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“I Don’t Fit in a Box; No One Does:” Intersectionality and Gay Male Identity

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ABSTRACT

Using an intersectionality framework, this qualitative study explores how stigma affects identity development and how intersecting identities can compound to either foster resiliency or create health concerns for 11 men who are emerging adults (18-29), same sex identified, African American, HIV +, and homeless. Semi-structured one-on-one interviews were conducted through RAIN (Regional Aids Interfaith Network) in Charlotte, NC. Questions were formulated to understand how participants view themselves and perceived stigmas, current/past health conditions, and their five to ten year prospects. This study uses grounded theory as a *guide* to analyze and interpret data. Themes explored include: risks (acquiring HIV through homeless status), biographical disruptions, and self-acceptance as a foundation to resiliency through self-empowerment. All participants in this study displayed resilient behaviors post-diagnosis to present, even those who experienced the worse “biographical disruptions.” Participants all spoke about being a survivor of sorts. I found that, for my participants, owning one’s identity created a buffer against the adverse effects of stigma.

Keywords: intersectionality, gay identity, HIV, resiliency, homelessness

INTRODUCTION

White privilege remains a controversial topic. Privilege, in general, is when one has special support due to skin color, gender, or other various aspects of identity. White privilege comes with many benefits. A white person can, for instance, go to a realtor and expect to be shown a home in a neighborhood that reflects their values, and expect to see people with their skin color in the neighborhood. They can also expect, if the house they are shown is trashy, it is not because of their race, it is probably due to their price range. White people can also expect to find shades of makeup in their color, and bandages to match their skin tone. They can expect to find someone who can do their hair in any commercial barbershop. White privilege is when your race is usually represented in history, positively. White privilege is being able to be passed off as cute instead of a criminal. White people do not usually have to fear being pulled over by the police. Many white people often get offended when their privilege is questioned. There is no way that white privilege exists, in the minds of many white people. Though, you can see it when their position in the hierarchy is threatened.

It’s hard to confront one’s privilege because it is usually something one doesn’t realize they have. It is something that has always been there, invisible, but ever-present. Whites grew up around other white people who had the same privileges. Many didn’t grow up in or around black neighborhoods where they could expressively see the lack of privilege and inequitable living conditions. Whites usually do not have to fear for their life when they are stopped by the police. The most I worry about is whether I am going to get a warning or an actual ticket. Therefore, it is hard for white people to realize they have this inherited unearned privilege that others don’t. Peggy McIntosh (1988), the author of *White Privilege: Unpacking the Invisible Knapsack*, states this when addressing her privilege:

In proportion as my racial group was being made overconfident, comfortable, and oblivious, other groups were likely being made inconfident, uncomfortable, and alienated. Whiteness protected me from exhausting daily anxiety, worry, fear, and anger owing to others’ treatment of people in my racial group. At the same time, I was subtly trained

to perpetrate or at least ignore the hostility and violence against people of color which exhausted and angered them (P.47).

People of color face more challenges throughout their life than their white counterparts, which is sure to have an effect on identity development.

In a research study I conducted last year, I explored the experiences of emerging adults who were homeless and LGB; I found that each person's experience with homelessness was significantly different and unique to themselves, though there were similar themes. Some were HIV positive, some were African American, and all had a varying degree of education. I lumped these individuals together as just "Gay People" with no regards to how their race or HIV status played a role in their experiences with homelessness. Too often researchers and agencies lump individuals together in groups based on gender, race, ethnicity, class, and sexual orientation because we believe that people who are similar share similar experiences. Intersectionality aims to look at an individual on multiple levels of intersecting identities. This is important because everyone has different experiences based on their various identities. These experiences impact their needs. For example, a straight African American male who is not diagnosed with HIV would have different experiences and needs than a gay African American male who is HIV positive.

Moreover, research that examines the LGBTQ community is often problem focused. While it is important to understand problems within the community, it can be detrimental because it creates an environment where LGBTQ individuals are only known to be problematic, suicidal, depressed people who do not possess the strengths to remain resilient and achieve goals. This is not the case at all. It's important for researchers to examine the strengths of this population, and ask questions that aim to discover how these individuals remain resilient despite the overwhelming number of obstacles they face. This information could be useful in creating new and innovative ways to empower clients.

THE LITERATURE

Identity & Intersectionality

Intersectionality. There are several theories regarding identity and identity development which were conceived by theorists such as Freud, Erikson, and Cass (Cass, 1979; Zastrow & Kirst-Ashman, 2013). These models are quite useful when one wants a generalized view of how identity develops over time; however, these models are somewhat dated and too generic to assess contemporary development accurately. Thus, for this study, intersectionality is used as a lens to view identity. Intersectionality is the study of how different "identities" such as race, sexual orientation, gender, class, age, and religion intersect on multiple levels to create an individual's entire identity. Intersectionality also examines the stigma associated with minority identities. For example, an individual from a lower-class background who is gay, African American, and HIV positive, experiences stigma and oppression at rates much higher than a middle-class, white, straight, able-bodied man (Marsiglia & Kulis, 2015).

Homeless identity. Homelessness presents a greater challenge than one just not having decent accommodations. Studies suggest that these individuals "lose their sense of identity and self-worth" (Boydell, Goering, & Morrell-Bellai, 2000). Terui and Hsieh (2015) compare homelessness to illness to describe how homelessness has an impact on identity:

Like illness, although the meanings of homelessness can be determined through "objective measures" (i.e., individuals without homes), the fluid boundaries of homelessness can provide ample opportunities and resources for people to redefine their identities and construct life meanings. Like stigmatizing illness (e.g., HIV or tuberculosis), homelessness entails social stigma and imposes limitations on individuals' everyday life. Experiencing homelessness has a profound impact on individuals' identities as one is confronted with the loss of valued attributes (e.g., social roles and personal outlooks). Recognizing that the label of

a homeless identity, just like an illness identity, can be dis-preferred and even traumatizing for some, we propose that people who are (at risk of) experiencing homelessness would adopt various resources to resist, negotiate, and redefine the labeling of a homeless identity. We argue that individuals can experience identity dilemmas as they face the increasing possibility and reality of their homeless status, resulting in widening gaps between a homeless identity and their desired identities (p.2)

They also found that homeless individuals utilize three strategies to manage their identity: differentiating themselves from other homeless, prioritizing certain aspects of life (such as education, past successes, and employment), and embracing the state of homelessness (Terui & Hsieh, 2015). Terui and Hsieh report that the longer these individuals stay on the street, the more likely they are to embrace their homeless identity and the less likely they are to come off the street. Therefore, it is imperative to find resources for these individuals to ensure they can effectively break this cycle of homelessness. Although individuals who couch surf are not roofless, they still are labeled with the same stigmas as those who are homeless. They do not have a stable place to live and are always moving from house to house, or house to shelter to house. The one fundamental difference between couch surfing and rooflessness is privacy away from the public eye. If these individuals are staying in someone's home, they are not endlessly scrutinized by the public as having a homeless identity. However, they are aware of the stigma that is attached to being homeless, and they are mindful of the fact that they do not have a stable home. One could argue that individuals who couch surf experience the same identity crisis as those who are roofless.

Gay identity. Along with a potential homeless status, same sex identified men who live on the street or couch surf must also come to terms with their sexual orientation and how that plays a role in their identity. Many times, these young people lack support and are socially isolated, which stems from the stigma attached

to the LGBTQ community. Many of these young people internalize feelings of guilt and shame due to their homeless situation (Grainger, 2015). These young people also feel isolated because of their sexual identity. Family members and peers often reject LGBT people, which can cause internalized homophobia and shame (Doty, Willoughby, Lindahl, & Malik, 2010). Doty, Willoughby, Lindahl, and Malik (2010), terms this as "sexuality stress," that is, additional stressors that are related to one's sexuality (Doty, Willoughby, Lindahl, & Malik, 2010; Grainger, 2015). In western cultures, there is a concept of hegemonic masculinity that associates manhood to power and dominance. Robert Brannon (1979) describes the cultural ideals of masculinity that men in the United States should possess as: no sissy stuff, be a big wheel, be a sturdy oak, and give 'em hell (David, Brannon, Brannon, & David, 1976). Those who deviate from these cultural ideals face the risk of being stigmatized by mainstream culture.

According to a study conducted by Rosario, Scrimshaw, and Hunter (2012), youth who display non-gender conforming traits at a younger age may be at a greater risk of encountering homelessness versus their more gender conforming counterparts. A common predictor of LGB (lesbian, gay, bisexual) identity in adulthood is gender nonconforming behavior in childhood. Studies have found that people can many times tell the difference between LGB individuals quite accurately based on voice, appearance, and other gender non-conforming cues (Rosario, Schrimshaw, & Hunter, 2012). Perceived sexual identity, regardless of whether youth self-acknowledges it, creates negative reactions from family, peers, and community members (Rosario, Schrimshaw, & Hunter, 2012). This negative stigma creates an environment for these individuals that puts them at a greater risk of becoming homeless due to being socially rejected at a younger age. Once they become homeless, they must cope with both intersecting identities, both of which are stigmatizing. Also, youth who are from a minority background may also face even more stigmatizing reactions from society based on their ethnic or racial identity.

Racial identity. Currently in the United States, racism and prejudice can still be witnessed nationwide. Discrimination is still seen in many aspects of life for racially minority groups. These individuals still face housing and job discrimination. Numerous instances of police brutality have been documented in several forms of media. Consequently, same-sex identified homeless men who are also a racial minority not only encounter instances of discrimination based on their orientation and homeless identity, but they also face further discrimination based on their racial identity. These hostile circumstances create an environment where some African American men may feel they need to hide their identity to gain acceptance within their own community, and the broader community (Marsiglia & Kulis, 2015).

Moreover, African American males face racism within the LGBTQ community (Marsiglia & Kulis, 2015). This lack of support from within their community and the gay community can affect their overall well-being, leading to greater health and safety risks for those who are both gay and African American. In fact, according to 2014 CDC (Centers for Disease Control and Prevention) statistics, 44% (19,540) of estimated new HIV diagnoses in the United States were among African Americans, who comprise 12% of the US population (Centers for Disease Control and Prevention, 2016). The CDC reports that “lower rates of linkage to care, retention in care, stigma, fear, discrimination, homophobia, and negative perceptions about HIV testing may also place many African Americans at higher risk and discourage testing” (Centers for Disease Control and Prevention, 2016).

Health/safety. Studies suggest that LGBTQ individuals who experience homelessness face greater health/safety risks than their heterosexual counterparts (Rosario, Schrimshaw, & Hunter, 2012). Risks include: mental health disorders, substance abuse, sexual/physical victimization, and survival sex that leads to greater chances of contracting HIV (Grainger, 2015). Rosario, Schrimshaw, and Hunter (2012) reported that LGB (lesbian, gay, bisexual) individuals were more likely to report

running away from home due to sexual abuse than their heterosexual counterparts. In a survey conducted by Saewyc, Skay, Pettingell, Reis, Bearinger, Resnick, Murphy, and Combs (2006), gay and bisexual boys reported a higher prevalence of physical abuse in the home, “with nearly 1 in 5 up to 1 in 3 reporting abuse, compared to 1 in 8 heterosexual boys” (Combs, Bearinger, Murphy, Pettingell Reis, Resnick, Saewyc, & Skay, 2006). It is not uncommon for these individuals to run away because of the abuse they face at home. Studies suggest that a high percentage of persons who are homeless couch surfed before they became homeless (Wright, Caspi, Moffitt, & Silva, 1998). Once these individuals are on the street, they face even greater chances of being sexually victimized. In my recent study, I found that many participants who utilized homeless shelters had experienced sexual assault while there (Grainger, 2015). Many reported that staff did nothing when they made reports of sexual assault, citing that the workers made LGBTQ individuals feel unwelcomed (Grainger, 2015).

Stigma. Not only must these young people cope with the stigma attached to being a part of the African American and LGBTQ community, but they must do so while facing the stigma of being homeless. According to Terui and Hsieh (2015), homelessness is a socially constructed concept. Meaning we, as a society, define what it “means” to be homeless. Typically, this definition places the blame on the individual who is homeless, rather than the organizational and institutional hurdles and injustices that these individuals encounter (Terui & Hsieh, 2015). Homeless individuals are generally stereotyped as lazy (unwilling to work), addiction-riddled, criminals, and at blame for their situation. In many cities, legislation has been passed that criminalizes common homeless behavior. For instance, panhandling in many states is illegal and sleeping on the sidewalk can get an individual jailed in many cities across America. Cities have gone as far as placing spikes on the pavement in areas where it is common for the homeless to sleep. This anti-homeless behavior sends a clear message to these individuals: you are not valued, and we do not want you here. Moreover, along with the

social isolation that homelessness brings, persons who are LGB are further isolated because of the stigma attached to the community. When these stigmas are compounded on top of each other, it can create the various stressors and mental health disorders that are seen specifically within this population.

Throughout American history, there has been stigma attached to those in the LGBTQ community. Legislation is slowly changing to provide equal opportunities for these individuals, which was witnessed when the Supreme Court ruled that gay marriage was legal in all 50 states. However, legislation such as the recent HB2 law in North Carolina only acts to further stigmatize members of the trans community and members of the LGBTQ community as a whole. Businesses still reserve the right to refuse service to these individuals. Hate crimes and murder against LGBTQ people are common. Stigma related to the LGBTQ community can in and of itself lead to homelessness for these young people. Parents who disapprove of their child's sexual orientation may, in time, throw their children out of the home or create environments where the child feels the need to run away. Once on the street, these young people face the stigma of being both homeless and LGBTQ.

HIV Status and Identity

To further exacerbate the situation, many of these individuals are also dealing with an identity crisis regarding their HIV status. Literature examining how HIV, specifically, has an impact on identity development is sparse. The literature usually classifies HIV as a chronic illness, comparing the two and showing instances of “biographical disruptions” which could be characterized as an intrapersonal conflict as a result of a perceptual loss of self (Baumgartner, 2007). Kralik, Koch, and Eastwood (2001) detail how self and identity are two separate entities: “The ‘self’ reflects international thinking of what it is ‘being a person,’ whereas ‘identity’ is shaped by social interaction” (Kralik, Brown, & Koch, 2001, p. 33). Much like being displaced from one’s home, an HIV/AIDS diagnosis requires one to reevaluate themselves, and examine how they

believe the condition influences their life. Since HIV/AIDS is a chronic disease that is no longer a death sentence, individuals with this diagnosis can plan to live longer lives. A longer life also means that they must face the stigma that is commonly associated with this diagnosis. Because of the stigma of HIV/AIDS, a diagnosis can often be quite traumatizing for the individual. The literature on HIV/AIDS and identity suggests that individuals experience a change in identity post-diagnosis.

A study conducted by Destiny Ramjohn (2012), suggests that an HIV diagnosis in young people resulted in a “biographical disruption.”

Respondents experienced a loss in their sense of self; post-diagnosis – Many participants “gave up” or suspended the identity development process, the consequences of which included “continued risky sexual behavior (e.g. unprotected sex, sex with a partner they know is infected with HIV); failure to comply with prescribed medication regimens (e.g. missing multiple doses of antivirals); or not pursuing previously set academic goals e.g. dropping out of high school (pp.4-5).

While some literature has established a link between chronic illnesses and negative developmental outcomes, this body of research is not conclusive. Many of my participants have found empowerment through their identities.

METHODS

Study Design and Research Questions

To ensure that research results are as accurate as possible, grounded theorists suggest that one have at least fifty hours of collected data (Charmaz, 2006). This study uses a grounded theory method as a guide to explore how different identities intersect to either foster resiliency or create health concerns for same-sex identified males who are African American, HIV positive, and homeless. There were four major phases of this study: research advertisement, participant selection, one-on-one interviewing, and data analysis. Once my proposal was accepted by the Winthrop Institutional Review Board, I began the initial stage of promoting the study. Since this is a

difficult population to locate, I enlisted the help of several agencies in the Charlotte/Mecklenburg area to advertise and promote the study. These organizations include: Regional Aids Interfaith Network (RAIN), The Powerhouse, and Urban Ministry. The staff at RAIN was by far the most helpful agency in the area. Thus far they have helped secure 11 participants and 8.25 hours' worth of data. Each participant was asked to distribute information about the project to other individuals who met the criteria and would be willing to participate in the study.

To take part in the study, each participant had to meet certain requirements: They must identify as HIV-positive, same-sex identified males, be between ages 18-29, identify as African American, and have an experience with homelessness that lasted more than six months. Each interview took place in public settings, mainly at the organization that the participant had an affiliation with. Interviews were audio-recorded and lasted between 15-45 minutes. Each participant was compensated with a \$20.00 Visa gift card for the interview regardless of full participation.

Data Gathering Procedures

During the initial interview, I ask participants to draw a stick figure or a circle to represent themselves. I then ask them to think about all the identities that make them who they are or that have an impact on their life. I draw a stick figure with the participant to give an example about a couple of my basic identities, such as being an able-bodied, gay, male. I give them time to think about all the different identities they may have. After they are finished writing, I talk with them about intersectionality, and explain how it is a concept that states ones' identity is not just based solely on one's race, gender, sexual orientation, status, etc. Rather, one's identity is formed by all these categories, which overlap to create the unique individual sitting before me, who has his own unique story to tell. I go on to ask them to pick a couple identities from their list that they believe represent who they are the most. I talk with the participants about why they think these identities have an impact on their lives. I also

ask them why they chose the identities they did over the others.

Participants are also asked questions based on how they view themselves and perceived stigmas, current/past health conditions, and future prospects. Participants were asked to describe the situation regarding how they first became homeless. From there, the conversation was guided around different aspects of the participant's lives, experiences, and identity. Questions were based on how participants view themselves and perceived stigmas, current/past health conditions, and 5-10 year prospects. Questions were designed in a way that would not influence participants' answers. They were neither positive nor negative in nature.

I asked participants to discuss how they first became homeless. Depending on the answer, I asked the participants to describe how they felt during the initial encounter of being homeless. Questions were based on determining how the experience changed how they viewed themselves, their situation, those around them, and society as a whole. I asked participants to then discuss other instances in which they were homeless, and how their prospects possibly changed, and how they viewed themselves and others during those periods of homelessness.

Participants were also asked how living with HIV has affected their lives. Initial questions were structured to gauge how participants first viewed their selves after being diagnosed, and follow-up questions were asked to assess how they view themselves currently. Participants were asked how family and loved ones reacted to their status, and how those reactions impacted how they felt about themselves. I also asked participants to describe how their condition has had both positive or negative effects on their life. To close out the interview, I always revisit and speak on the growth and resiliency that I've witnessed from them through hearing their incredible story. Lastly, I asked participants where they see themselves in five years, and how they plan to make their prospects a reality.

Ethics

To ensure that participation was completely voluntarily, I thoroughly went over

an informed consent at the beginning of each interview, which was then given to participants. Participants were informed that this was a voluntary study in which they had the right to withdraw at any time. Participants were also informed that interviews would be audio-recorded and they had the option to stop recording at any point in the interview in which they felt uncomfortable. Throughout the interview process, I took every precaution possible to ensure the confidentiality of participants. Before starting and recording interviews, participants were given the option to choose a pseudonym, which would be used throughout the interview and transcription process. All audio files were secured in a thumbprint locked file. Participants were provided with an informed consent statement and given a chance to ask any questions before starting the interview. Participants were also informed that they could request that audio-taping be stopped at any point during the interview and advised that they did not have to answer any question that made them feel uncomfortable. I also reinforced the fact that skipping any question or asking to turn off audio recording would not impact their compensation.

Data Analysis

For this study, I used grounded theory as a guide to analyze and interpret data. Grounded theory can be compactly summed up through this quote by Strauss and Corbin (1998):

If someone wanted to know whether one drug is more effective than another, then a double-blind clinical trial would be more appropriate than grounded theory study. However, if someone wanted to know what it was like to be a participant in a drug study, then he or she might sensibly engage in a grounded theory project or some other type of qualitative study.

Elements of grounded theory include: question formulation, interview transcribing, data coding, analytic memoing, theoretical sampling, and constructing theory. After formulating my questions and gathering data, I collected roughly 8.25 hours' worth of interviews, which I

transcribed. Once the transcription process was over, I coded all the collected data and developed concepts based on thematic similarities. According to Charmaz (2006), "grounded theory methods consist of systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories 'grounded' in the data themselves" (Charmaz, 2006). After looking at similarities within the data, I worked with my mentor, Dr. Brent Cagle, to better ensure objectivity when analyzing data and constructing theories.

Researcher Role

As an identifying gay male who has experienced homelessness as a young adult, there is the possibility that bias could have influenced the data gathering process. My experiences may have also influenced the way I analyzed and interpreted the data. As a social worker and researcher, I must continually work towards self-awareness, and separate my experiences from those of the participants and the research project. Throughout this study, I consulted with my mentor, Dr. Brent Cagle, to ensure that my work was as non-biased as possible.

FINDINGS

Risks

For many participants, HIV infection was ultimately a result of a lack of stable housing. Participants spoke about being raped on the street, in the home of someone who was providing temporary housing, or in public shelters.

Demetri: "um, I was younger an livin' with this guy a friend had introduced me to. He was letting me crash on his couch at the time because I had nowhere to go. I had a job, so I would only be there at night. One night I woke up with him on top of me... um, a few months later I started to feel sick, like I had the flu. Turns out I was infected."

John: "Well, I was at the shelter, and obviously I'm fem... The guys there would expose their junk to me and even try to force their way on me. This one guy tried to get with me in the bathroom but I turned him down. The

next night he cornered me at this spot I used to lounge at, I knew what he was there for. I had nowhere to go and I didn't know what he would do if I were to try and fight my way out. I asked him to leave, but he said no.... I didn't sleep with just anyone, I know it was him who gave it to me."

Biographical Disruption

All participants experienced a brief period of "biographical disruption" post diagnosis. This period lasted from six months up to two years. When talking about the post-diagnosis period (period in which participants are likely to experience biographical disruption), participants spoke about suicidal ideation, depression, being reclusive due to feeling ostracized by family and peers. Biographical disruptions were a result of a loss of self and a fear of stigma associated with the virus.

Jay: "I lost my smile for a long time man. Nothing made me happy anymore... I just gave up. I was on the streets, I didn't care. I was trickin' with other pos people. It was like I was sick, but I wasn't...ya know? I had dreams, but I couldn't see myself achieving them."

Demetri: "Um, its as if everyone pitied you, or was scared of you. And that scared me shitless. I would wonder if that is how everyone was gonna look at me. I was worried everyone knew. And going to the doctor was awful, I thought they were always scared to touch me. I eventually stopped taking my meds. It was a lot of complications because my body is so sensitive to the virus. It came to a point where I was living on the street in the winter sick as f*** and I refused to go to the doctor. I was going to die. My friend talked me into going. That was the lowest point I've ever been. I didn't fear dying, I feared living and having to tote all of this on my back."

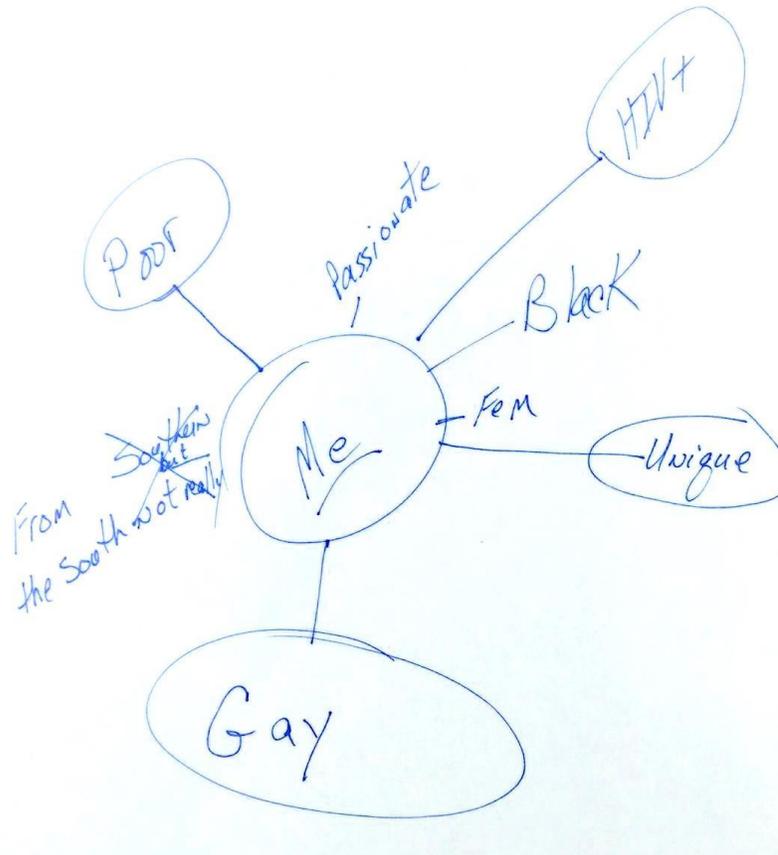
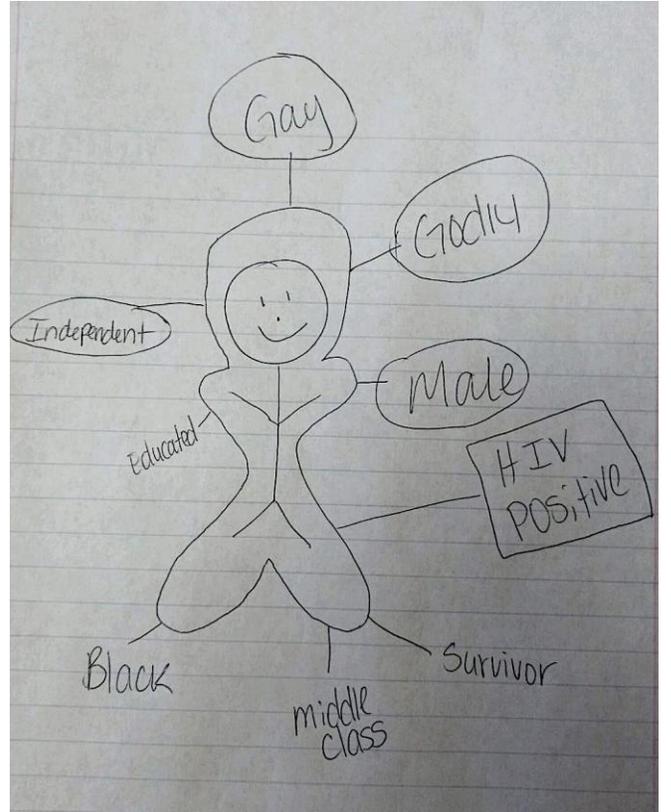
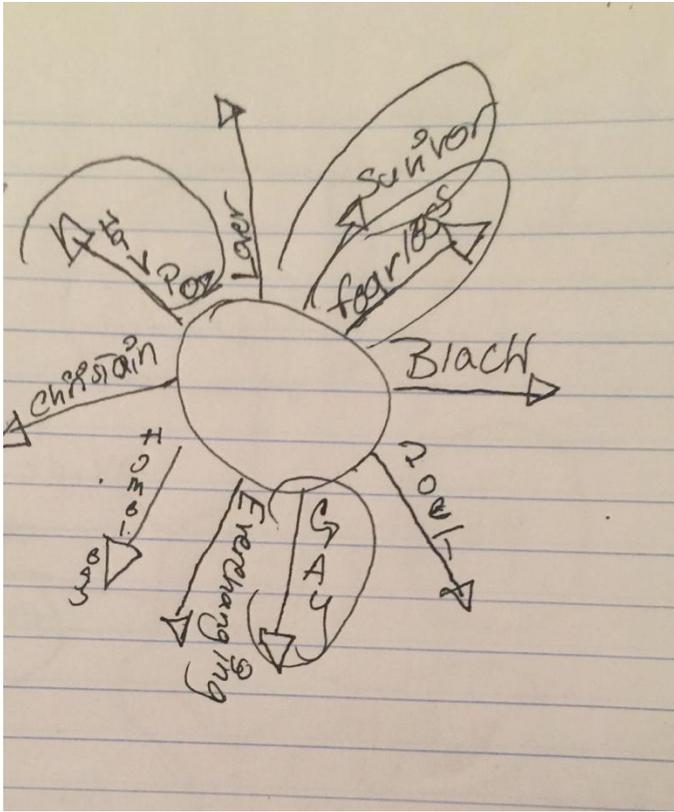
John: "I feared no one would understand my situation, or how it made me feel. I felt stuck and I kept asking myself what was next? I was sure this was then end. I couldn't see past the virus. There was

no future for me.... Just death. I was sentenced to death by a man I didn't want to even touch me. People don't understand. They automatically assume you asked for it. They place you in a little box, and say you did this to yourself. They look at you like it's your fault. I don't fit in their box. No one does."

Resilience

Talking about their experiences was a source of strength for participants', and owning ones' identity was self-empowering, and seemed to be the foundation for building resiliency and overcoming instances of biographical disruption. Participants who had stable safety networks such as family, peer and organizational support, displayed more cases of resilient and self-accepting behavior than those who did not. However, I noticed that participants who cut ties with family members who did not embrace their gay and HIV identities were more apt to "own" their identity vs. those who kept tempestuous relationships; and owning identity is essential to self-empowerment.

For many participants, owning one's identity meant accepting they were African-American, Gay, AND HIV+ and realizing they could still live a fulfilling life regardless of associated stigmas; this resulted in an ability to inhibit self-defeating behaviors like skipping medicine regimes, halting educational endeavors, reclusiveness, etc. Moreover, when I asked participants to write down identities that they thought affected their lives, several participants used words such as fearless, lover, unique, passionate, etc. These self-descriptors of strength and kindness seem to be empowering for these individuals, and important when describing themselves.



Jay: “It took a year, but I made it out of that depression. My family really helped me. My moms never gave up on me, ya know. She was really the push I needed. She pushed me to find help, and I did. I finally have my smile back. And that means everything to me.”

Demetri: “I found myself through finding myself (Laughs). I had to say fu** what everybody else thought about me and take care of myself for me, not for them. I have goals, and this is not a death sentence anymore. I had to figure out what kind of life I was gunna live. I really had to figure out what I was gunna do to get myself off the street... I cut hair now, and I’m doing alright. I wouldn’t say I’m perfectly happy, I have my moments, we all do. But I accepted myself, every bit. And here I am, I’m alive and kicking.”

King: “My ma was there sometimes, but not usually. She would leave when I was a kid, we never knew when she was gonna check back in. We fended for ourselves, Sh** never could depend on no one. It’s like that now. I sat her down a couple years back and was like, look moms, I’ve got HIV and I’m gay. She didn’t take it well. She’s crazy man. But she is my mom, only one I have. She wasn’t happy about me being gay at first, and she was scared as sh** about the HIV. She didn’t understand what it was, what I had. After a few weeks she came around. It wasn’t no brady bunch shit. We was still struggling. But it was nice to know she was still there for me I guess. If you want to call it that. As far as me I take care of myself now. I gotta. I am who I am, and that’s a bit** who doesn’t want to die, not anymore. I have plans for my life. Write that down.”

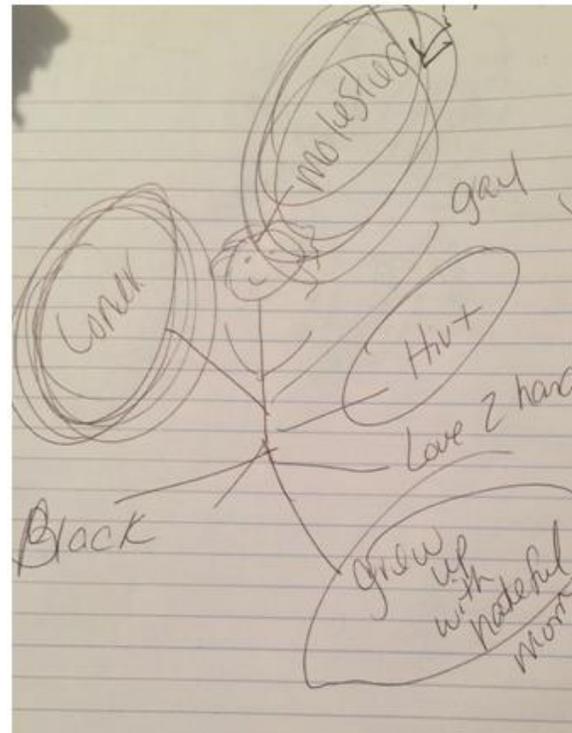
Pat: “Um, I am fearless, I found that out through my status. Um, I would say that being fearless is an important part of who I am. I try to love with everything in me. unconditionally. Until it compromises me. I’ve been hurt by

plenty of people. My family, friends, people I wouldn’t expect to hurt me. They had to go. I love you, but bye. My health is important to me and if you can’t support that you gotta go honey.”

Some used seemingly negative descriptors as well, but these descriptors also seemed to be a source of empowerment for these individuals.

When I asked King to describe what the identities he chose meant to him, he described being a loner as something that was necessary to maintain his health.

King: “You can’t just let anybody in. people thinks that’s a problem. If you don’t let them in right away, they like what’s wrong with you. Sh** I think its unhealthy to let any ole stranger in my life. I have friends. But ultimately, I’m in charge of me. I do what’s necessary to maintain myself. I know letting people I don’t know in is unhealthy for me. I’m happier this way. Not everyone can understand me, I let people in that can.”



LIMITATIONS

According to Charmaz, one should have 50 hours of collected data to reach saturation. Considering I only have 8.25 hours of data, I have yet to reach any conclusive results. A well-done ground study on this topic would have taken years, if not a lifetime to complete.

The literature is mixed on African American views towards homosexuality. Some research indicates African Americans may be more accepting of LGBTQ individuals than their Caucasian counterparts, while some suggest otherwise. Future research should examine how accepting the African American community is towards the Idea of Queer identity.

DISCUSSION

The central theme of emerging adulthood is the discovery of self and one's place in broader society. Further research using intersectionality to examine how minority identities play a role in this period of self-discovery is needed; the literature is often whitewashed, outdated, or too generic to apply to such a specific population. Searching several databases, I could only find a handful of relevant articles related to HIV and Identity formation, development, impediment, etc. (HIV & identity anything). Intersectionality is a relatively new concept, and there is still much to be learned about identity intersection, and how this affects identity development.

Many participants who were homeless spoke of experiences in which people assumed they were homeless because they were HIV positive, when in fact, many times, the acquisition of HIV was a result of unsafe shelter conditions; whether it be public shelter or shelter provided from an acquaintance or stranger. Over the past two years that I have spent working with individuals who lack stable housing in Charlotte, I have heard countless stories about sexual assault in Charlotte's shelter, and the lack of support from shelter staff.

During a recent presentation at the NASW-SC spring symposium, I passed out an anonymous survey that asked attendees

questions about their biases, and comfort level of working with LGBTQ people. Many attendees stated that based on their religious beliefs, they felt being gay, lesbian, bisexual, or transgender is abnormal and sinful. I also remember someone answering that they thought gay, lesbian, bisexual, or transgender people should not tell people their identity unless asked; and a few still opposed same-sex marriage. These oppositional feelings towards queer identity, if left unchecked, can create a rift in the client/professional relationship.

One of my professors frequently used the term "cultural humility" in place of cultural competency during my undergraduate years at Winthrop. Her reason being that we can never say we are truly culturally competent; we can only really strive to be culturally humble. It is important to remain aware that each culture has different customs, and to keep in mind you always have something to learn from them. Educational training that promotes cultural humility is necessary to equip social workers with the knowledge and tools that will enable them to work with this vulnerable population successfully. Furthermore, social work "gatekeepers" need to examine the attitudes and morals of their students carefully, to pinpoint red-flags, and weed out those who cannot put their biases aside to work with clients effectively. As professionals, our sole purpose is to benefit our clients. Any behavior on the part of social workers that could impede or degrade a client's progress is unacceptable. The NASW (2008) Code of Ethics, Section 4.02 states:

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability (National Association of Social Workers, 2008).

The Code of Ethics has a clear stance on discrimination; it's not tolerable—and lacking the capability to work with someone based on their sexual orientation is innately a form of discrimination.

Current literature portrays LGBTQ+ individuals as innately problematic. Focus is placed on what these individuals are doing wrong, rather than on what they are doing right. Despite facing overwhelming obstacles, all participants in this study displayed resilient behaviors post-diagnosis to present, even those who experienced the worse “biographical disruptions.” They all spoke about being a survivor of sorts. I found that, for my participants, owning one’s identity created a buffer against the effects of stigma. Building self-confidence is key for one to truly own their identity. While there are programs specifically for HIV treatment that offer one-on-one counseling and peer support services, they are few and far between, particularly for individuals in rural areas and who lack transportation. Organizations like RAIN, who provide transportation assistance, are making a difference in the lives of those who require their services in the Charlotte-Mecklenburg area.

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