigners (i.e., assume that they are immigrants, despite their actual citizenship or long family histories in the USA) (Wu, 2003). AAPI gay men may also experience stigma and discrimination based on their sexual orientation. Gay and bisexual men have been reported to be victims to hate crimes (Herek, 2009) and heterosexist prejudice (Meyer, 2003), and may even experience microaggressions (or subtle forms of discrimination) based on their sexual orientation or gender identity and expression (Nadal, Rivera, & Corpus, 2010). Understanding the spectrum of discrimination based on sexual orientation may be especially important for AAPI gay men, given that one study reported that Asian American gay men perceived more discrimination due to sexual orientation and not due to race/ethnicity (Chan, 1989).

Furthermore, AAPI gay men may be susceptible to experiencing stigma and discrimination that is based on the intersections of their race, ethnicity, gender, and sexual identities (Choi, Han, Paul & Ayala, 2011). As previously discussed, it is quite common for LGBTQ people of color to encounter discrimination from their racial/ethnic communities, from the general LGBTQ community, and both. For AAPI gay men specifically, they may be taunted and teased by their family members

because of their sexual orientation, invalidated, excluded, or devalued in the general LGBTQ community based on their race. They may also be treated as second-class citizens as a result of both their race and sexual identities. One commonly reported experience for Asian gay men is that they are often exoticized, in that they are treated like sexual objects by other gay men, particularly White gay men (Han, 2006; Nadal & Corpus, 2012). For instance, in a qualitative study of lesbian and gay Filipino Americans, participants shared that they felt exoticized as Asians or Filipinos, in that they were stereotyped as being "oversexual" or "subordinate" (Nadal & Corpus, 2012). AAPI gay men also report feeling invisible in the general LGBTQ community, particularly because they do not fit the White standards of beauty or cultural norms; they are often told (directly and indirectly) that they are not attractive enough (especially in comparison to White men) and/or that they are not "man enough" (Han, 2006; Nadal, 2013). In fact, one study found that 80% of AAPI MSM participants reported instances of racism within the gay community (Dang & Hu, 2005), suggesting that racial discrimination is a common experience for this community.

Furthermore, the stigma and discrimination experienced by AAPI gay males may also negatively impact one's health behaviors, which in turn can affect one's HIV status and health (Ayala, Bingham, Kim, Wheeler, & Millett, 2012). For instance, one qualitative study examined how the intersection of race and sexuality influenced the sexual behaviors of AAPI MSM (Han, 2008). Based on 15 qualitative interviews with AAPI MSM, three major themes that were identified:

1. Racism was seen as a primary factor in the way that API gay men came to view their experiences within the larger gay community.
2. Racism in the gay community led to the creation of a social context of sexual behavior that placed gay API men at a disadvantage in partner selection.
3. The disadvantage resulted in API gay men competing for White male partners that involved taking on the submissive role during sexual intercourse, thus having less ability to negotiate safer sexual behavior with their White partners (Han, 2008, p. 830).

The findings from this study demonstrated how racism contributed to the types of experiences that AAPI MSM men had in their romantic and sexual relationships, as well as their participation in the broader gay community. Furthermore, racism often resulted in AAPI MSM feeling isolated or unwanted, which also had an impact on their selection of sexual partners. Finally, racism resulted in AAPI MSM stereotypically assuming a sexually submissive role (i.e., to be the anal recipient or "bottom"), which increased their risk for HIV and other sexually transmitted infections.

Psychological stressors based on the intersection of race and sexuality may influence AAPI gay men's mental health (Choi, Paul, Ayala, Boylan, & Gregorich, 2013). For instance, one study found that Asian American gay men were more likely than heterosexual Asian American men to have reported a recent suicide attempt (Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007). This finding poses significant considerations for the mental health needs of AAPI gay men. For example, research

has shown that multiple gender role expectations that AAPI men experience to be heterosexual, masculine, strong, and individuals who bring honor to the family can be psychologically challenging for those who may be struggling with their sexual identity (Nadal, 2010). AAPI gay men may also develop depressive symptoms as a result of not being able to accept one's sexual identity, which may potentially lead to suicidal ideation (Cochran et al., 2007).

Furthermore, the experiences of discrimination and stigma for AAPI gay men may influence one's susceptibility to mental health issues. For instance, in a study with MSM of color (e.g., African American MSM, Latino MSM, and AAPI MSM), experiences of racism in the general community and homophobia among one's heterosexual friends were related to both depression and anxiety, while homophobia in the general community was related to anxiety (Choi et al., 2013). The results from this study also indicated that AAPI MSM were the only group in which racism in the gay community had a negative influence on their mental health (Choi et al., 2013), suggesting that racism in the gay community is significantly distressful for AAPI gay men. Based on these cultural considerations, AAPI gay men may develop mental health issues because of the racism encountered in LGBTQ communities, racism in the general community, homophobia experienced among friendship circles, and homophobia among the general community. This supports previous literature that has cited that AAPI gay men may be more susceptible to psychological issues than his heterosexual AAPI or gay White counterparts who only have to deal with one type of discrimination (Chan, 1989, 1992, 1995; Chung & Singh, 2008; Chung & Szymanski, 2006; Nadal, 2010; Nadal & Corpus, 2012).

Another problem that may negatively influence AAPI gay men's health behaviors and their increased vulnerability for HIV transmission is substance use and abuse (Nemoto et al., 2011). While one study revealed that AAPI men in general (i.e., heterosexual, gay, and bisexual AAPI men) were least likely as compared to other racial/ethnic groups (i.e., Whites, African Americans, and Latino men) to report use of cocaine, ecstasy, marijuana, and poppers (Grov, Bimbi, Nanin, & Parsons, 2006), there are several studies that support that drug and alcohol use is quite high among AAPI MSM (Toleran, et al., 2012). For example, one study found that AAPI MSMs in San Francisco engaged in more substance use than other racial groups (Greenwood et al., 2001). Operario et al. (2006) reported that alcohol use was very pervasive among AAPI MSMs (94% of participants drank alcohol in their lifetime and 89% drank in the past 6 months); other drugs that were used by majority of the sample included marijuana (61% lifetime, 44% past 6 months) and ecstasy (58% lifetime, 47% past 6 months). Meanwhile, Nemoto et al. (2011) revealed that AAPI MSMs were more likely than heterosexual AAPI substance abusers and AAPI incarcerated offenders to use "club drugs" (i.e., hallucinogens such as MDMA, LSD, and GHB), which are drugs that often used when engaging in unprotected anal sexual intercourse.

Perhaps one main reason why AAPI gay men may turn to substances is to cope with the discrimination that may experience. Because many AAPI men in general may have difficulty connecting to their feelings, have difficulty asking for help, have trouble talking about their insecurities or vulnerable topics, substance use may

be a more viable option (Iwamoto, 2010; Nadal, 2000, 2011). In fact, through an analysis of studies focusing on AAPI men in general, Iwamoto (2010) discussed how alcohol use has increased significantly among AAPI men over the past 10 years, citing that stress and cultural factors may be reasons for use. In another study, researchers found that conformity to masculine norms and Asian values influenced substance abuse and discussed how AAPI men may turn to drugs and alcohol in an attempt to escape their problems and alleviate psychological anguish (Liu & Iwamoto, 2007). Further, there has also been some literature that has revealed that substance use is perceived as culturally acceptable in various Asian American ethnic groups, particularly for youth and for AAPI men, and that factors like peer pressure, difficulties with acculturation, and familial pressures to achieve may influence substance use (Fang, Barnes-Ceeney, Lee, & Tao, 2011; Nadal, 2000). Finally, specific to substance use and AAPI MSM, one study reported that drug and alcohol use often increased feelings of sociability and comfort among AAPI MSM (Nemoto et al., 2003), suggesting that AAPI MSM may use substances in order to feel less isolated and to fit in with their peers.

Racism and heterosexism may also influence substance use behaviors among AAPI gay men. First, one study found that when AAPIs (both women and men) were not treated as "Americans," they were likely to be at risk for tobacco use, alcohol use, and substance use (Yoo, Gee, Lowthrop, & Robertson, 2010). Second, a study examining experiences of lesbian, gay, and bisexual (LGB) adults found that individuals who encountered more discrimination would be more likely to develop a substance use disorder (McCabe, Bostwick, Hughes, West, & Boyd, 2010). Finally, in one study that examined Asian adolescents in Canada, it was found that the heterosexual Asians were less likely to engage in illicit drug, marijuana, and alcohol use than their Asian Canadian LGB counterparts (Homma, Chen, Poon, & Saewyc, 2012). While there are many reasons that may influence this disparity, it can be hypothesized that differential experiences due to sexual orientation may be one major influence.

Because AAPI gay men experience a great deal of stigma due to their race and sexual orientation, it may be difficult for them to cope if they become infected with HIV/AIDS. Some authors have cited that disclosure of HIV status may be particularly difficult for AAPIs because of the cultural shame that accompanies it. Because HIV is also often associated with drugs and homosexuality, which are all topics deemed to be "taboo" in Asian cultures, it may be difficult for AAPIs in general to disclose their HIV statuses (Chin & Kroesen, 1999). So when an AAPI gay man actually is infected with HIV, he may experience difficulties in disclosing his status to loved ones seek help, or both. Furthermore, for AAPI gay men who have not disclosed their sexual identity, becoming infected with HIV or developing AIDS further complicates their ability to come to terms with their sexual identity. They may repress their sexual orientations even further, which may influence their risky behaviors, their mental health, or both.

The stigma and shame of HIV/AIDS may be so salient for AAPI gay men who are diagnosed with the disease, that many may even avoid seeking medical care. In fact, one study found that AAPI people who are living with HIV/AIDS avoid

Western medical care due to cultural stigma and shame, but also due to the lack of knowledge of Western medicine (Wilkinson, 1997). Because the mental health field has been traditionally viewed as a Western practice, in that talking about one's problems (particularly with an outsider) is viewed as unnecessary and selfish, many AAPI people may turn to religion, spirituality, or alternative forms of healing as a culturally appropriate way of coping with one's problems (Sue & Sue, 2008). Additionally, AAPIs living with HIV/AIDS may underutilize health care due to the cultural mistrust of American hospitals and medical institutions, the lack of culturally competent services, and language inaccessibility (Chin, Kang, Kim, Martinez, & Eckholdt, 2006; Operario & Hall, 2003). Cultural mistrust refers to the tendency for people of color to mistrust Whites, across a variety of sectors (e.g., mental health practice, hospitals, educational settings), due to the historic mistreatment and discrimination against their racial groups (Bell & Tracey, 2006). Some research has found that cultural mistrust can explain the high rates of premature termination in psychotherapy (Sue & Sue, 2008). Other research supports that LGBT people of color may have a dual cultural mistrust due to their dual identity statuses and the historical mistreatment and discrimination of both LGBT people and people of color (Green, 1997). Finally, some literature describes how LGBT clients are likely to feel less connected to their therapists when they commit microaggressions, or behaviors that convey subtle forms of discrimination or discrimination (Shelton & Deglado-Romero, 2011).

For AAPI MSM immigrants living with HIV/AIDS, there are even more complex factors that influence their views of the health care system and their reasons for seeking or not seeking treatment. First, given that 73% of AAPIs speak a language other than English in their homes (Barnes & Bennett, 2002), language becomes a barrier that can negatively impact HIV knowledge, health education, HIV testing and counseling, and medical treatment. For AAPI MSM immigrants specifically, language deficiencies may negatively influence sexual practices. For instance, one study found that young AAPI MSM are at higher risk for HIV when meeting partners on the Internet because they lack skills to negotiate safer sex in person (Santa Clara County, 2008). For AAPI MSM undocumented immigrants, the fear of deportation may negatively influence one's ability to get tested, seek medical treatment, or utilize other HIV-related services (Chin et al., 2006).

A Critical Response: HIV/AIDS Intervention Strategies and AAPIs

Behavioral interventions have shown to be one of the most powerful tools to reduce the HIV epidemic, particularly through reducing HIV risk behaviors (Lyles et al., 2007). In order to successfully achieve this goal, HIV/AIDS scholars have developed curricular interventions aimed at educating communities at risk for HIV. The Centers for Disease Control and Prevention, along with other federal and private agencies, provides funding for these researchers to develop HIV prevention

interventions. Once developed and implemented, these agencies then evaluate the findings and deem these interventions as "effective" in reducing risk behaviors. The CDC then accumulates these proven effective interventions in a compendium, which is known as the Diffusion of Effective Behavioral Interventions (DEBIs). Each of these interventions specifically targets specific populations, among them for example, youth, women, and people of color communities. The CDC provides training and education for community organizations to implement these interventions. The Evidence Based Intervention (EBI) is the adaptation of DEBIs to be effective for implementing in "emerging populations."

Despite the many interventions proven effective by the CDC, there is a lack of prevention interventions designed for, or even adapted for, AAPIs (Han, 2009). Furthermore, while there have some prevention interventions that have been created for MSMs (e.g., Choi, 1995), there has not been an EBI that has specifically looked at AAPI MSM. As previously discussed, the percentage of diagnoses of HIV infection and AIDS for AAPIs remains relatively small compared to other racial/ethnic groups. However, because of the aforementioned research that supports that AAPI MSMs engage in high-risk behaviors (e.g., McFarland et al., 2004; Nemoto et al., 2011; Schwarcz et al., 2007), evidenced-based interventions are still necessary for this group.

In 2005, the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Prevention (SAMHSA/CSAP) awarded Minority AIDS Initiative (MAI) grants to only three AAPI organizations of approximately 80 nationwide grantees, but only one of them focused on high-risk groups of adult men who have sex with men. Other organizations such as the CDC provided a similar or smaller percentage of awards to AAPIs in comparison to other racial groups. To the authors' knowledge, there are seven known AAPI-adapted HIV EBIs—four of which have been implemented in San Francisco, California, by the Asian & Pacific Islander Wellness Center. None of these three EBIs have been conducted in geographical regions where large populations of AAPI reside and none included other high-risk populations (i.e., substance users and re-entry individuals).

The limited number or lack of interventions for AAPIs may be due to the aforementioned heterogeneity of the AAPI community. Because the AAPI umbrella comprises diverse ethnicities, nationalities, languages, dialects, cultural histories, and disparate socioeconomic statuses, a universal AAPI intervention may not be appropriate for the entire group. For instance, because a large number of AAPIs live at below the federal poverty level, while many AAPIs belong to a much higher socioeconomic status, some subgroups may respond differently to HIV prevention interventions. Similarly, some qualitative studies have found that there is a community concern for lack of culturally and linguistically appropriate HIV prevention programs for AAPIs (Jemmott, Maula, & Bush, 1999). Thus, tailoring prevention interventions to meet the needs of this culturally and socioeconomically diverse population is a challenge for various institutions.

Furthermore, as previously discussed AAPI health problems are compounded by the low utilization of HIV health services (Ye, Mack, Fry-Johnson, & Parker, 2012). AAPIs access health services less than other racial and ethnic groups due to culture,

including values and norms related to family reputation, shames, stigma, denial, taboo surrounding sexuality and drug use, and fear of immigration status (Chin et al., 2006; Operario & Hall, 2003). In order to overcome these issues, adaptation of interventions must address these cultural barriers for people to attend and feel comfortable enough to participate in HIV prevention programs. The prevalence of these diseases and behaviors, deficient number of culturally appropriate HIV, hepatitis, or substance use service providers, social/cultural barriers and decreasing government and private budgets and resources have deterred high-risk AAPI populations from accessing and participating in these integrated prevention services.

There are many additional variables that influence why some interventions have not been effective for AAPI MSMs. Han (2009) conducted focus groups with AAPI MSMs who described the most important issues that needed to be addressed in providing HIV prevention for AAPI gay men. Five themes emerged including: (1) the need to address racism in the gay community, (2) the need to address homophobia in the AAPI community, (3) the need to increase self-esteem, (4) the need to promote a gay AAPI community, and (5) the need to provide positive role models. Based on these participants' experiences, it would be necessary for any intervention program to address racism and homophobia directly, as it appears to be a major factor that may influence AAPI individuals' behaviors and mental health, which in turn can increase risk for HIV infection. Furthermore, based on participants in Han's (2009) study, it would be crucial to promote a healthy gay AAPI identity and expose gay AAPI men to role models and a greater community, in order to endorse healthy psychological well-being.

Finally, some scholars have cited that one of the main reasons why HIV disparities are still prevalent among AAPI communities is because of the lack of funding that provides program development, data collection, and research of AAPI HIV-related issues (Sabato & Silverio, 2010). Because many funding institutions focus on the low prevalence of HIV/AIDS among AAPIs, many may not provide adequate amounts of funding for organizations that focus specific on AAPI populations. Thus, it is necessary for HIV/AIDS researchers, educators, and practitioners to inform others that HIV/AIDS is still an issue affecting AAPIs, particularly MSM who are not getting tested or who are still engaging in risky behaviors. In doing so, it is hoped that others will realize that the epidemic is still affecting the community and that funding can still be made available for them.

Psychological Approaches for Working with AAPI Gay Men Living with HIV/AIDS

In addition to systemic recommendations that are necessary to improve the lives of AAPI gay men living with HIV/AIDS, we conclude this chapter by providing suggestions for individuals who work directly with this population. While we speak specifically about clinicians (e.g., HIV counselors, psychologists, social workers), this section can also be applied to other practitioners including medical doctors,

nurses, teachers, health educators, and others. Because there is a dearth of clinical and counseling services for people living with HIV/AIDS (Lam, Naar-King, & Wright, 2007), it is crucial for clinicians and other practitioners to develop strong therapeutic relationships with their clients, in order to prevent treatment dropout rates (Leeman et al., 2010). Furthermore, because LGBT people have reported to drop out of psychotherapy due to cultural insensitivity and stigma (Green, 1997) and because Asian Americans have been known to underutilize mental health services and drop out of psychotherapy as well (Tewari & Alvarez, 2009), it is necessary for clinicians and other practitioners to become culturally competent in working with AAPI gay men who are living with HIV/AIDS. Finally, because gay-related stigma consciousness, or one's ability to perceive heterosexist stigma, has been found to be a significant predictor of depressive symptoms (Lewis, Derlega, Griffin, & Krowinski, 2003), it is crucial for clinicians to manage or minimize their stigma in their therapeutic relationships, in order to provide the most effective treatment for their clients.

Utilizing the multicultural competence model can be beneficial in working with all clients of diverse backgrounds, but particularly gay male clients who are living with HIV/AIDS (Nadal & Rivera, 2012). The model involves three parts: (a) knowledge, (b) awareness, and (c) skills. The knowledge component involves the notion that clinicians have gained appropriate education about cultural topics and identities that are different from their own experiences. Specific to AAPI gay men living with HIV/AIDS, there are many facets of a person's experience that a culturally competent counselor will be knowledgeable. First, the clinician will be educated in HIV research and treatment, in order to understand how a client's HIV status may influence his mental health and everyday experiences. A clinician will have a working knowledge of AAPI cultural values and experiences, as well as familiarity with various issues affecting the LGBT community. For instance, perhaps an understanding of the racial dynamics in gay male interracial relationships will allow a clinician to validate a client's experiences. Having a basic understanding of certain cultural issues (and working to improve this knowledge) is necessary for clinicians and other practitioners because it is important that clients are not spending great amounts of time educating counselors during psychotherapy, when time could be spent on exploring emotions and engaging in therapeutic interventions.

The awareness component of multicultural competence involves a clinician being cognizant of their cultural attitudes, biases, and worldviews, particularly the ways that such perspectives could negatively impact therapeutic relationships. For instance, if a therapist maintains any prejudice against people living with HIV/AIDS (conscious or unconscious), this bias can impede her or his working relationship with the client. If the client perceives a therapist's discomfort, anxiety, or prejudice, it is possible for the client to disengage or even drop out of therapy. Moreover, in working with AAPI gay men, it is possible for clinicians to have multiple biases about the clients' multiple identities. For example, the therapist may have negative stereotypes about gay men or gay male relationships, while also having prejudicial views of Asian American cultural values. If the clinician is unable to admit to, or manage, these biases, it may be difficult for her or him to convey empathy, which in turn may make it difficult for the client to feel trusting or open the clinician.

While it is very difficult for individuals to admit to any prejudicial attitudes, acknowledging these thoughts may be helpful in order to prevent them from affecting one's working relationships.

Finally, the skills component of multicultural competence refers to the notion that therapists learn and practice the most effective approaches or techniques in working with various clients. For clinicians working with AAPI gay men living with HIV/AIDS, this may involve utilizing or adapting the evidence-based treatments that have been empirically supported to be effective. A culturally competent clinician may also adapt techniques that they have found to be useful in their own practice, particularly with certain cultural groups. However, the most competent therapist is one who is able to utilize interventions that are based on a client's multiple identities. Given a client's unique experiences with race, gender, sexual orientation, age, socioeconomic status, HIV status, and other identities, it may be necessary to adapt one's methods from various treatment models in order to most effectively serve their clients.

There are some specific skills that have been recommended for working with AAPI patients or clients. First, one scholar describes the importance of teaching a bicultural approach for care, particularly in working with AAPI clients living with HIV/AIDS. Because AAPI patients and clients, particularly those from immigrant backgrounds, may be less acculturated to American ways of being, it is necessary to respect and validate AAPI patients' cultural ways of doing things (Yu, 1999). Similarly, it is necessary for practitioners to respect traditional forms of healing, particularly with clients who may have a distrust or fear of Western medical models (Yu, 1999). Sometimes, it is necessary for practitioners to be direct with AAPI, particularly because of the shame and stigma that may prevent them from seeking help. For example, some scholars describe how AAPI people must be encouraged to seek medical assistance, even when symptoms are obvious and persistent (Jemmott et al., 1999). Finally, because of the cultural shame and stigma regarding HIV within the AAPI community, it is crucial that practitioners engage the client in an empowerment approach to care (Yu, 1999). Because AAPI culture sometimes tends to encourage deference to authority, it can be common for AAPI patients to not fully comprehend their health issues, to not voice their concerns to a medical practitioner, or to not self-advocate for themselves. Having an open and honest conversation and ensuring that a client understands every aspect of her or his medical or psychotherapeutic treatment can truly empower the client to take control of her or his life.

Conclusions

In this chapter, we aimed to highlight the overall experiences of Asian American and Pacific Islander gay men who are living with HIV/AIDS. Because there is limited research that focuses on this community, we advocate for future research and scholarship to emerge with this group. Based on the review of the literature, one of these core research priorities would be to create culturally appropriate evidence-based interventions for AAPI gay men and MSM. Another key priority would be to

examine how racism and homophobia may be related to risky behaviors, particularly unprotected sexual intercourse and substance use. In terms of advocacy, it is necessary for systemic and institutional changes to occur (e.g., national institutes must provide funding, or create treatment models, for this population), while also promoting change on individual levels (e.g., practitioners must attempt to be culturally competent in working with this group). Finally, in order to improve the lives of AAPI gay men, it is important for our society as a whole to recognize the unique needs of this group. Because AAPI gay men experience adversity on many levels (e.g., racism in the LGBTQ community, homophobia in their families, lack of role models and acceptance), it is the role of society as a whole to provide an environment where they are validated and accepted.

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