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COUNTERING THE NARRATIVE: EXPLORING THE RELATIONSHIP AMONG
WELLNESS, RESILIENCE, AND EMPOWERMENT WITHIN BLACK MEN WHO HAVE
SEX WITH MEN LIVING WITH HIV (BMSM+).

by

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B.S. The Ohio State University, 2013
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A dissertation submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
in the Department of Child, Family, and Community Sciences
in the College of Education and Human Performance
at the University of Central Florida
Orlando, Florida

Summer Term
2018

Major Professors: M. Ann Shillingford-Butler & J. Richelle Joe

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ABSTRACT

The HIV epidemic continues to disproportionately impact marginalized populations, where one in two Black men who have sex with men (BMSM) will be diagnosed with HIV in their lifetime. The lack of research regarding the wellness of Black men who have sex with men living with HIV (BMSM+) inhibits understanding, which could hinder professions missioned with bettering the wellness of BMSM+. Consequently, the purpose of this study was to investigate if resilience and empowerment predict BMSM+'s wellness. However, a lack of internal consistency among the empowerment measurement required the researcher to remove the scale and adjust the scope of the study. A simple linear regression determined that resilience predicted wellness with statistical significance $F(1, 247) = 726.012, R^2 = .745, p = .000, f^2 = 2.92$. Descriptive statistics revealed that there were no significant differences in overall wellness when comparing BMSM+ ($N = 249$) to norming samples representative of the U.S. population, $t(248) = 1.575, p = .12$ and African-Americans, $t(248) = -1.444, p = .150$; though BMSM+ had higher overall wellness when compared to men, $t(248) = 9.926, p = .000$. Most of the BMSM+ in this study had a resilience score that was somewhat low to very low ($M = 123.39$), which was significantly lower than norming samples of the U.S. population, $t(248) = -8.345, p = .000$ and men, $p = .000$; males: $t(248) = -7.938, p = .000$. Additionally, the researcher ran two post hoc analyses that used multi-factor ANOVAs that revealed significant differences in resilience and wellness between groups when examining participants' HIV viral load detectability, CD4 count, mode of HIV contraction, level of religiosity/spirituality, education, and relationship status. Overall, the findings of the current study challenge the assumption that BMSM+ are unwell and

has implications for counseling practitioners, counselor educators, researchers, and community-based organizations.

I dedicate my dissertation to the following:

“You’ve come too far to come close!”

- Lil’ Wayne

My mother, Viola Grissom Heard, my father, Norman James Heard, and my sister Nia Jeneé Heard who have been my everything;

“Calm down, get back, ghetto people got this!”

-Mos Def

my beautiful community that persists beyond all odds;

“If there’s a book you want to read but, it hasn’t been written yet, then you must write it!”

-Toni Morrison

and BMSM+ everywhere who are more than a statistic.

ACKNOWLEDGMENTS

Family, we did it! Mom, I made it to the river! Thank you for reminding me to look forward even though there were all those times I wanted to look back. I love you so much Yogi! Thank you for holding me down. Papa, the best coach I have ever had in my life! Thank you for always being there for me and giving me a pep talk whenever I needed it! You always told me I was made for greatness, and I was just trying to be great enough to make you proud. NiNi! I hear they still mad that the wed wepasent the westsiiii... thank you so much for asking for me, teaching me how to read, putting me on, challenging me, and being my biggest fan and advocate! Nora, No No, and Nasir you all make me so proud every day, there is nothing any of you could ever do that would make me stop loving you.

Dr. Joe, I am so honored to be your first graduate assistant and dissertation advisee. Thank you so much for all your mentorship, support, challenge, perspective, opportunities, empathy, and the list goes on. You're an incredible leader and role model, I am so honored to say I got to study under you. Dr. Shillingford, thank you for being there since day one and creating opportunities and spaces for safety, courage, and cultural authenticity. Thank you for your calm, your check-ins, and spirit. You have been a light for me throughout this program. Dr. Boote, thank you for empowering me, believing in me, encouraging me, allowing me to take up all of your afternoons... and nights... and weekends... I appreciate your willingness to walk with me side-by-side even when I was wandering. Dr. Dollarhide, words cannot begin to express the gratitude I have for you and your role in my professional and personal development. You are a wonderful model of a great counselor educator and an even better person who I aspire to be. Thank you for joining me on my journey ever since you had me in class back in Fall of 2014.

Dr. Butler, thank you for all your mentorship along my doctoral journey! I feel like you have been there the whole way. From firing shots in Advanced Practicum, teaching Multicultural Class during the Pulse Tragedy, then teaching Groups class, to working together for two years trying to make the future brighter for little Black and Brown gentlemen. Thank you for taking me under your wing! Dr. Hopp, thank you for being my Orlando mother, giving me a family, in Holmes, and supporting me. Your unapologetic self provided me with the opportunity to carve my own space, how I see fit in academia. Krista Pedragovich, I will never be able to repay you what you were able to provide me. Your essence allowed me to cope, excel, and wonder. It is something indescribable, I just know it when I feel it. I'm excited about the fact that so many others will get to experience your awesomeness as well. Chris Belser, thank you for all your wonderful guidance, your pep talks, and just sheer looking out for me. I appreciate you so much and think the world of you. You have been a wonderful mentor to me!

Thank you my Stupendous Seven Squad- Dr. Y, Michelle, Laura, Caitlyn, EP, and Seungbin! Yvetter, we started this journey together and the growth of our friendship is why I would not take a chance in ever changing anything about this experience (and that's a one!). Michelle, sister girl, we put on for our cities and families, while reaching back along the way! Laura, thank you for being brave, which gave me permission to do the same, I'm so excited to see all the lives you touch! Caitlyn, legit the coolest person I know, you are the paragon of an ally, which I aspire to be! EP your authenticity gave me space to show my authentic self, I will forever be grateful! Brother, thank you for the rides, laughs, and help!

Wooten, AT, Mo, Shoney, Fouchie, Cassi, Marcus, Nico, J.P., and Preshus thank you for being patient with me, for visiting me, for providing me an escape. I have been blessed by having

the most wonderful people in my life, and how blessed I am to have met you all. I have appreciated our adventures and I look forward to what is to come!

Family & Friends

In order of appearance (...basically)

Donald Grissom (RIP) – Jennie Martin (RIP) – Eleanora Heard (RIP) – James Heard (RIP) – Bessie Mae Hill (RIP) – Blossom Peek (RIP) – Hendra Peek (RIP) – Rozell Martin (RIP) – James Heard Sr. (RIP) – James Heard Jr. (RIP) – Willy Grissom (RIP) – Ophelia Hawkins – Peggy Walker – Frank Heard – Charles Heard – Cecil Heard – Stella Heard – Jeff Peek – Jazmine Martin – Lana Horton – Jenea Walker – Jamal Walker – Daisha Horton - Sabrina Martin – Davareon Talley – Walker Birgade- Aunt Cynthia – College Hill – Avondale – Nativity – Mrs. Hoeffler – The Hagerty's – The Muething's – The Listo's – The Little Red Machine – Holy Trinity Bearcats – St. John's Eagles – Bond Hill – The O'Brien's – The Michell's – The Yarborough's – Chris Long – The Daughtery's – Evanston – Mr. Ebert – Companion Scholars Program – St. Xavier High School – Jerry Valentine – Ean Harris – Steve Daniels – Byron Keeling – Patrick Akujobi – Brandon Wilkins – Isiah Baines – Greg Scruggs – John Richardson (RIP) – Michalea Siewert – Coach Papa Castner – Coach Nardini – Coach Specht – Mr. Ravenna – Ms. Mascari – Ms. Julie Doyle – Mr. Marchal – Rod Hinton – Akeem Duncan – Sharon Thomas and Son – Marvin Lewis and Foundation – Cincinnati Archdiocese – Terrence Wooten – Aaron Thomas – Anthony Mosinski – Roy "Shoney" Whifield – Zach Fouch – Preshuslee Thompson – Ohio State Rec Sports – Rob Jech – Eric Fletcher – Dexter Shorter – Bonnie Swan – Chris Stewart – Gwenna Blanden – Kalantra Franklin – Jordan Boon – Ohio State Rugby – Coach Rooney – Coach Wes – Coach Weir – Higgle – Tejas Sinhas – Robert – Gareth Williatt –

Baby Boy – Luke Hickey – David Stauder – Cory Harmon – Chad – Alex House – Greater Columbus Mpowerment Center – Chris Davis – Josh Eckford – Cleveland Rockers – Krista Pedragovich – Dr. Ana Berrios – Adam Clevenger – Kaden Edwards – Brian – Tory –Meredith – Carly – Beth –Shayla – Danny – Ohio State Counseling & Consultation Services – Harry Warner – Abby Carter Logan – Carrie Fielder – Curtis – Simon Wolliver – Bev – Sarah Del Propost – Jamarie – Luke Moore – CCS Front desk – Dwayne Seward – Adrian McNeil – Erica Mendoza – Chris Belser – Shay Harris – Elizabeth Crunk – Patrice Leopald – Ashlei Rabess – Kevin Threat – Marc Campbell – Chelsea Davis – Nathalia Justin Gonner – Giscard Petion – SEC/Young Knights Mentors – Holmes Family – Dr. Sister Amanda Wilkerson – Sandra McCall – Heather Geils – Amber Norman – Whitney Hanley Sandi Tabet – UCF Cohorts – Hungerford Elementary – Dr. Martha Lue-Stewart – Dr. David Ford – Dr. Michael Brooks – Dr. Kim Hughes – Dr. Kocet – Dr. Joel Filmore – Impulse Orlando –Siljestrom Family – Miracle of Love – Gays on the Move – Lester – Ty Hamilton – Carlos – Daniel Downer – Preshard – Kayla C. Elliot – Tim Finklea – Walgreens – Josef Hobdy – Dr. Clark – Black Women everywhere

Donors

Kayla C. Elliot – Tim Finklea – Patrice Leopold – Alecia Blackwood – Amanda Wilkerson – Stefanie Johnson – Yvette Saliba – Elizabeth Pennock – Caitlyn Bennett – Sandi Tabet – Michelle Mitchell – Nicole Elinoff – Jayna Mumbauer – Heather Geils – Dr. Nia Heard-Garris – Herald Kane – Julia and Chris Bushaw – Amber Norman – Ura Mazing – Frankie Gaw – Natalie Montanez – Christian Kamrath – Anonymous – Everyone who sent good vibes, prayers, and encouragement

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CHAPTER I: INTRODUCTION

The following section serves as the introduction for the current study, and will provide a general overview. This section includes background information regarding the problem that the current study seeks to address, the integrated framework of the current study, and the methodology of the current study.

Background and Overview

Currently, there are approximately 1.1 million people who are living with the Human Immunodeficiency Virus (HIV) in the United States (Centers for Disease Control, 2017g). In the most recent data, 2014, there were an estimated 40,058 new HIV transmissions (CDC, 2017a), which marked a decline among the overall population from the year 2010 (41,900). However, when sorting by race, the Black community made up the plurality of new HIV transmissions (17,573, 43.9%; CDC, 2017a). Additionally, the Black community has the highest proportion of people living with HIV/AIDS (PLWHA); in fact, in 2016, Black people made up 44% of people diagnosed with HIV but only accounted for 12% of the U.S. population (CDC, 2018b). When examining new HIV diagnosis further within the Black community, transmission via male-to-male sexual contact comprised the majority of new HIV diagnosis (10,173, 57.9%; CDC, 2017a). In general, men who have sex with men (MSM) account for 83% of new HIV diagnoses though they only make up approximately 2% of the general population (CDC, 2018d). The manifestation of how current HIV transmission trends affect both Black and MSM communities together has resulted in an

approximation of 1 in 2 Black men who have sex with men (BMSM) receiving a positive HIV diagnosis in their lifetime (CDC, 2016c).

Today, there are approximately 218,546 Black men who have sex with men living with HIV (BMSM+) in the United States (CDC, 2016a; CDC, 2018a). The most recent data from the CDC (2018c) shows that the incidence for HIV among BMSM was 10,223 for the year of 2016, which was the highest number among gay and bisexual men subgroups and represents the highest lifetime risk of any subgroup overall. The way in which HIV has impacted BMSM highlights the need to conduct more research regarding BMSM+ (Wilson et al., 2016b). The need for more research on BMSM+ is especially needed within the counseling field as this population is rarely mentioned in counseling literature. Specifically, there is a need for more studies that address the wellness among BMSM+ given that this group is disproportionately affected by HIV. The need to investigate the wellness of the BMSM+ population is drawn from the advances in medicine that allow for people living with HIV (PLWH) to live a long full life (CDC, 2018f).

Research that comes the closest to studying the BMSM+ population customarily used BMSM as the research population and considered HIV status to be an outcome measure. Those studies routinely used a seropositive HIV status as an unwanted outcome (Aholou, Nanin, Drumhiller, & Sutton, 2017; Eaton, Driffin, Smith, Conway-Washington, White, & Cherry, 2014; Maulsby, Millett, Lindsey, Kelley, Johnson, Montoya, & Holtgrave, 2013; Young & McLeod, 2013). Thus, research has framed the very existence of BMSM+ as something negative. Additionally, past research has historically used a medical model approach, which is not holistic, regularly aggregates all BMSM, and views HIV as a deficit. In the review of literature, studies involving BMSM, which oftentimes include BMSM+, were consistently framed through lenses that

heavily focused on sexual practices and preventative sexual health. Thus, the experience of BMSM+ outside of their sexuality is unknown. Furthermore, little is known about the experiences surrounding the wellness of BMSM+, which stifles the ability to deliver appropriate and adequate services when aiding BMSM+.

Researchers have used meta-analyses that showed research involving BMSM has focused on the following factors: HIV prevention, identity, risk behaviors, mental health, biology, community engagement, sociocultural circumstances, stigma, and resilience (Wilson et al., 2016b). Even when a variable outside of sexuality was investigated it was usually framed within a medical model and the context of HIV risk. For example, Buttram (2015) conducted a qualitative study that interviewed 21 participants to investigate the experience of resilience in BMSM substance users. However, resilience was conceptualized as protection from contracting HIV. Again, HIV was the unwanted outcome.

Though literature among disciplines concerning BMSM+ has predominantly been unidimensional, mostly focusing on prevention, the literature has been virtually non-existent in the counseling field. The lack of literature regarding BMSM+ in the counseling field is an issue because the absence of information does not allow for appropriate interventions to be discovered nor utilized. BMSM+ experience higher rates of psychological distress (Arnold, Rebechok, & Keagles, 2014). Higher rates of psychological distress among BMSM+ is partially explained by *minority stress* (Flenar, Tucker, & Williams, 2017), which is the anxiety that accompanies people with a marginalized identity because of societal prejudice and discrimination. Thus, BMSM+ may experience compound stress because of their racial identity, sexual minority status, and HIV positive status. Traditionally, due to historical determinants and social factors both Black and

sexual minorities have not accessed mental health services as frequently as their counterparts (Office of Minority Health, 2014). Consistent with other research, Basta, Schscam, and Reece (2008) found that BMSM did not access mental health services as often as their counterparts; however, when they did it was after being connected with another service because of an HIV diagnosis. Thus, a positive HIV diagnosis can serve as an entry point into mental health care services for BMSM+. However, due to difficulty in training counseling students in the area of multiculturalism and specifically HIV, students reported not feeling adequately equipped to help People Living with HIV/AIDS (PLWHA) (Ulery & Carney, 2000).

The lack of research regarding the wellness of BMSM+ calls into question the preparedness of counselors to serve BMSM+. Without research regarding the wellness of BMSM+ any practice and intervention purposed with empowering BMSM+ to achieve wellness through the counseling process lacks an evidenced-based foundation (Prendergast, 2011). Thus, the proposed study serves to add to the literature gap surrounding the wellness of BMSM+ within a culturally relevant framework. The implementation of a culturally relevant framework to the current study will increase the appropriateness of the findings in the investigation of BMSM+'s wellness, and will address the shortcomings of previous studies that did not account for the cultural realities of the BMSM+ population.

The current study sought to use a descriptive, correlational research design situated within a Critical, Race, Queer, and Disability (CRQD) framework to get a culturally appropriate and holistic depiction of BMSM+'s wellness. The current study provides statistical data on the wellness, resilience, and empowerment levels of BMSM+. Additionally, the use of the CRQD framework to inform the choices made in the current study allows for culturally appropriate approaches to study

design, data collection, and analysis to reflect the cultural realities of BMSM+. The current study differs from previous research that oftentimes situated the experiences of BMSM+ in culturally-blind models that further marginalized and oppressed that population. The results of the study will have implications on the delivery of helping and mental health services and interventions, public policy and distribution of resources, and community based organization's program implementation for BMSM+.

Statement of Problem

Since 2011, approximately 10,000 BMSM have contracted HIV every year (CDC, 2018c). As of 2016, there were approximately 218,546 BMSM+ (CDC, 2016a; CDC, 2018a). Today half of BMSM will contract HIV in their lifetime if current HIV transmission rates continue (CDC, 2016c). Living with HIV can be difficult, especially when taking other marginalized identities into account (Arnold, Rebehook, & Keagles, 2014; Flenar, Tucker, & Williams, 2017). However, the presence of HIV among BMSM does not necessarily eliminate the possibility to be well. Thus, there is a need to explore the wellness among BMSM+.

It has been well established in research that the health of BMSM+ is a concern, but less attention has been paid to the population's wellness (Hightow-Weidman, n.d.; Ribaldo, et al., 2013). Current approaches to investigating the wellness of BMSM+ have been primarily through a HIV prevention lens, have not been holistic, or have been inversely related to wellness. For example, a study purposed with examining if well-being could be impacted by the interacting effects of psychological empowerment and ethnic identity among youth of color did not actually use a well-being measure; instead well-being was conceptualized as the absence of negative health

constructs (Lardier, Garcia-Reid, Reid, 2017). Such studies tell little about wellness and sometimes disregard the BMSM who are already living with HIV. Oftentimes studies did not focus on BMSM+ specifically and used frameworks that were culturally inappropriate for BMSM+, which also can overshadow, erase, and further marginalize the experiences of BMSM+. While studies like (Lardier, et al., 2017) inform the field to some degree, studies that are specific to BMSM+, investigate wellness, and are culturally appropriate are needed.

The lack of literature specific to the wellness of BMSM+, renders helping professions missioned with improving the wellness of the people they serve without culturally-relevant, evidenced-based practices. Thus, research investigating the wellness among BMSM+ is essential for providing best practices to the BMSM+ community. The continuation of research concerning BMSM only through HIV risk behaviors and prevention lenses without research regarding BMSM+, is at best avoiding the reality of BMSM+, at worst communicating that BMSM+ do not matter. Consequently, research is needed that not only uses BMSM+ as the research population but investigates variables beyond sexuality and risk behavior.

The current study addresses the limitations of previous research by using a CRQD framework to explore the wellness (as measured by the Five Factor Wellness Inventory; Myers, 2014) of BMSM+ as the study's population. This approach applies a culturally relevant framework to understand the aspect of wellness among BMSM+, and the relationship among wellness, resilience, and empowerment. The results of this study will be able to appropriately describe the wellness among BMSM+ and inform helping professions and public policy.

Purpose Statement

At the end of 2016, there were approximately 218,546 BMSM+ living in the United States (CDC; 2016a; CDC, 2018a). The lack of research regarding the wellness of BMSM+ inhibits understanding, which could hinder professions missioned with bettering the wellness of BMSM+. Consequently, the purpose of this study, which sought to use a descriptive, correlational design, was to investigate if resilience (as measured by the Resilience Scale; Wagnild, 2009) and empowerment (as measured by the Sociopolitical Control Scale; Wagnild, 2009) predict BMSM+'s wellness (as measured by the Five Factor Wellness Inventory; Myers, 2014).

Conceptual Framework

This study used an integrated framework that incorporated Critical, Race, Queer, and Disability (CRQD) theories. The CRQD framework largely guided the study's methodological decisions, such as variable selection, data collection procedures, survey items, and interpretation of findings. This section describes the CRQD conceptual framework.

Critical Theory

Critical theory centers around empowering individuals to transcend the limitations placed on them by race, gender, class, and other socially constructed identity markers (Creswell, 2014). Historically, theorists have disagreed on the conceptualization of critical theory, which manifests as a constant evolution of the theory (Kincheloe, McLaren, Steinberg, & Monzó, 2017). The most recent conceptualization of critical theory denounces systems of power and domination by deconstructing normalized notions of freedom, democracy, opportunity structures, and social

justice (Kincheloe, et al., 2017). While Kincheloe et al. (2017) stated that a reduction of critical theory to universal language of revolution or prescribed strategies would be problematic, highlighting the assumptions of critical theory are necessary. These basic assumptions include:

- socially and historically constituted power relations fundamentally mediate all thought;
- facts can never be isolated from the domain of values or removed from some form of ideological writing;
- a relationship between concept and object and between signifier and signified is never stable and oftentimes is mediated by social relations of capitalism;
- language is essential to the formation of subjectivity (unconscious and conscious awareness);
- certain groups are privileged over others in a given society and particular societies, while the reasons for privileging may vary, the oppression that describes modern societies is most forcefully replicated when subordinates accept their social status as necessary, inevitable, or natural;
- oppression is multifaceted, and concentrating on only one facet at the expense of others (e.g. class oppression vs. racism) often ignores the interconnections among them
- mainstream research practices are implicated in the maintenance of capitalist production which results in the reproduction of systems of oppression, such as poverty, racism, sexism, heteronormativity, religious oppression, ableism, and others.

In short, critical research is inquiry with the aim of confronting structures of oppression, and creating conditions for empowerment and social justice (Kincheloe, et al., 2017). Within the context of this study critical theory recognizes the oppression of BMSM+ and accounts for the need

to create conditions of empowerment and social justice for this population. In accounting for the relationship between societal oppression and wellness (Flenar, et al., 2017), and societal oppression and empowerment it becomes necessary to explore how empowerment contributes to wellness. Thus, the researcher chose to use empowerment as one of the variables within this study, and investigate how empowerment contributes to the wellness of BMSM+.

Race Discourses and Critical Race Theory

Racialized discourses raise important questions about the control and production of knowledge, particularly about people and communities of color (Ladson-Billings, 2000). Thus, racialized discourses questions who controls the narrative. Similarly, Critical Race Theory (CRT) is a set of theories that rely on intersectionality, critiquing liberalism, using critical social science, combining structural and post-structural analysis, denying neutrality in scholarship, and incorporating counter-narratives to speak against dominant discourses (Donnor & Ladson-Billings, 2017). CRT was an “intellectual movement” rooted in American law scholarship. Initially, CRT focused on critiquing the role of law in constructing and upholding unequal sociopolitical relationships by race (West, 1995). Thus, CRT has an emphasis on creating change by affecting law and policy. According to Donnor & Ladson-Billings (2017), race is the most practical and consistent reasoned tool for holistically understanding and changing the collective realities of people of color in the United States. CRT researchers have discussed using counter-narratives and focusing on intersectionality to bring about that change (Donnor & Ladson-Billings, 2017). Intersectionality is a concept that recognizes the reality that perceived identity can make people targets of bias, yet because people are simultaneously composed of various identities, the

complexity of the people's identities shapes the specific way they each experience that bias (Gilborn, 2015). Counter-narratives implies resistance against those in power by telling the stories of those who have been historically marginalized (Donnor & Ladson-Billings, 2017). In education research, counter-narratives have been essential and fundamental to understanding the nature of reality, specifically for people of color (Milner & Howard, 2013).

The researcher uses the concepts of intersectionality and counter-narrative in the current study. The essentialism of intersectionality guides this study in recognizing the reality of culture and the dynamics of power and privilege. Additionally, intersectionality necessitates the need for a study that uses a population that is exclusively, Black, sexual minorities via male-to-male sexual contact, and HIV+; so, that the reality of their circumstances is neither erased nor overshadowed by using a more heterogeneous sample like in past research. Counter-narrative helped to guide the researcher in choosing wellness as the dependent variable in this study. By the original definition of health and wellness, which is foundational to wellness and used throughout literature, PLWHA or any chronic illness could never achieve wellness (World Health Organization, 1946). Thus, this study seeks to counter the idea that the wellness of BMSM+ is less than any other person or non-existent.

Queer Theory

Queer theory approaches are concerned with conveying the voices and experiences of individuals who have been oppressed through cultural and political means, without objectifying those individuals (Gamson, 2000). Rooted in questioning and challenging social and political constructions of sexuality and gender identity (Alexander, 2018), Queer theory requires the act of

“contesting scholarship and politics, contesting categories, contesting identity, contesting liberalism, contesting truth, contesting history, and contesting subjectivity” (Alexander, 2018, p. 278). *Queering* is a social and political intervention that expounds and promotes alternative ways of being beyond a gendered identity (Alexander, 2018). However, queer theory does not act as an alternative to normal or standard sexual performative identities, but instead acknowledges the reality of existing difference that is present in daily practical, political, and academic spaces. Thus, Alexander (2018) declared that research rooted in queer theory is anti-foundational work that focuses on the opposition of fixed identities and characteristics. Research approaches rooted in queer theory accomplish the antifoundational work by lifting the voices of people who are different.

Within this study Queer theory recognizes the spectrum of behaviors and possible reasons for those behaviors of BMSM+. Queer theory takes into account the social construction of gender, sexual orientation, and how both are performed within society, where performativity is the illusion of gender that is socially symbolic and social constructed through gestures and language (Appelrouth & Edles, 2007). Two concepts within Queer theory, also reflected in gender studies are performativity and bifurcation of consciousness. Performativity is the illusion of gender that is socially symbolic and constructed through gestures and language; and bifurcation consciousness refers to the separation between the world as an individual actually experiences it and the dominant view to which an individual must adapt (Appelrouth & Edles, 2007). The researcher used MSM as an identity marker, which is used frequently in public health research as a way to reduce stigma and increase prevention efforts (Trichler, 1999). Historically and still today, HIV is thought of as a gay man’s disease (Feldman, 2010). The use of MSM allowed for the HIV disparities to be

connected to a behavior rather than an identity marker. MSM refers to men who engage in sexual activity with other men. While the term MSM can include men who identify as gay or bisexual, it also includes men who identify as straight, pansexual, or any way else; this is because the term MSM refers to behavior and not identity. Additionally, using sexual behavior is the more appropriate categorization of the population used in the current study and is aligned with Queer theory by challenging the political constructions of sexuality and gender.

Disability Inquiry

Disability inquiry seeks to better understand the sociocultural perspectives of people who are disabled (Mertens, 2009). Disability inquiry's emphasis on sociocultural perspective allows individuals with disabilities to take control over their lives rather than being narrowly viewed through a biological understanding of disability (Mertens, 2009). Disability research has shifted through stages of development, starting with the medical model of disability then moving toward an environmental response to individuals living with a disability (Mertens, 2003). Today, researchers who use a disability inquiry focus on disability as an aspect of human difference rather than as a defect. Thus, disability is socially constructed and viewed as an aspect of human difference similar to race, gender, sexual orientation, and other identities that are constructed by society (Mertens, 2003). Consequently, researchers, through language and labels, consider how the data collection will benefit the community, and the reporting of data in a way that is respectful of power relationships reflects disability inquiry (Mertens, 2003). Thus, within the current study, the social construction that HIV is a condition that hinders wellness and has created the narrative that PLWHA cannot be well is challenged directly.

Previous narratives in society, perpetuated through research oftentimes tried to understand HIV and the individuals living with the condition through a biological and medical lens. Those narratives focus on HIV as a physical ailment, which in turn has socially constructed the stigma around HIV and the notion that it is a limiting disability, especially in the cases of health and wellness. Fear toward HIV and HIV stigma emerged from the start of the HIV epidemic in the 1980's and is still present today (Feldman, 2010). People still associate HIV and AIDS with mortality, deviant sexual behavior, irresponsibility, and morality (Feldman, 2010). That narrative in society that associates HIV with mortality is challenged in this study directly by measuring the wellness among BMSM+.

Conceptual Integration

The CRQD framework guided the current study. Specifically, the CRQD framework recognizes the need for intersectionality, dissent and counter-narrative, challenging social structures and scholarship, disability as a social construction, and HIV as an aspect of difference and not a defect. Within the current study the CRQD lens was used to inform the proposed research question, variable selection, methodological choices, the interpretation of findings, and how the data is reported.

Constructs of Study

The constructs used in the current study included wellness, resilience, and empowerment. The researcher's use of positive psychological constructs among a population that has been

routinely studied through medical and deficit models is congruent with the CRQD framework.

Wellness, resilience, and empowerment are discussed in the following sections.

Wellness

Wellness theory is rooted in positive psychology and is fundamental to the counseling process (American Counseling Association, 2014). In fact, the definition of counseling proposed by the American Counseling Association (2014) declares that greater wellness is an expected outcome of the counseling process. While there has been debate over the conceptualization of wellness, the inaugural definition was used interchangeably with health and given by the World Health Organization (WHO) in 1946. The definition of wellness set forward by the WHO (1946, p. 1) was “not just the absence of illness, but complete, mental, and social well-being.” While the definition provided by the WHO has remained popular over the years, wellness has grown in its conceptualization, where the dimensions that make up wellness have varied. Hettler (1980) proposed six dimensions of wellness, which has since grown to eight (SAMSHA, 2017), which include: emotional, intellectual, physical, occupational, financial, creative, social, and environmental.

Indivisible Self Wellness Theory

The framework of the current study uses a conceptualization of wellness known as the Indivisible Self (Myers & Sweeney, 2005). The theory of the indivisible self was developed by Myers and Sweeney (2005) and was informed by the Wheel of Wellness, Sweeney’s previous work. The model was founded on Adlerian principles particularly, the concept of holism and the

indivisibility of the individual (Myers & Sweeney, 2005). Holism is a concept that asserts that all aspects of an individual connect to all other aspects of that same person and cannot be understood by examining parts in isolation from the whole system (Adler, 1954).

The Indivisible Self model takes into account the higher order of relationships between aspects of wellness and categorizes those relationships into five different selves (Myers & Sweeney, 2005). The Five Factor Wellness Inventory resulted from the development of Indivisible Self Model of wellness and is an assessment which takes into account the higher order level between certain components of wellness. The Five Factor Wellness Inventory measures the occurrence of the same five factors of the Indivisible Self model. (Myers, 2014). The Five Selves make up total self, or the indivisible self, and seventeen subtasks (see Table 1). The Five Selves include: Essential Self, Creative Self, Coping Self, Social Self, and Physical Self (Myers, 2014).

Table 1

Five Factors and Subtasks (Myers, 2014)

Five Factors	Subtasks	
Creative Self	Thinking	Mentally active and open minded; ability to be curious, creative, and troubleshoot; capacity to reduce stress
	Emotions	Awareness of feelings; appropriate emotional expression; ability to enjoy positive emotions and cope with negative ones; avoiding chronic negative emotional states
	Control	One's beliefs about confidence, competence, and mastery; goal setting and obtainment; assertiveness
	Work	Satisfaction with work; financial and job security; feeling appreciated at work; getting along with coworkers
	Positive Humor	Ability to laugh-off mistakes and unexpected things that happen; ability to laugh at others when appropriate; recognition of world's irony
Coping Self	Leisure	Satisfaction with free time activities; playful approach to tasks
	Stress Management	Self-management and regulation; assessment of one's coping resources
	Self-Worth	Self-acceptance; affirmation of one's own value and uniqueness
	Realistic Beliefs	Accuracy of perceptions; logical and rational thinking
Social Self	Friendship	Non-marital, sexual, and familial social relationships
	Love	Ability to be intimate, trusting, and self-disclosing; concern for others; satisfaction with sex life and family support systems
Essential Self	Spirituality	Practiced personal beliefs that recognize individuals are more than mind and body
	Gender Identity	Satisfaction with one's gender identity and the support received from it; ability to be androgynous
	Cultural Identity	Satisfaction with one's cultural identity and the support received from it; ability to assimilate culturally
	Self-Care	Preventative self-care habits such as: timely medical care, avoiding substance use, adequate sleep
Physical	Exercise	Sufficient physical activity; flexibility
	Nutrition	Balanced diet

While the Five Selves of the Indivisible Self Model are important Myers & Sweeney (2005), assert the need to also consider contextual variables to fully understand an individual's experience of wellness. People's attitudes, knowledge, and behaviors regarding wellness are influenced by the systems in which they are in. The Indivisible Self Model contains four contextual variables that reflect the impact of systems and work in combination with the Five Selves (Myers & Sweeney, 2005). The four contextual variables in the Indivisible Self model include: Local Context, Institutional Context, Global Context, and Chronometrical Context (Myers & Sweeney, 2005).

Local Contexts are microsystems in which individuals interact most often. Thus, local contexts can include families, neighborhoods, and communities (Myers & Sweeney, 2005). Institutional contexts are macrosystems which indirectly and directly affect individuals (Myers, 2014). Institutional Contexts oftentimes have strong negative or positive influences of which can be difficult to detach (Myers & Sweeney, 2005). Institutional Contexts include education, religion, government, business, and media (Myers, 2014). Global Contexts can be less salient and are often seen and influenced through media consumption (Myers & Sweeney, 2005). Global Contexts include politics, culture, global events and environments (Myers, 2014). The last context is the Chronometrical Context which refers to life span and reflects that people change in significant ways over time (Myers & Sweeney, 2005). Similar to the Wheel of Wellness the Indivisible Self necessitates holism.

Resilience

Resilience is a concept found across education, psychology, and mental health research. Resilience has been conceptualized in various ways and shares similarities to research that investigates perseverance, social determinism, and grit (Himmel, 2015). Resilience theory has changed over time but refers to an individual's ability to overcome obstacles and "bounce back" (Smith, Tooley, Christopher, & Kay, 2010). For the sake of this study resilience will be conceptualized and defined as the ability to cope effectively when faced with adversity, which connotes inner strength, competence, optimism and flexibility (Wagnild, 2009). Wagnild (2009) asserted that there are five original characteristics, purpose, perseverance, equanimity, self-reliance, and authenticity, that make up the resilience core and enable one to overcome adversity. Wagnild (2009) deemed Purpose as the most important characteristic, which was one's own meaning to life. Perseverance referred to the determination to continue on despite challenges and difficulties (Wagnild, 2009). Equanimity referred to harmony and balance and encapsulated one's ability to keep a positive outlook (Wagnild, 2009). Wagnild (2009) asserted that self-reliance reflected one's understanding of their own limitations and abilities. Lastly, authenticity, or existential aloneness refers to "comfort in your own skin" and acceptance of self (Wagnild, 2009; p. 17). While the five characteristics of the resilience core are represented in the Resilience Scale, they are not subscales of the measure (Wagnild, 2009). In this study, resilience is believed to be a mechanism that allows BMSM+ to obtain wellness by overcoming general barriers and barriers unique to them given their social location.

Psychological Empowerment

Psychological empowerment is a concept often used in social work, social welfare, and community research. Psychological empowerment theory is rooted in agency and social action. Psychological empowerment can be defined as the process by which an individual gains mastery over issues of concern to them (Zimmerman, 1995). Zimmerman (2000) further conceptualized psychological empowerment to be broken into three parts: intrapersonal, interactional, and behavioral. This study examined the intrapersonal component of empowerment, i.e. how empowered one feels, and proposed that empowerment played a role in increasing BMSM+'s perception regarding their ability to obtain wellness.

Definition of Terms

Black: Black refers to the social construct of racial classification where people within this racial group have a darker complexion and generally come from an ethnic background within the African diaspora (Clemente, 2011).

MSM: MSM is an acronym which stands for Men who have sex with Men. This term was coined and introduced by epidemiologist to reflect the notion that behaviors place individuals at risk for HIV not identity (Young & Myer, 2005).

HIV+: An HIV positive status is where an individual has contracted the Human Immunodeficiency Virus and has more than 200 CD4 T-cells (white blood cells) (CDC, 2017d).

Viral Load: The amount of HIV in the body. (CDC, 2017c).

Anti-Retroviral Therapy (ART): HIV medicine that reduces the amount of HIV in the body to a very low level known as viral suppression (CDC, 2017c).

Viral Suppression: Having less than 200 copies of HIV per milliliter of blood, which allows the immune system to function properly and prevent illness (CDC, 2017c).

Undetectable: Effective viral suppression to the point that a HIV test cannot detect the virus in the body (CDC, 2017c).

Viral Load Detectability: Is a measure of if an individual's viral load can be detected by a HIV test, or if the individual's viral load is undetectable.

Intersectionality: Intersectionality is the notion that various identities overlap to create a whole that is different from the components of individual identities combined. The overlapping social identities and the interplay between them as they relate to systems of oppression, domination, and discrimination (Collins & Blige, 2016).

Wellness: A lifestyle orientation toward optimal health and well-being where mind, body, and spirit are purposefully integrated in order to live a fuller life (Myers, 2014). In this study, wellness encapsulates one's Creative Self, Coping Self, Social Self, Essential Self, and Physical Self within the contexts of the systems within society (Myers, 2014).

Resilience: Resilience is the ability to cope effectively when faced with adversity and connotes inner strength, competence, optimism, and flexibility (Wagnild, 2009).

Empowerment: Empowerment refers to the process by which an individual gains mastery over issues of concern to them (Zimmerman, 1995).

Key Abbreviations

HIV. Human Immunodeficiency Virus.

MSM. Men who have Sex with Men.

BMSM. Black Men who have Sex with Men.

BMSM+. Black Men who have Sex with Men who living with HIV.

PLWHA. People Living With HIV/AIDS.

FFWEL. Five Factor Wellness.

RS. Resilience Scale.

SPCS. Sociopolitical Control Scale.

CRQD. Critical Race, Queer, and Disability Theories.

Methodology

The current study sought to use a descriptive, correlational research design rooted in a Critical, Race, Queer, and Disability (CRQD) framework. The researcher set forward to analyze the data by using a standard multiple regression to investigate the relationships among wellness, resilience, and empowerment in BMSM+.

Research Questions and Hypotheses

The following section provide the research question, research sub-question and hypotheses which guided the current study. This investigation was conducted to answer research questions relating to a quantitative study that used a descriptive, correlational design. Using a CRQD conceptual framework, the following research question and complementary sub-questions guided this research study:

RQ 1: Do resilience and psychological empowerment, as measured by the Resilience (Wagnild, 2009) and the Sociopolitical Control scales (Zimmerman, 1995) respectively, predict wellness as measured by the Five Factor Wellness Inventory (Myers, 2014) in Black Men who have Sex with Men living with HIV?

Sub RQ1: How much of the variance in wellness as measured by the Five Factor Wellness Inventory (Myers, 2014) among Black Men who have Sex with Men living with HIV is explained by resilience and psychological empowerment as measured by the Resilience (Wagnild, 2009) and the Sociopolitical Control scales (Zimmerman, 1995)?

Null Hypothesis 1: The wellness of Black men who have sex with men living with HIV cannot be significantly predicted by resilience.

Null Hypothesis 2: The wellness of Black men who have sex with men living with HIV cannot be significantly predicted by psychological empowerment.

Null Hypothesis 3: None of the variance in wellness of Black men who have sex with men living with HIV can significantly be explained by resilience and empowerment.

Variables of the Study

The variables selected within the study are reflective of the CRQD framework which provided an opportunity for counter-narrative, queering what is assumed to be standard (poor wellness among BMSM+), and conceptualizing positive HIV status as an identity of difference rather than a defect. The selection of positive psychological variables to report on the state of well-

being of BMSM+ is counter to a medical model approach and is aligned with the CRQD framework. Wellness was selected as the dependent variable in the study due to the lack of literature on the wellness of BMSM+. Additionally, resilience and empowerment were believed to play a role in helping BMSM+ obtain wellness, thus resilience and empowerment would be able to predict the wellness of BMSM+

Dependent Variables

In line with multiple regression this study had one dependent variable, wellness. The study will use participant's Five Factor Wellness Inventory total score as the dependent variable.

Wellness

In the current study, wellness was measured by Myers' (2014) Five Factor Wellness Inventory (FFWELL). Within this scale wellness was defined as a holistic approach in which mind, body, and, spirit is integrated in a purposeful manner with a goal of living life more fully (Myers, 2014).

Independent Variables

The current study included two independent variables as predictors for the multiple regression model. Each variable is discussed below.

Resilience

In the current study, resilience was measured by Wagnild's (2009) Resilience Scale. Within this scale resilience was defined as the ability to cope effectively when faced with adversity and

connotes strength, competence, optimism, and flexibility. The measure produces a total score that represents the participant's level of resilience (Wagnild, 2009).

Psychological Empowerment

In the current study, psychological empowerment was measured by Zimmerman's (1995) Sociopolitical Control Scale. The Sociopolitical Control Scale measured the intrapersonal dimension of psychological empowerment and was defined within the scale as the process by which an individual gains mastery over issues of concern to them (Zimmerman, 1995). The measure produces two subscale scores but the total score will be used to represent the participants' level of empowerment (Zimmerman, 1995).

Research Design and Rationale

A descriptive, correlational design was employed to answer the research question, sub-question, and test the hypotheses. Researchers have noted a need for more research that investigates BMSM in the context of the HIV epidemic (Dillon, & Basu, 2014; Wilson et al., 2016a). Furthermore, little research has been conducted in the area of wellness with BMSM+ as the population, thus quantifiable and statistically significant literature is needed.

Quantitative Research Methodology

The current study used a standard multiple regression where wellness served as the dependent variable and resilience and empowerment were the independent variables. The correlation coefficients that result from the procedure served to inform the researcher of the

relationship among wellness, resilience, and empowerment for BMSM+. Additionally, the eta squared among the independent variables and dependent variables explained the variance among the variables.

Population and Sampling

Black Men who have Sex with Men is the population where the selection requirements for the sample were (a) Black or African-American, (b) 18 years of age or older, (c) have engaged in sexual activity with a man, (d) be a cisgender male, (e) identify as HIV positive, (f) live in the U.S., and (g) have an adequate command of the English language. Criterion and snowball sampling procedures were used to acquire a sample that reflected the BMSM+ population.

Data Collection

In this section the researcher provides a description of the data collection procedures for the current study. The researcher collected data via a survey format that used online questionnaires, contained an informed consent, participant inclusionary criteria, demographic questionnaires, and three psychometric instruments. Three psychometric instruments were used to measure the constructs of wellness, resilience, and empowerment.

Instruments

The three instruments used in the current study included the Five Factor Wellness Inventory (DV; Myers, 2014), the Resilience Scale (IV; Wagnild 2009), and the Sociopolitical Control Scale (IV; Zimmerman, 1995). The battery was distributed through an online Qualtrics survey.

Five Factor Well

The Five Factor Wellness Inventory developed by Jane Myers (2014) has good internal consistency reliability .80 to .96 and validity. It measures one's general well-being or total wellness. The assessment contains 91 psychometric items and uses a four point Likert-type scale. The FFWEL produces 23 factor scores, four context scores, and a one-item validity index. Respondents' scores represent each of the factors of wellness, contextual variables, a life satisfaction index score, and a total wellness calculation.

Resilience Scale

The Resilience Scale developed by Wagnild (2009) has been supported in having good internal consistency reliability (.73 to .91) and good validity. It incorporates an individual's beliefs in their ability to cope, overcome, "bounce back" which is used to produce a total score. The assessment contains 25 items and uses a seven-point Likert-type scale. The respondent's total score represents the test-taker's overall resilience level.

Sociopolitical Control Scale

The Sociopolitical Control Scale developed by Zimmerman (1995) has good internal consistency reliability .75 to .78 with good construct validity (Fischer & Cocoran, 2007). It measures individual's beliefs on their ability to make change on an individual, community, and social, level (Zimmerman, 1995). The Sociopolitical Control Scale is composed of two subscales, Leadership Competence and Policy Control, which combine to make the total score. The assessment contains 17 items and uses a six-point Likert-type scale. The respondents' total scores,

which indicate their perception of their sociopolitical control, signify their level of intrapersonal empowerment.

Data Analysis

This descriptive, correlation study used standard multiple regression for data analysis. Standard multiple regression was used to determine if resilience and psychological empowerment contribute to the wellness of BSM+. Additionally, Pearson's correlation was used when deemed necessary.

Standard Multiple Regression

The researcher sought to conduct a standard multiple regression, utilizing wellness as the dependent variable (DV) and resilience and psychological empowerment as the independent variables. IBM's Statistical Package for Social Sciences 25 was used to run the multiple regression where the process outlined by Laerd (2015a) was used, which included checking for assumptions, fitting the regression model, and then interpreting the results.

Protection of Human Research Participants and Ethical Issues

The current study was conducted after being granted approval by the Institutional Review Board at the University of Central Florida. All stipulations for conducting human behavioral research were followed, and all people with access to data were CITI trained to work with human subjects and data. The use of anonymity was necessary in ensuring the minimization of risk and

safety of participants given the sensitivity of health information, specifically HIV which could have negative social and legal ramifications.

Limitations

The present study was designed to investigate if resilience and empowerment contribute to the wellness of BMSM+. The study is believed to have several limitations, some of which are inherent to the research design used. A limitation of multiple regression includes the possible presence of an unacknowledged confounding variable. Also, possible type I and II error may be limitations of the current study.

Additionally, there are a few limitations of the study which are inherent to the data collection process. The survey used to collect data consisted of 169 items and used self-report. Given the length of the survey, survey fatigue was expected to be an issue. However, only three participants did not complete the survey. Still, survey fatigue may have affected how participants answered questions given the length of the survey. Additionally, the survey relied on self-report where participants may have answered based on desirability.

Other limitations of the study were intrinsic to the sampling methods used. The study did not reach the members of the BMSM+ who are under 18 and did not have access to technology, thus possibly making aspects of the study less generalizable.

Professional Significance

This study will add to the little existing literature, which uses variables within positive psychology to better understand the experiences of BMSM+. Specifically, this study sought to

describe BMSM+ levels of wellness, resilience, and empowerment; as well as the ability to predict the wellness of BMSM+ from resilience and empowerment. The data collected could be used to inform clinical mental health practices through assessing the needs of BMSM+ clients as it relates to wellness. This information is necessary given counselors' mission to empower diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals (ACA, 2014). In addition, the data collected will inform social justice and advocacy needs of this population. Lastly, the findings of this research could have an impact on policy and how funding is allocated to programs entrusted with ensuring the wellness of BMSM+ within community-based organizations. More studies that use culturally appropriate frameworks and variables of positive psychology to understand the lives and experiences of the BMSM+ should be conducted.

Summary

The initial section of this chapter discussed background information pertaining to BMSM+. The researcher then provided an overview of the integrated framework that guides the study. Next, the researcher provided a statement of the problem, purpose statement, key definitions and abbreviations. Then, the researcher discussed the methodology including research questions, design, population, sampling, ethical issues, instrumentation, data collection, and data analysis. Finally, the study's limitations and professional significance were discussed briefly before the conclusion of this chapter.

CHAPTER II: LITERATURE REVIEW

The purpose of this study was to investigate the relationship among wellness, resilience, and empowerment within BMSM+ using a descriptive correlational research design. The current study sought to answer the following research question: Do resilience and psychological empowerment predict wellness among BMSM+? Additionally, the current study also investigated how much of the variance in wellness among BMSM+ was explained by resilience and psychological empowerment.

In this chapter, the researcher reviewed and analyzed the literature on wellness, resilience and empowerment as it pertains to BMSM+. Although studies in the social sciences have examined BMSM+ in relation to their sexuality, these studies have not informed social sciences much beyond that. In addition, although numerous studies in helping professions have researched factors including identity, HIV risk behaviors mental health, and community engagement, little analytic attention has been given to resilience, empowerment, and wellness regarding BMSM+ (Wilson et al., 2016b). As such, this literature review provides additional insight into the factors of resilience, empowerment, and wellness among BMSM+. The need for research involving BMSM+ to consider factors beyond sexuality is addressed by the researcher in the current study.

The literature reviewed and analyzed in this chapter were found by conducting a literature search using the databases PsycINFO, PubMed, Academic Search Complete, Web of Science, and ProQuest Dissertations and Theses. The researcher used the search terms “Black,” “African-American,” “gay,” “bisexual,” “MSM,” “Men who have sex with men,” “sexual minority,” “HIV,” “HIV positive,” “HIV+,” “AIDS,” “wellness,” “well-being,” “quality of life,” “resilience,” “empowerment,” and “agency”. The researcher conducted several searches from June 14, 2017

through June 22, 2018. The publication years were limited to 2007 to 2017, however there were exceptions where the year range was widened to include seminal works or when searches did not yield many results.

Before reviewing the literature on BMSM+ as it relates to the constructs examined in the current study it is necessary to provide a background of literature pertaining to identity markers of BMSM+, building on each marker of identity that composes the population. Reviewing literature that brings awareness to the possible lived experiences of BMSM+ before examining literature regarding the population as a whole is necessary given the infrequent use of BMSM+ as research populations in counseling and wellness literature. While the intersection of all their identities creates the holistic experience of BMSM+ an awareness and understanding of the range of literature among identity markers may provide a greater context to better understand the sociocultural realities that BMSM+ face. The CRQD framework will be used as a tool to review the literature. Thus, chapter two will discuss the role of the CRQD framework in the review literature; literature regarding identity markers of BMSM+, including PLWHA, Men who have sex with men living with HIV (MSM+), and BMSM+; ending with a review of the literature on wellness, resilience, empowerment and the role of each in BMSM+ research.

CRQD Framework as a Critical Tool for Reviewing Literature

This section discusses the role of the Critical, Race, Queer, and Disability (CRQD) framework in reviewing the literature and how aspects of the CRQD framework has been used in research in the past. The CRQD lens was used within the current study to account for the multiple identities of BMSM+ to produce a useful and culturally relevant study. To review the literature

from a critical lens, the current study relied on principles drawn from Critical, Race, Queer, and Disabilities theories including intersectionality, contesting scholarship, contesting truth, counter-narratives, disability as a social construct and aspect of difference, and countering biological understandings of disability. The role of the CRQD principles used as a literature review tool are discussed in the next following sections.

Using Intersectionality to Contest Scholarship

In the review of literature the researcher used the concept of intersectionality, derived from theories which discuss race (Collins & Blige, 2016), as a method for contesting scholarship, which is derived from Queer theory (Gamson, 2000). Intersectionality was coined as a term in 1989 by legal scholar, Kimberlé Crenshaw; however, scholars had been discussing the concept of intersectionality before the 1970s (Collins & Blige, 2016). Intersectionality is a concept that refers to understanding that someone's being, life events, conditions, and experienced social inequality are shaped by multiple axes of social division (Collins & Blige, 2016). Additionally, the axes themselves interact to create a complex experience for the individual, which is seldom understood by looking at one axis (Collins & Blige, 2016). In general, intersectionality is an analytic tool and gives individuals better access to global and intrapersonal complexities (Collins & Blige, 2016). Researchers have asserted the need for intersectional approaches to understand individuals' experiences after studying privilege, power, and oppression's complex interconnectedness between intrapersonal social constructions of race, gender, sexuality, and ability (Boylorn & Orbe, 2014). Thus, what is commonly understood about people when using an intersectional lens is that all aspects of one's identity must be taken into account when trying to reach an understanding of that

individual's experience. Intersectionality required the researcher to consider the impact of identity when reviewing the literature regarding the wellness, resilience, and empowerment of BMSM+. Furthermore, in reviewing the literature, study samples that reflected a similar identity make-up as BMSM+ were included and critiqued as necessary since there was a scarce amount of literature specifically pertaining to the wellness of BMSM+. Studies that did not include exclusive BMSM+ research samples are contested in their generalizability to BMSM+ given the principles of intersectionality.

Contesting "Truth" through Counter-Narrative and Social Deconstruction

Critical Race and Queer theories have been used in educational and social science research to address social inequities while using counterstorytelling and queering to disrupt and contest "truths" and normalized discourses established by dominant power structures across institutions (Stovall, 2006; Renn, 2010). Researchers who have used counter-narratives in studies identify and acknowledge the narratives that have emerged in the literature regarding the population or phenomenon being studied, and conducts research that seeks to counter and disrupt those narratives (Milner & Howard, 2013). Similarly, queering refers to deconstructing normalized categories and labels that are socially produced (Mizzi and Setbbins, 2010). The current study investigated the wellness of BMSM+ as a way to disrupt the notion that PLWHA, BMSM+ specifically, cannot be well or automatically get categorized as unwell (Grierson & Canavan, 2007; WHO, 1946). In doing so, the researcher also relies on aspects of disability theory that focuses on viewing disability as a socially constructed aspect of difference and countering the biological understanding of said difference (Mertens, 2003). Researchers who have used disability theory frameworks usually

conduct their studies with a critical lens that challenges stereotypic beliefs about the disability found in both literature and society (Herson, 2016). The researcher's choice to explore the wellness, resilience, and empowerment of BMSM+ serves to disrupt the narratives surrounding the lack of wellness among BMSM+, which persists in literature and society. The researcher critiqued literature that focused on myopic and narrow framings of PLWHA and perpetuated the narrative that the current study sought to challenge.

PLWHA, MSM+, and BMSM+ in the Literature

This section of chapter two discusses the literature regarding identity markers of BMSM+. Within this section of chapter two, relevant information and literature pertaining to PLWHA, MSM+, and BMSM+ are discussed.

People Living with HIV/AIDS in the United States

During the early 1980s the United States paid little attention to a newly discovered disease commonly referred to as the 'gay plague' (Curran & Jaffe, 2011), which in two years after the disease's discovery claimed the lives of 853 individuals (Calonico, 2015). The disease now known as the Acquired Immune Deficiency Syndrome (AIDS) would take more than 4000 additional lives before President Ronald Regan mentioned AIDS publicly for the first time (Calonico, 2015). While in some cases AIDS is still considered to be life-threatening, HIV is considered to be a chronic disease (Deeks, Lewin, & Havlir, 2013) as long as someone diagnosed with HIV remains adherent to their antiretroviral therapy (ART; medication regimen). Similar to other chronic illnesses, medication adherence among people living with HIV (PLWH) can ensure a long and healthy life

(CDC, 2108f). PLWH who are adherent to their medication can obtain an undetectable viral load, which means that viral suppression has been obtained and copies of HIV cannot be detected by standard viral load tests (CDC, 2018f). Furthermore, medication adherence serves as a form of HIV prevention known as treatment as prevention (TasP). TasP is where someone living with HIV who has an undetectable viral load cannot transmit the virus to someone else (CDC, 2017c; Prevention Access Campaign, 2016). In 2010, the White House identified priorities and strategies believed to reduce HIV contraction and promote care for PLWHA (CDC, 2015). Today, with technological advances in medicine made to prevent AIDS, HIV became the focus of medical treatment and prevention efforts (CDC, 2017d). The United States' HIV political efforts and advancements in medicine led to a focus of research on HIV prevention and treatment (CDC, 2017d).

People Living with HIV/AIDS & Research

This section of chapter two discusses the literature relative to PLWHA, and introduces literature that accounts for BMSM+ identity related to their positive HIV status. At the end of 2015 there was an estimated 1.1 million PLWHA in the United States (CDC, 2017d). Out of the last eight years, on average, approximately 39,000 people were diagnosed with HIV per year (CDC, 2017a), with the greatest proportion occurring in the South, followed by the Northeast, West, and Midwest (CDC, 2018g). Given the epidemiological presence of HIV, most studies involving PLWHA were biological in nature focusing on the virus itself and have investigated the biological and medical components of exposure, transmission, prevention, and treatment (Finitsis, Pellowski, Huedo-Medina, Fox, & Kalichman, 2016; Grierson & Canavan, 2007; Lakshmi, Beekmann, Polgreen, Rodriguez, & Alcaide, 2018; Moore, Mao, & Oramasionwu, 2015). Research regarding

PLWHA and their experiences has increased over time with the advancement of medicine such as antiretroviral therapy (CDC, 2017b). Still, literature in the counseling field regarding PLWHA is scarce. A search of the literature with HIV or AIDS as the search terms among the counseling field's flagship journal, the *Journal of Counseling & Development*, yielded a total of 57 articles. Only six articles pertaining to HIV or AIDS were published in the last ten years, with 44 of the 57 publications taking place from 1986-1996. There were approximately 30 articles focused on HIV or AIDS found among the American Counseling Association's divisional journals. Once again, the rate of articles published in ACA divisional journals has lessened in recent years.

Early HIV-focused articles in the counseling literature discussed HIV, PLWHA, and people affected by HIV/AIDS in the context of the 1980's AIDS crisis. However, due to medical advances in the prevention and treatment of AIDS, the reality of HIV/AIDS, PLWHA, and those affected by HIV/AIDS has changed dramatically (CDC, 2018f). Consequently, the researcher expanded the review of literature to disciplines outside of counseling including psychology, social work, nursing, and public health to provide a thorough review of the literature pertaining to PLWHA. After expanding the scope of disciplines, the researcher found that research regarding PLWHA could oftentimes be categorized into HIV risk behaviors, health, mental health, and the continuum of care, with HIV commonly used as the variable that explained the phenomenon being studied. Those categories of research are discussed in the following subsections. Additionally, counselor-trainee preparation was an area of PLWHA research that was unique to the counseling literature and is discussed first.

Counselor Trainee Preparation

Counselor trainee preparation in working with clients living with HIV/AIDS was routinely found in the counseling literature. Researchers conducted a study in 2015 that examined HIV/AIDS knowledge among professional counselors and counseling students living in Ohio (Rose, Sullivan, Hairston, Laux, & Pawelczak). The study included 70 participants who were licensed mental health counselors ($n = 29$), licensed school counselors ($n = 23$), and counseling students ($n = 16$) and used an 18-item HIV Knowledge Questionnaire (Rose, et al., 2015). Results of the study showed that the sample's average score was 16.47 (91.51%), and the older a participant was, the less was known about HIV transmission ($r = -.28, p < .05$; Rose, et al., 2015). However, the questionnaire only reflected participants biological understanding of HIV transmission, which may not be all that helpful in working with clients already living with HIV outside of psychoeducation. Nevertheless, the researchers asserted the need for more HIV/AIDS training among counselors, which they noted was lacking in the counseling profession (Rose, et al., 2015). Additionally, other research has supported the need for more HIV/AIDS specific training among counseling students (Joe, Heard, Yurcisin, 2018a, 2018b). Joe et al. (2018a) conducted a descriptive content analysis that explored counseling students' perceptions of factors related to comfort when working with a client living with HIV/AIDS. The study had 111 participants where race and gender were representative of the counseling field, participants were from every geographical region, and approximately 41% of the participants had at least completed practicum (Joe et al., 2018a). The researchers identified six themes that participants said would affect a counselor's comfort when working with a client living with HIV/AIDS, including knowledge, fear, HIV stigma, personal experience, personally held beliefs, and sex/sexuality. Knowledge was the most frequently mentioned theme at 104, with the

next being fear at 28. In a similar study conducted by Joe et al. (2018b), participants that were students indicated the challenges a counselor may face when working with a family affected by HIV/AIDS. This study had a sample of 111 participants who were representative of the counseling profession and used a descriptive content analysis to identify themes within the data (Joe, et al., 2018b). Knowledge and beliefs, empathy, grief, HIV stigma, and resources and support were the themes found in the study, with knowledge and beliefs mentioned most frequently at 55 (Joe et al., 2018b). Specifically, participants indicated that a lack of knowledge about HIV/AIDS would serve as a challenge to counselors working with a family affected by HIV/AIDS (Joe, et al., 2018b). Both Joe et al. (2018a, 2018b) studies indicated the need for more HIV/AIDS specific training for counseling students in the studies' implications.

HIV Risk Behaviors

HIV risk behaviors are factors that increase one's likelihood of acquiring HIV and has been widely researched (Wilson et al., 2016b). HIV risk behaviors can describe the lived experiences of PLWHA, however, literature oftentimes studies risk behaviors for prevention efforts. Thus, the positive HIV diagnosis individuals have and how they came to acquire the HIV diagnosis is used for the aid of others. For example, a meta-analysis that reviewed studies purposed with reducing HIV risk behaviors among PLWHA proposed that the HIV epidemic is best addressed through TasP efforts (Crepaz, et al., 2014). Such an implication benefits PLWHA by trying to get them all in treatment and virally suppressed, however it also puts all the onus to end the HIV epidemic on PLWHA (Crepaz, et al., 2014). The researchers reviewed 48 studies published from 1988 through 2012 and found that the key components of evidence-based interventions for HIV risk behavior

reduction interventions included behavioral change motivation, HIV misconceptions, mental health issues, medication adherence, and HIV transmission risk behavior (Crepaz, et al., 2014). However, because of the varied delivery of evidence-based interventions the researchers determined that the greatest impact on HIV prevention was through HIV treatment (Crepaz, et al., 2014).

A study in the counseling literature that discussed HIV and BMSM focused on HIV risk behaviors and prevention. Amola and Grimmatt (2015) conducted a correlational study that examined the relationships between sexual identity, depression, self-esteem, HIV risk behaviors, HIV status, and internalized homophobia among BMSM. The researchers found that there was a positive relationship between internalized homophobia (dependent variable), depression ($r = .79, p < .001$), and three different HIV risk behaviors (number of different sexual partners, condom use with primary partner, condom use with non-primary partner, $p < .001$). Additionally, internalized homophobia was negatively correlated with self-esteem ($r = -.92, p < .001$; Amola & Grimmatt, 2015). Participants who reported that they did not have HIV ($M = 48.12, SD = 19.38$) had significantly lower internalized homophobia levels than participants who did not know their HIV status ($M = 124.90, SD = 6.75$) or were living with HIV ($M = 98.84, SD = 42.39$; Amola & Grimmatt, 2015). Twenty percent ($n = 40$) of the study's sample was living with HIV, but due to the design of the study only one finding delineated the results by HIV status, making the generalizability to BMSM+ difficult in some aspects (Amola & Grimmatt, 2015). Additionally, while this study does provide relevant information on BMSM+, still literature regarding the wellness of BMSM+ is needed.

Health

Studies involving PLWHA that investigated variables related to health were also frequent in the literature and usually utilized a medical model. Consistent with the medical approach, within health-related studies there was a focus on negative or illness-oriented outcomes. For example, in two meta-analyses within the category of health, hypertension (Xu, et al., 2017) and sedentary lifestyles (Vancampfort, Mugisha, De Hert, Probst, Stubbs; 2017) were the focus and framing.

The researchers who used a meta-analysis that examined the prevalence of hypertension among PLWHA was published for medical disciplines. The estimated prevalence of hypertension among PLWHA in the overall sample was 25.2% with a 95% confidence interval (Xu, et al., 2017). However, the studies used in this meta-analysis contained international samples with varying demographics, making the results less generalizable to BMSM+ living in the United States.

The researchers who used a meta-analysis that investigated the effects of a sedentary lifestyle analyzed 45 studies with a combined total of 13,167 participants (mean age range = 30.5-58.3 years; 63.2% male) and found five consistent correlates of lower levels of physical activity: older age, less education, lower CD4 cells, exposure to ART, and presence of lipodystrophy, an abnormal distribution of fat in the body (Vancampfort et al., 2018). This meta-analysis used studies containing samples within the United States where many of those samples were exclusively Black and had a majority of Black participants (Vancampfort et al., 2018).

While the examination of health through a medical model does add to the literature such a framing can be further marginalizing to PLWHA through the continued emphasis on illness and looking at HIV as a defect rather than difference (Aholou et al., 2017; Eaton et al., 2014; Maulsby, et al., 2013; Young & McLeod, 2013). The continued framing of those with chronic illness as

living with a defect, that then gives way to other adverse events, in this case hypertension (Xu, et al., 2017) and sedentary lifestyle (Vancampfort, et al., 2018), limits the understanding of the well-being of PLWHA. Specifically, the medical model is limiting to a greater understanding of well-being and wellness because the medical model is not holistic. Consequently, research regarding PLWHA that expands the understanding of their circumstances beyond a medical model is necessary, as in the current study.

Mental Health

Mental health was another widely studied construct among PLWHA. Studies have shown that PLWHA have a high prevalence rate of clinically significant symptoms related to depression, mood disorders, and anxiety (Evans et al., 2005; Vitiello, Burnam, Bing, Beckman, & Shapiro, 2003). Mental health is often researched among PLWHA because of the correlation between mental health and HIV treatment outcomes. Studies have consistently shown that PLWHA are at a higher risk of poor adherence to ART, HIV related mortality and morbidity, increased viral load, and decreased CD4 count if they have depressive and anxious symptoms (Gonzalez, Batchelder, Psaros, & Safren, 2011; Ironson, O’Cleirigh, Fletcher, Laurenceau, Balbin, & Klimas, 2005; Leserman, Petitto, Perkins, Folds, Golden, & Evans, 1997). Thus, there is an interplay between mental and physical health among PLWHA, which can influence overall well-being and quality of life. Consequently, the interplay between mental and physical health situates counselors in a unique position where they could have an impact on the total wellness of PLWHA. Theoretically, counselors may be able to use their training to decrease symptoms of depression and anxiety, subsequently having a positive impact on the unique needs of their clients living with HIV, such as

medication adherence, viral load, and CD4 count (Dillard, Zuniga, & Holstad, 2017; Zeligman & Robinson, 2014).

The mental health of PLWHA is believed to be greatly affected by psychosocial factors including lack of support, isolation, drug use, discrimination, isolation, and stigma (Earnshaw, Bogart, Dovidio, & Williams, 2013; Nanni, Caruso, Mitchell, Meggiolaro, & Grassi, 2015; Vitiello et al., 2003). In a meta-analysis study where researchers reviewed 62 studies to investigate the benefits of psychosocial interventions for the mental health of PLWHA, researchers found that psychosocial interventions had a small positive effect on the mental health of PLWHA, with larger effects found based upon the mental health training of the provider (van Luenen, Garnefski, Spinhoven, Spaan, Kraaij, & Dusseldorp, 2018). This study provides implications for the role of counselors and other helping professions committed to facilitating the wellness of PLWHA (van Luenen, et al., 2018). However, the meta-analysis only included one study which focused on Black males who have sex with men and women (BMSMW) living with HIV (van Luenen, et al., 2018). Specifically, the researchers of that one study used an intervention design that examined a stress-focused sexual risk reduction intervention for African American men who have sex with men and women (MSMW) who had experienced childhood sexual abuse (Williams, Glover, Wyatt, Kisler, Honghu, & Muyu, 2013). The study found that a stress-focused intervention was more efficacious than a general health promotion intervention in decreasing unprotected anal insertive sex ($p < .05$) and reducing depression symptoms ($p < .01$; Williams, et al., 2013). While this study's findings are helpful in providing mental health evidence-based interventions, the design focuses on mental illness and not mental health/wellness. Thus, more investigations regarding the mental health and

overall well-being of PLWHA most affected by HIV at the intersection of race and sexuality, such as BMSM+, are necessary.

Mental health was a construct that was present in HIV research in the counseling literature. Zeligman, Barden, and Hagedorn (2016) conducted a study that sought to inform the counseling profession about the experiences of PLWH and took a resilience approach that examined posttraumatic growth among PLWH. The researchers used a descriptive, correlational study to investigate if social support moderated the relationship between HIV stigma and posttraumatic growth (Zeligman, et al., 2016). Ultimately, the researchers found that there was a positive significant relationship between posttraumatic growth and social support ($r = .27, p < .05$), and a negative significant relationship between posttraumatic growth and HIV stigma ($r = -.24, p < .05$). While 44% of the study's participants were Black with 31% female, sexuality was not reported. While the current study does not measure posttraumatic growth, it does measure coping ability and resilience, aspects of posttraumatic growth which may provide better insight to that experience among BMSM+.

Another recent study in the counseling literature that pertained to mental health was an exploratory investigation of treatment strategies for Black MSM who use methamphetamine (Jerome & Halkitis, 2014). The researchers found that recruitment strategies, therapist attributes, group characteristics, and elements of the interventions were relevant for BMSM and BMSM+ seeking treatment for methamphetamine use (Jerome & Halkitis, 2014). A review of counseling literature revealed that Jerome & Halkitis (2014) are two of few researchers who had an empirical study that reported BMSM+ as participants in any scientific journal associated with the American

Counseling Association. Thus, more counseling studies and published articles involving BMSM+ specifically are necessary (Hongryun & Nanseol, 2017; Wilson et al., 2016b).

Continuum of Care

Lastly, research pertaining to PLWHA oftentimes focused on the care continuum. The HIV care continuum is a model that outlines the sequential stages of HIV medical care that PLWHA go through from initial diagnosis to achieving the goal of viral suppression (U.S. Department of Health and Human Services, n.d.). While conceptually and practically the continuum of care has been established within medical professions, care refers to support provided to PLWHA along their journey to viral suppression (Lakshmi et al., 2018). Historically, case managers and peer mentors, employees of community-based organizations who are living HIV, have been the ones to provide care and support to better the mental health and overall wellness of PLWHA (Gwandz, et al., 2017; Shacham, Lopez, Brown, & Ritz, 2018). Nevertheless, counselors can also play a significant role in fostering care and support through mental health and wellness interventions (Dillard, Zuniga, & Holstad, 2017; Zeligman & Robinson, 2014).

Generally, studies that explored the HIV care continuum provided a more complex depiction of PLWHA, as specific barriers that affected the delivery of care were discussed. For example, factors such as geographical location and spirituality were often discussed in relation to the HIV care continuum (Kendrick, 2017; Pellowski, 2013). Researchers who used a meta-analysis that examined barriers of care for PLWHA in rural areas identified 27 barriers when it came to the delivery of care, with the most common including transportation, provider stigma and discrimination, confidentiality concerns, and lack of financial resources (Pellowski, 2013). Within

the study there were two studies where the sample demographics shared an additional identity marker of the sample in the current study (BMSM+), Black or MSM. One study included a sample of Black women living with HIV (Vyavaharkar, Moneyham, & Corwin, 2008) and the other study used a sample of Latino MSM (Rhodes, et al., 2010). Both studies found a similar theme of lacking a resource, which was not reflected in the results of Pellowski's (2013) meta-analysis. In the study with Black women there was a lack of services and inferior quality of available services (Vyavaharkar, et al., 2008), and in the study with Latino MSM there was a lack of accurate information about HIV and prevention (Rhodes et al., 2010). This illustrates how the experiences of marginalized, minority groups within heterogeneous samples go overshadowed or are erased.

In another study researchers sought to determine whether religion and spirituality were barriers or facilitators to treatment among PLWHA and reviewed 33 studies that explored the spiritual and religious contexts of the HIV care continuum (Kendrick, 2017). Religion and spirituality were associated with poorer adherence and clinical health outcomes in twelve studies (Kendrick, 2017). There were seven studies that did not find a significant association between religion and spirituality and HIV outcomes (Kendrick, 2017). Lastly, there was little consistency concerning the measurement of religion and spirituality among all studies (Kendrick, 2017). Two studies within the meta-analysis had significant result for Black PLWHA. One study that included a sample of African immigrants and refugees found that cultural and religious beliefs (i.e. sex and marriage) created a distrust among participants' that influenced their decision to stay in HIV treatment in community settings (Othieno, 2007). The other study found that Black participants who were more likely to be adherent to their medication were less likely to be religious; however, religious coping was correlated to better HIV treatment adherence (Sunil & McGhee, 2007). Both

the Othieno (2007) and Sunil and McGhee (2007) studies indicated that cultural factors impact the experiences of PLWHA, which suggests that the experiences of BMSM+ are unique. The prevalence of literature on PLWHA in regard to the care continuum has also led to a focus on populations who are disproportionately affected by HIV as researchers try to better understand how and why certain communities are more affected than others. One population who is often researched because of how they are disproportionately affected by HIV are men who have sex with men (MSM).

MSM+: Men who have Sex with Men and HIV

This section of chapter two discusses literature regarding the sexual minority and HIV statuses of BMSM+ with an important discussion around terminology. Men who have sex with men or MSM is a concept that originated in the public health field as a labeling mechanism and is used throughout literature to denote men who have engage in sexual activity with another man (Young & Meyer, 2005). MSM has historically focused on cisgender men, men whose sense of personal identity and gender corresponds with their male birth sex (Scheim, et al., 2016). By definition, MSM includes gay and bisexual men as well as any man who may not identify as gay or bisexual but has engaged in sexual activity with other men. Though the term MSM includes men who identify on the LGBTQ+ spectrum such as questioning, queer, pansexual, and asexual, its introduction historically served as a marker for men who identify as straight and do not want to be characterized with the stigma attached to the LGBTQ+ community (Treichler, 1999).

MSM+ in the Literature

MSM was a way for epidemiologists to convey that behavior places an individual at risk for HIV and not identity (Young, et al., 2000). The belief was that the use of MSM would lessen stigma and increase prevention efforts (Treichler, 1999). However, it is important to note that the term MSM does come with some controversy. Social constructionists assert that the epidemiologist who created the term sought to reduce gay identity to its most basic core (Young & Meyer 2005). Social constructionist argued the term, MSM, could expand society's conceptualization of sexual orientation identity, where the main categorizing factor is on sexual activity to a more complex understanding of sexuality (Young & Meyer, 2005).

Furthermore, Young & Meyer (2005) critiqued the use of the terms such as MSM in public health discourse and asserted that the term erased people's sexual minority identities. They suggested necessary strategies that public health professionals should consider when discussing sexually minority populations, which all revolved around adopting more nuanced and culturally relevant language (Young & Meyer, 2005). One specific suggestion Young & Meyer (2005) proposed was for researchers to report the identity terms represented in samples by allowing participants to identify themselves. Young and Meyer (2005) asserted that reporting the specific sexual minority identities was essential considering intersectionality and the nuances of experiences, and the prevalence of HIV among MSM. Young & Meyer's (2005) suggestions were similar to those provided by Garcia, Parker, Parker, Wilson, Philbin, and Hirsch (2016) who conducted a community-based ethnography that explored the limitations of BMSM as a category. Garcia, et al. (2016) asserted the need to bring back sexual orientation in HIV research, and highlighted the important role of acknowledging the subjectivity and diversity among BMSM. The

researcher used terminology consistent with the description of the HIV disparity used by the CDC, MSM, but allowed participants to identify their sexual orientation using an open response item.

MSM account for 70% of new HIV contractions in the United States, and an estimated 615,400 gay and bisexual men are living with HIV in the United States (CDC, 2018d). Recently, the overall HIV transmission rates among gay and bisexual men have declined (CDC, 2018d), and there has been a substantial amount of research regarding MSM and HIV in terms of transmission, prevention, disclosure, testing, and risk factors (Halkitis, Wolitski, & Millett, 2013; Nelson, Pantalone, Gamarel, Carey, & Simoni, 2018; Otis et al., 2016; Whitfield, Kattari, Walls, & Al-Tayyib, 2017). While HIV disproportionately affects MSM, there is an even greater disproportion at the intersection of race and sexual orientation which affects Black MSM (BMSM) and has resulted in them as the subpopulation most affected by HIV in the United States (CDC, 2018c).

The Changing Face of HIV/AIDS: BMSM+

This section of chapter two discusses statistics and literature specific to BMSM+, the population used in the current study. While HIV can affect anyone regardless of gender, race, sexual orientation and other identity constructs, certain groups remain disproportionately affected by the disease (CDC, 2017d). In the United States the Black community is the racial group most impacted by HIV (CDC, 2018b). When viewed by racial/ethnic group, the Black community accounted for the highest proportion of new HIV diagnoses, people living with HIV, and people who have received an AIDS diagnosis (CDC, 2018b). The combination of how HIV has affected MSM and Black communities has manifested in the HIV disparity among BMSM. In the United States, HIV affects no other group more than Black gay and bisexual men (CDC, 2018c). In fact,

one in two Black gay and bisexual men will be diagnosed with HIV in their lifetime (CDC, 2016c). In recent years, gay and bisexual men overall, only had a 1% increase in HIV diagnoses, and HIV diagnoses among Blacks overall have declined; however, HIV diagnoses for Black gay and bisexual men increased 22% during that same period (CDC, 2017a). The trend has since leveled off and approximately 10,000 BMSM acquire HIV per year (CDC, 2018c). As of 2014 there were 196,928 Black gay and bisexual men living with HIV in the U.S. (CDC, 2018a).

The Intersectional Research of BMSM+

Much of the literature throughout disciplines such as medicine, public health, psychology, and counseling has discussed BMSM+ through a narrow lens. The lenses that researchers use when studying BMSM+ and BMSM is usually clinical and connected to HIV prevention (Grierson & Canavan, 2007). Oftentimes studies included BMSM and BMSM+ populations and considered HIV status to be an outcome measure or study variable, where seropositivity was an unwanted outcome (Aholou et al., 2017; Eaton et al., 2014; Maulsby, et al., 2013; Young & McLeod, 2013). Thus, research has framed the very existence of BMSM+ as something negative, this has often been the case in HIV prevention studies where a positive HIV diagnoses is seen as a failure (Garcia, Colson, Parker, & Hirsch, 2015). The negative framing of HIV can also be seen in research that indicates a positive HIV diagnosis as a mediator to other negative outcomes. Even when a variable outside of sexuality was investigated it was usually framed within the context of HIV risk. For example, a qualitative study conducted to investigate the experience of resilience in BMSM substance users among 21 participants conceptualized resilience as protection from HIV (Buttram, 2015). Buttram (2015) had three findings related to resilience against social disparities

associated with HIV transmission risk including: (a) the presence of various, co-occurring contributing elements reflective of inner strength, social relationships, diverse experiences, and religion/spirituality, altruism, and creativity; (b) a difference in how social support was experienced among participants who did or did not have gay and bisexual friends; (c) the influence of diverse experiences and relationships on resilience development. Consistent with the research of other identities such as PLWHA and MSM+, studies involving BMSM+ frequently used a medical model approach. Research with a medical model approach usually interpreted HIV as a deficit or defect, investigated outcomes measured by negative variables, and was not holistic. Studies involving BMSM+ were consistently framed only in the context of prevention, down low (defined below), and stigma.

HIV Prevention

Studies involving BMSM+ were commonly focused on prevention or had implications for prevention interventions and strategies. For example, a correlational study that had 1533 participants who were BMSM (7.4% HIV+) assessed the frequency and relationship of HIV testing and late diagnosis (Mannheimer et al., 2014). Mannheimer, et al. (2014), found that infrequent HIV testing, undiagnosed infection, and late diagnosis were common among BMSM (odds ratio: 4.8, 95% CI: 3.2, 7.4, $p < 0.0001$). Much of the focus of the study's findings emphasized targeted prevention through increased testing efforts.

Researchers of another study used a phenomenological research design to describe (a) BMSM's healthcare experiences, (b) perception of the influence of their race and sexual orientation on healthcare experiences, (c) perceived barriers to healthcare, (d) quality of communication

between patient-doctor, and (e) factors affecting medication adherence (Malebranche, Peterson, Fullilove, & Stackhouse, 2004). The researchers conducted eight focus groups with a total of 81 participants (46.9% of them were BMSM+) and found that discrimination by race and sexuality ostracized BMSM and were compounded by negative encounters within healthcare systems (Malebranche, et al., 2004). When BMSM internalized experiences of perceived discrimination healthcare utilization, HIV testing, communication, and adherence behaviors were lessened (Malebranche, et al., 2004). While Malebranche, et al. (2004) made a call for more racially and ethnically diverse service providers and improved cultural competency, they only do so for prevention efforts. However, racially and ethnically diverse service providers and improved cultural competency is also necessary for BMSM who are already living with HIV.

Moving Away from the “Down Low”

Another common theme in research involving BMSM+ surrounded a phenomenon known as the *down low*. The down low refers to BMSM who also engage in sexual activity with women (BMSMW) (Lassiter, 2009). The prevalence of HIV diagnosis among Black women living with HIV has oftentimes been blamed on BMSMW (Lassiter, 2009). References to the down low are seen as stigmatizing and an oversimplification of the HIV epidemic’s impact on the Black community (Lassiter, 2009). Yet, empirical investigations of BMSM on the *down low* is prevalent.

For example, researchers conducted a study where they reviewed articles related to the “down low” phenomenon ultimately found that there were no empirical studies that looked exclusively at HIV and BMSMW (Bleich & Taylor-Clark, 2005). The researchers outlined the needs for future research, which included an examination of role of media on health-seeking

behaviors; co-infection rates of HIV and other STIs; empirical research on the relationship between HIV, Black women, and BMSMW; better understanding of identity construction; exploration of spirituality; and BMSMW research design challenges (Bleich & Taylor-Clark, 2005). Additionally, Bleich & Taylor-Clark (2005) provided future recommendations, which included culturally competent HIV prevention and treatment services and intervention strategies catered to the specific needs of the targeted population (Bleich & Taylor-Clark, 2005).

Researchers of another literature review study that took place nine years later explored the concept of the down low as well (Pettaway, Bryant, Keane, & Craig, 2014). The researchers of the study reviewed 22 articles published from January 2007 through June 2012 (Pettaway, et al., 2014). The researchers' review of literature found an inconsistent understanding of down-low identity, an association between HIV/AIDS and down-low identity, and heteronormativity (Pettaway, et al., 2014). The researchers critiqued the Western society's reductive ways of organizing the sexual orientation and sexuality of BMSM and women (Pettaway, et al., 2014).

While not mentioning the "down-low" directly, researchers of another recent study that used that same population, BMSMW living with HIV (BMSMW+), investigated the ability of BMSMW+ to access and maintain HIV-related health care and treatment adherence given the population's discretion around their same-sex desires (Arnold, et al., 2017). The researchers found that barriers to HIV-related health care and treatment adherence included: (a) competing survival needs (i.e. housing and food), (b) HIV medication side effects, (c) characteristics of the site providing care, (d) disclosure and social support, and (e) the need of BMSMW+ group-based interventions (Arnold, et al., 2017). This study provided relevant insight regarding the experiences of a subgroup in the current study's population.

Stigma

The role of stigma was another theme commonly researched among BMSM+. The stigma can be external or internal, refer to stigma regarding racial identity, sexuality or HIV status, or a combination of all. Researchers conducted a longitudinal study that looked at the experiences of stigma and healthcare engagement among BMSM+ who were newly diagnosed with HIV (Eaton, et al., 2018). Specifically, the researchers evaluated the experiences of stigma related to healthcare both prior to and post HIV or STI diagnosis among 151 BMSM living in the Atlanta, GA metro area. The findings of the study supported the relationship between inadequate health care engagement and post-diagnosis anticipated stigma ($b = -0.38$, $SE = 0.17$, $p \leq .05$; Eaton, et al., 2018). Additionally, pre-diagnosis prejudice was a predictor of post-diagnosis enacted ($b = 0.39$, $SE = 0.14$, $p < .01$), anticipated ($b = .28$, $SE = 0.14$, $p < .05$), and internalized ($b = .22$, $SE = 0.06$, $p < .001$) stigmas (Eaton, et al., 2018). In this study (Eaton, et al., 2018), enacted stigma referred to experiencing mistreatment; anticipated stigma referred to the expectation of experiencing future mistreatment; and internalized stigma referred to a personal endorsement of stereotypes and biases.

Other researchers who studied stigma among BMSM+ investigated the role of stigma on HIV-status disclosure using a correlational design (Overstreet, Earnshaw, Kalichman, & Quinn, 2013). The researchers used a sample of 156 BMSM+ and focused on HIV disclosure among sexual partners and family members using a hierarchical linear regression (Overstreet et al., 2013). Internalized stigma was negatively associated with HIV status disclosure to family members ($p < 0.05$; Overstreet et al., 2013). A logistic regression was conducted to investigate the relationship between HIV stigma and disclosure among sexual partners where internalized stigma was a statistically significant predictor of HIV status disclosure to one's sexual partner, and the more

internalized HIV stigma a participant experienced, the less likely their HIV status was known by their current sexual partners ($\chi^2 (1) = 4.72, p = 0.03$; Overstreet et al., 2013).

While common themes of studies that used BMSM+ as the population included prevention, the down low, stigma, and disclosure, oftentimes the study was connected back to prevention. The linkage of BMSM+ to mental health services (Basta et al., 2008); lack of counseling literature on BMSM+ (Hongryun & Nanseol, 2017); the prevalence of the medical model and the focus on prevention in research dictates the need for research that expands the counseling field's understanding of BMSM+. This study seeks to fill the gap on BMSM+, specifically in the areas of wellness, resilience, and empowerment to inform the counseling field.

Wellness, Resilience, and Empowerment among BMSM+

This section of chapter two discusses the literature regarding variables examined in this study including wellness, resilience, and empowerment. Literature that discussed each construct is presented before discussing the research of each construct, followed by research of each construct specific to BMSM+.

Indivisible Self Model of Wellness

Research has supported the inclusion of multiple dimensions in the conceptualization of wellness as a whole (Hettler, 1980; Myers & Sweeney, 2005; Roscoe, 2009). The current study used Myers' (2014) conceptualization of wellness, which included five factors developed from the previous research and asserted the indivisibility and holism of an individual within one's social context, which is consistent with the concept of intersectionality (Adler, 1954; Ansbacher &

Ansbacher, 1967; Myers & Sweeney, 2005). The five factors of wellness were conceptualized to make up the indivisible self and include Creative Self, Coping Self, Social Self, Essential Self, and Physical Self. The five factors include 17 subtasks (See Table 1).

The components of the Coping Self refers to the ability of an individual to control their responses to life events while providing a means for surpassing life event's negative effects (Myers & Sweeney, 2005). The Creative Self, includes subtasks such as Emotions, Control, Positive Humor, and Work and can be thought of as "the combination of attributes that each of us forms to make a unique place among others in our social interaction and to interpret our world" (Myers., 2014, p. 7). The Social Self represents an individual's ability to gain support through platonic and romantic and relationships, which can shelter one from feeling isolated and alienated and increase overall health and life duration (Myers & Sweeney 2005). The Essential Self relates to how one ascribes meaning to life, self and others (Myers and Sweeney, 2005). The interplay between the components of the Essential Self, such as Spirituality and Cultural Identity, allows one to have a sense of meaning, purpose, and hopefulness, while contributing to quality of life (Myers, 2014). The last self, is the Physical Self which is made up of exercise and nutrition, though Myers (2014) has asserted that the Physical Self is often over emphasized in the conceptualization of wellness.

Literature pertaining to wellness is discussed in this section and was able to be categorized as research that was informative regarding dimensions of wellness and barriers and mediators of wellness. Then research that explored wellness among BMSM+ and similar populations is discussed and critiqued to conclude this section of chapter two.

Attributes of Wellness in Research

This section discusses constructs that are attributes of wellness and have been supported by empirical research. As previously mentioned, subscales of wellness have been supported in their relation to wellness through research designs that use structural equation modeling and confirmatory factor analysis, though, this section includes other empirical research that reported statistical significance to contributing factors of wellness. A review of literature found age, cultural identity, and social support to be statistically significant attributes of wellness.

Age

While age itself does not represent a subscale in the Indivisible Self model of wellness, the role of time and age is thought to have an impact on wellness as reflected the Chronometrical Context variable (Myers, 2014). Researchers have used various models and measurements of wellness that have documented that the passing of time impacts health and wellness (Hettler, 1984; Meyers, et al., 2005; National Wellness Institute, 1983). The use of the Chronometrical Context variable in the Five Factor Wellness Inventory (Myers, 2014) recognizes that individuals change over time in important ways which affect wellness.

Researchers used a correlational design that examined the relationship between multiple dimensions of wellness and cognition among aging adults (Strout, & Howard, 2015). The study included a sample of 5,605 male participants 60 years of age and older (Strout, & Howard, 2015). The researcher found that within three dimensions of wellness, emotional, physical, and spiritual, there was a statistically significant mean difference between cognitively healthy older adults and cognitively impaired older adults $F(4, 5,595) = 47.57, p < .05$ (Strout, & Howard, 2015). The

strongest association was among emotional wellness then physical wellness and spiritual wellness, $F(5, 5,372) = 50.35, p < .001$ (Strout, & Howard, 2015). Researchers who investigated age and wellness compared the wellness among heterosexual, lesbian, and bisexual women (Degges-White & Myers, 2006). Degges-White & Myers' (2006) study implication involving wellness most relevant to the current study explored whether or not participants who subjectively felt younger (subjective age) had better wellness outcomes when compared to participants who felt their age (chronical age) or older. The study included a sample of 221 women (lesbian=81, bisexual=14, heterosexual=126) between the ages of 35 to 65 years old (Degges-White & Myers, 2006). The researchers found that among participants who were lesbians, there was a significant relationship among subjective age, chronological age, and wellness $F(2, 221) = 3.798, p < 0.05$; Degges-White, & Meyers, 2006); where wellness was higher among participants who reported a younger or equivalent subjective age than their chronological age (Degges-White, et al., 2006). Additionally, the researchers found that subjective and chronological ages were not significantly related among lesbian $F(2, 221) = 0.344, p = 0.71$ and heterosexual participants $F(2, 221) = 0.743, p = 0.48$ (Degges-White, et al., 2006). The Five Factor Wellness Inventory used in the current study has a Chronometrical Context subscale, which measured the impact of time on wellness. While both studies were consistent with literature and reflected that age and aging can have an impact on an individual's wellness; the impact of aging and time on the wellness of BMSM+ is unclear given the samples of previous studies and warrants investigation.

Cultural Identity

Cultural identity was another attribute of wellness that was investigated in research (Rayle & Myers, 2004; Spurgeon & Myers, 2008). Within the Five Factor Wellness Inventory Cultural Identity was defined as satisfaction, support, and transcendence (cultural assimilation) with one's cultural identity and emphasized race and ethnicity (Myers, 2014). A study where researchers examined the influence of ethnic identity, acculturation, and mattering on adolescent wellness found that mattering and acculturation explained a significant portion of the variance of wellness in six areas: spirituality, self-direction, schoolwork, leisure, love, and friendship for the total sample ($p < .05$; Rayle & Myers, 2004). The researchers defined mattering as a sense of feeling important to others and belongingness; and acculturation as the process of changing cultural attitudes, values, and behaviors after coming into contact with two or more distinct cultures, in order to adapt to the new culture (Rayle & Myers, 2004). Ethnic identity did not significantly predict wellness (Rayle & Myers, 2004). The sample included 462 participants (229 males and 233 females; 286 White, 119 Black, 28 Latino American, 14 Asian American, and 4 Native American; 14 to 19 years old, with a mean of 16.24 and $SD = 1.25$; Dixon, et al., 2004). Cultural assimilation appeared in the current study through the Cultural Identity subtask of the Five Factor Wellness Inventory. The impact of cultural identity and assimilation on the wellness of BMSM+ is uncertain given the intersections of their identity and the Rayle & Myers (2004) study in this area may not necessarily be relevant.

Researchers of another study included a sample of 245 African American male students (20 through 23 years of age; with a mean of 21.5 and $SD = 2.22$) to investigate the relationship between cultural identity and wellness (Spurgeon & Myers, 2008). The researchers found statistically significant differences among internalized racial identity attitudes ($F = 6.34, p = .01$),

physical self-wellness ($F = 9.06, p = .003$), and social self-wellness ($F = 10.01, p = .002$) when comparing Black students attending predominantly White institutions (PWIs) and historically Black colleges and universities (HBCUs; Spurgeon & Myers, 2008). However, similar to the previous Rayle & Myers (2004) study that examined the role of ethnic identity, there was not a relationship between racial identity and wellness (Spurgeon & Myers, 2008). This means that in Spurgeon & Myers' (2008) study cultural identity influenced aspects of wellness but not wellness as a whole. Again, the complexity of experiences, given intersectionality, calls the generalizability of Spurgeon & Myers' (2008) study to BMSM+ into question and implies the need of the current study.

Social Support

Social support has been established as an attribute of wellness throughout research. In fact, a review of wellness theory models demonstrated that the dimension of social wellness was one of the few that was reflected in every major wellness model (Roscoe, 2009). Within the Five Factor Wellness framework social wellness appeared as one of the five factors of wellness, as the Social Self, and contained the Friendship and Love subtasks (Myers, 2014). Shurts (2005) used multiple regression to examine the relationships among marital messages received, marital attitudes, and relationship self-efficacy, and wellness in never-married traditional-aged college students. The study included a sample of 211 traditional-aged, undergraduate students who had never been married at three North Carolina universities (Shurts, 2005). The researchers found that marital attitudes and family marital messages received predicted proportions of the variance in total wellness with statistical significance ($p < .05$; Shurts, 2005). Additionally, the researchers saw that

the most significant differences were determined by participants' family of origin marital status (Shurts, 2005). The findings of this study may mean that BMSM+ from a household with married parents may have higher levels of wellness than those from a household where their parents were not married. Additionally, this study provides a need to explore the impact of family of origin characteristics on current wellness.

Barriers and Mediators to Wellness

This section discusses constructs that served as barriers or mediators to wellness and have been supported by empirical research. Barriers and mediators are discussed together because often in research their relationship is inverse. For example, in a study where researchers found that lack of time was a barrier to wellness behaviors among psychology students, adequate time served as a mediator of wellness (El-Ghoroury, Galper, Sawaqdeh, & Bufka, 2012). Thus, the determination of a construct as a barrier or mediator of wellness can generally be inferred through the consideration of the inverse relationship. In the literature regarding wellness, barriers and mediators usually fell under the category of happenstance, personal attributes, and identity attributes.

Happenstance

Happenstance usually refers to an event that happens by chance and within this review of literature happenstance is a method for organization and emphasizes a lack of control (Krumboltz, 2009). The concept of happenstance can relate to all BMSM+ when considering general life events such as loss of a loved one or job termination (Krumboltz, 2009). Happenstance may more readily inform the understanding of BMSM+ at vulnerable intersections such as low socioeconomic status,

where people may be more transient and have less control over their day-to-day interactions (Pampel, Krueger, & Denney, 2010). Furthermore, when acknowledging the impact of stigma in society, even BMSM+ at the intersection of religion may be more vulnerable to negative happenstance outcomes when considering possible ostracism or shunning (Kendrick, 2017; Othieno, 2007). There were two common themes in literature surrounding barriers to wellness that fell within happenstance. The first common theme in literature is time, specifically the unpredictability of scheduling that does not allow one to engage in wellness behaviors. The second happenstance barrier is an unexpected life event.

In research, a lack of time whether that was from unpredictable work schedules or just a busy schedule in general was a barrier to achieving wellness (El-Ghoroury, et al., 2012; Lindholm, Johnston, Dong, Ablah, & Moore, 2016). Additionally, studies in psychology research have supported that wellness may be sensitive to life events such as unemployment or divorce (Lucas, Clark, Georgellis, & Diener, 2003; Richard, Andrew, Yannis, & Ed, 2004). For example, researchers of one study found that levels of life satisfaction were significantly impacted by job termination and, on average, life satisfaction never returned to the baseline when compared to participants' previous employment ($SE = .04$), $z(3726) = -7.4$, $p < .001$ (Richard, et al., 2004). Yet, the impact of happenstance on the wellness of BMSM+ is undetermined, however the Control and Positive Humor subtasks measured within the Five Factor Wellness Inventory (Myers, 2014) and the Resilience Scale (Wagnild, 2009) may reveal how happenstance and coping impacts the wellness of BMSM+.

Personal Attributes

Personal Attributes was another method of organizing the literature related to barriers and mediators of wellness. Personal attributes that act as barriers or mediators of wellness reflect personality traits, personal attitudes, self-efficacy, and coping strategies. In the context of the current study reviewing the literature on wellness that discussed self-efficacy and coping strategies also could provide insight to the relationship among wellness resilience, and empowerment.

Studies have highlighted the role of low self-efficacy as a barrier to wellness, which has implications for the level of empowerment (Perez-Calhoun, 2017; Schopp, Bike, Clark, & Minor, 2015). Researchers who conducted a quasi-experimental wellness standard of care comparison among 91 individuals found improved self-efficacy led to improved health behaviors when comparing the control group to the treatment group SRA: $F = 12.45, p < 0.001$; HPLP-II: $F = 25.28, p < 0.001$ (Schoop, et al., 2015). The current study's measurement of Control as subtask in the Five Factor Wellness Inventory provide a conceptualization of BMSM+ self-efficacy levels, which may be related to empowerment.

Lastly, the ability to cope has been supported as a barrier or mediator of wellness. Within the context of the current study, the ability to cope is directly related to the construct of resilience, given that resilience refers to the ability to cope with adversity (Wagnild, 2009). While coping strategies can be taught, there are some aspects related to coping that are seen more as personal attributes and traits, such as resilience (El-Ghoroury, et al., 2012). Researchers conducted a study on nurses that investigated the influence of resilience on mental health and well-being (Gao, et al., 2017). Using a correlational research design with 365 participants, the researchers found that

resilience was correlated with well-being ($r = .41$; $p < .001$; Gao et al., 2017). Thus, in the current study BMSM+ with higher levels of resilience should also have higher levels of wellness.

In an exploratory study where researchers investigated the barriers and mediators of wellness of people with disabilities ($n = 99$, $M = 47.6$ years, 53% White, 14% Hispanic, 13% Black, 10% Native American, 2% Asian American, 1% Pacific Islander, & % Other) through interviews, personal attitudes were the most prevalent barriers (Putnam, Geenen, Powers, Saxton, Finney, & Dautel, 2003). There was diversity among the disabilities of participants including spinal cord injuries, cerebral palsy, brain injuries, and chronic illnesses. Personal attitudes referred to frame of mind, affirming, and optimistic outlooks (Putnam, et al., 2003). Puntam, et al.'s (2003) study is consistent with literature that discussed the role of positive attitudes and personality traits as mediators of wellness and well-being (Costa & McCrae, 1980; Diener, Oishi, & Lucas, 2003). Thus, the wellness of BMSM+ may be influenced by personality traits.

Identity Attributes

Identity attributes served as another method for organizing the literature related to barriers and mediators of wellness. Within the context of barriers and mediators of wellness, identity attributes refer to age, race, sexuality, and gender. It is important to note that while research has supported the prevalence of wellness as it relates to identity markers, the phenomenon is not fixed. Additionally, there was often a psychosocial component related to systems of power and oppression that explained the wellness disparities (Malebranche, et al., 2004; Watson, 2014). For example, researchers investigated how young Black males navigate health care systems in a qualitative study and found that racism was a theme (Watson, 2014). In this case, the issue is not

actually the race of the healthcare consumer but the system of racism and oppression in healthcare, which was similar to previous studies where healthcare consumers had difficulty navigating systems of care due to sexuality and sexual orientation stigma (Malebranche, et al., 2004). The oppression within healthcare systems reflects the need to get an understanding of BMSM+ unique experiences due to their intersecting marginalized identities. Another identity attribute that can serve as a barrier or facilitator of wellness is gender, though much of the literature described gender as binary (Avera, Zholu, Speedlin, Ingram, Prado, 2015), which may make generalizability to BMSM+ difficult when considering their identities in the context of the CRQD framework. However, researcher have demonstrated that women's well-being has been in decline since 1972 and that there is a gap in wellness between women and men (Stevenson & Wolfers, 2009). Thus, one might expect for BMSM+ to have lower levels of wellness based off their racial identity and sexuality alone. However, when considering how the gender identity of BMSM+ intersects with their other identities through a CRQD framework, the impact of gender on wellness may be more nuanced, especially when considering performativity and bifurcation of consciousness. Performativity among BMSM+ may be necessary as they experience a separation between the world as they actually experience it and the dominant view to which they must adapt, also known as bifurcation consciousness (Appelrouth & Edles, 2007).

The literature on wellness has focused on the dimensions of wellness and the barriers and mediators of wellness. However, wellness research at large provides us with little insight on the wellness of BMSM+. Additionally, as emphasized by the CRQD framework, intersectionality is essential in how one navigates the world, thus a more focused review of literature on wellness with samples that closely match the population of the current study is necessary.

BMSM+ Wellness Research

This section discusses the research in the area of wellness which uses BMSM+ as the research population or similar populations. Wellness is a construct that has not often been researched among BMSM+. Thus, the inclusion of studies that use positive psychological variables similar to wellness are necessary for this literature review. Furthermore, studies that did use positive psychological variables similar to wellness rarely used a research population that was exclusively BMSM+. Studies that may allow one to make inferences of wellness due to the investigation of reciprocal variables are out of the scope of this study. For example, studies that investigated psychological distress, which may allow one to make inferences about emotional wellness were not included in this literature review along with other similar variables. The exclusion of the variables inversely related to wellness in the literature review is also informed by this study's CRQD framework, which postulates that such unfavorable variables are used in research involving BMSM+ too often.

The scarce literature regarding wellness, quality of life, and well-being that exists does offer some interesting findings and provides insight to the possible experiences of BMSM+. Vidrine, Amick, Gritz, & Arduino (2003) examined sociodemographic and behavioral variables associated with quality of life among multiethnic, economically disadvantaged patients with HIV/AIDS. The study used a cross-sectional survey and found that Black participants with HIV/AIDS reported significantly better mental functioning than White participants ($p < .05$; Vidrine, et al., 2003). Brown (2015) conducted another study in completion of dissertation that found that three indices of well-being, self-acceptance $r(93) = .77, p < .001$; personal relationships $r(92) = .62, p < .001$, and environmental mastery $r(92) = .63, p < .001$, correlated strongly with spirituality such that those

participants who were more spiritual showed higher levels of well-being (Brown, 2015). When comparing participants' ethnicities, the study found that spirituality and well-being were moderated by sexuality and that relationship is stronger for Black men who identified as non-heterosexual (Brown, 2015). Brown's (2015) study may provide context for the differences in spirituality and wellness among BMSM+ in the current study.

Literature also discussed the effect of mental health interventions on wellness. Researchers who conducted a randomized intervention study that delivered positive affect skills to 159 newly diagnosed participants found that antidepressant use decreased ($p .006$, $d .78$), and less intrusive and avoidant thoughts related to HIV occurred ($p .048$, $d .29$; Moskowitz, et al., 2017). Consequently, the brief positive affect skills intervention achieved modest improvements in psychological health, supported adjustment to a new HIV diagnosis, and lowered HIV in the blood stream (Moskowitz, et al., 2017; Paul, 2017). While research investigating wellness, quality of life, and well-being can be commonly found in literature, research specific to the wellness of BMSM+ is scarce; there are three major critiques regarding what does exist in the wellness literature regarding BMSM+.

Criticism of BMSM+ Wellness Research

The first major critique of BMSM+ wellness research is that wellness was rarely used as a construct specifically. Constructs that are commonly used similar to wellness include well-being and quality of life, which, all three are in opposition to illness (Meiselman, 2016). There has been difficulty in defining and measuring quality of life (Meiselman, 2016). The WHO has led the field of quality of life research and defined the concept as "individual's perception of their position in life in the context of the culture and value system in which they live and in relation to their goals,

expectations, standards and concerns” (Meiselman, 2016; WHO, 1997). Part of the difficulty in measuring quality of life was that it was believed to have objective and subjective indicators; however, recently scholars have moved toward the belief of quality of life as a subjective concept (Meiselman, 2016). While there is not total agreement over the definition in research, the concept is generally believed to be a combination of balancing positive-negative affect and life satisfaction (Dodge, Daly, Huyton, and Sanders, 2012; Meiselman, 2016). While wellness, quality of life, and well-being all oppose illness; the dimensions that are considered to make one well or healthy vary, thus asserting the need for wellness to be measured.

The second major critique of BMSM+ wellness research is that studies rarely used BMSM+ as the target research population or sample. Oftentimes, researchers of wellness studies did not report the aspects of BMSM+ identities such as race (Black), gender (cisgender male), sexual minority status, and HIV positive status of their samples. Other times an identity marker of BMSM+ might be lumped in with others. As a result, findings may not reflect the actual experiences and state of BMSM+ because intersectionality is not accounted for in the studies that did not delineate the specific experiences and results for BMSM+. For example, multiple studies looked at Black people living with HIV but included women and heterosexual people within the sample, making it hard to interpret the experiences of BMSM+ specifically (Brown, 2014; Catalan, Tuffrey, Ridge, & Rosenfeld, 2017; Dalmida, Koenig, McDonnell, & Wirani, 2013). Dalmida, et al. (2013) found that PLWHA have high rates of depressive symptoms, which adversely impact health outcomes. Additionally, religious coping, perceived stress, and social support satisfaction served an important role in depressive symptomatology among PLWHA, emphasizing the need for holistic services with working with PLWHA (19.3 ± 12.8 ; 56.7% $n = 164$). While these findings

provide insight in to the conditions of PLWHA and inform care, the sample that was used in this study was predominantly Black, impoverished, unemployed, and heterosexual (Dalmida, et al., 2013), which still leaves uncertainty regarding the specific state of BMSM+.

The third critique of research opposing illness with positive constructs such as wellness, quality of life, and well-being was that the findings were often still framed in a negative way, which seemed to further marginalize the population studied. Oftentimes, the study used variables that reflected adverse conditions that shaped the framing of the findings; those variables included risk factors, depression, or economic disadvantage, and other negative aspects of life (Emlet, Frediksen-Goldsen, & Kim, 2013; Dalimida, et al., 2013; Vidrine, et al., 2003). Studies that counter the negative framing of BMSM+ are needed, at the very least research needs more balanced studies like Emlet et al.'s 2013 study, which investigated risk and protective factors with health-related quality of life among older gay and bisexual men living with HIV. The researchers found that self-efficacy and social support represent intrapersonal and interpersonal resources that can be enhanced through interventions to improve health-related quality of life ($F = 13.20$; $p < .001$; Emlet, et al., 2013). While Emlet et al.'s (2013) study also discussed comorbidity, functional limitations, and lifetime victimization as risks to quality of life among older gay and bisexual men with HIV disease ($F = 28.82$; $p < .001$), it provides a more balanced exploration of the experiences older gay and bisexual men living with HIV than other studies.

Resilience Theory and Research

Resilience was one of the variables explored in the current study and used to inform the experience of wellness among BMSM+. Resilience originally emerged as a concept in the literature

within psychopathology in the early Seventies, where it was conceptualized as a stable personality trait (Luthar, Sawyer, & Brown, 2006). However, more research has shifted the conceptualization of resilience and because of such research resilience is now considered to be an ongoing, dynamic, process between oneself and one's setting (Luthar, et al, 2006; Luthar & Zelazo, 2003; Vanderbilt-Adriance & Shaw, 2008).

Originally, invulnerability and invincibility were used to describe the process of adaptation following adverse circumstances prior to the conceptualization of resilience (Earvolino-Ramirez, 2007). Invulnerability described an aspect of an individual's makeup that was static and "absolute" (Luthar, Cicchetti, & Becker, 2000; p. 544). Researchers expanded their investigations into the concept of resilience after research provided support for the notion that adaptive reorientation despite hardship occurred along a developmental progression (Luthar et al., 2000).

More recent scholars asserted that people with high levels of resilience could protect themselves against adversity and antecedent ailments such as interpersonal difficulties, depression, stress and anxiety, and resist psychopathology, which added to the conceptualization of resilience (Burton, Pakenham, & Brown, 2010; Campbell-Sills, Cohan, & Stein 2006; Ingram & Price 2001). Such a stance on resilience inferred resilience's existence along a continuum with vulnerability (Ingram & Price, 2001), which implied that in some cases resilience was "a resistance to psychopathology, though not a total invulnerability to the development of psychiatric disorder" (Burton, Pakenham, & Brown, 2010; Campbell-Sills et al., 2006)

Over the years resilience has been conceptualized as a trait, process, continuum, and a system (Jackson, Firtko, & Edenborough, 2007) but for the sake of this study which conceptualizes the resilience of BMSM+, Wagnild's (2009) definition was used. Thus, in the current study,

resilience a multi-faceted reflective of purpose, perseverance, equanimity, self-reliance, and authenticity and represents the ability to cope effectively when faced with adversity, which connotes inner strength, competence, optimism and flexibility (Wagnild, 2009).

Literature pertaining to resilience is discussed in this section and was able to be categorized in four waves. Then research that explored resilience among BMSM+ and similar populations is discussed and critiqued to conclude this section of chapter two.

Resilience Research

A review of research on resilience revealed that most research on resilience could be categorized into four waves, which reflected how resilience was conceptualized at the time among scholars (Grafton, Gillespie, & Henderson, 2010). The four waves included: (1) resilience as a trait, (2) resilience as a dynamic process, (3) mediated resilience, and (4) integrative resilience (Grafton, et al., 2010; Wright, Masten, & Narayan, 2013). The structure of the reviewed literature on resilience research follows the layout of the four waves.

Trait Resilience

Trait resilience conceptualized resilience as a set of personality characteristics and was oftentimes measured as hardiness, coping, and self-efficacy (Himmel, 2015). Researchers who studied trait resilience research often examined individuals' ability to cope as it related to adversity or trauma (Baron, Eisman, Scuello, Veyzer, & Lieberman, 1996). At the time of the first wave, there was little agreement on the conceptualization of resilience but major findings of the time on

trait resilience included (a) resilience as a protective factor, and (b) the psychological and biological aspects of resilience (Grafton, et al., 2010).

Researchers who conducted a meta-analysis on trait resilience as a protective factor to mental health found four major findings after analyzing 60 studies and 11 effect sizes (Hu, Zhang, & Wang, 2015). The first finding that the researchers discussed was the negative correlation between trait resilience ($r = -0.361$, $z = -80.228$, $p < .001$, $k = 76$, 95% CI = $-0.369, -0.353$) and negative indicators of mental health, such as depression, anxiety, and negative affect, and the positive correlation to positive indicators of mental health, such as life satisfaction and positive affect ($r = 0.503$, $z = 78.299$, $p < .001$, $k = 35$, 95% CI = $0.493, 0.514$; Hu, et al., 2015). The second finding the researchers discussed was the moderating effect that age had on the relationship between trait resilience and negative indicators among adults ($r = -0.379$, 95% CI = $-0.388, -0.370$, $p < .05$), which was a stronger association than for children and adolescents ($r = -0.273$, 95% CI = $-0.291, -0.254$, $p < .05$; Hu, et al., 2015). The third finding that the researchers discussed was the moderating role of gender on the relationship between trait resilience and mental health, where there was a weaker effect size was observed as the percentage of male participants increased $Q_{\text{Model}}(1, k = 76) = 12.863$, $p < .001$; Hu, et al., 2015). Lastly, the researchers found that the relationship between trait resilience and mental health was moderated by adversity ($r = -0.386$, 95% CI = $-0.406, -0.366$, $p < .05$; Hu, et al., 2015). In the current study, the Five Factor Wellness Inventory's Chronometrical Context subscale and Gender Identity subtask may provide evidence into whether or not the results of Hu, et al.'s (2015) study are true for BMSM+.

Dynamic Resilience

The second wave of resilience research focused on the conceptualization of resilience as a dynamic process (Grafton, et al., 2010). Dynamic resilience referred to the wisdom one received after facing adversity (Gillespie, Chaboyer, & Wallis, 2007; Rutter, 1999) and suggests that resilience can be taught and learned. Dynamic resilience acknowledged the role of culture, such as spirituality, as a contributor to resilience (Wright & Masten, 2005). Studies that focused on resilience developed attribute found increases among self-efficacy and adaptability when practicing cognitive transformations related to building resilience (Jackson, et al., 2007). Leppin, et al. (2014) conducted systematic review and meta-analysis purposed with synthesizing and evaluating the evidence for resilience intervention programs for improving mental health and capacity among adult populations and persons with chronic diseases. The study reviewed 25 small trials and found evidence that supported with low confidence that resilience intervention programs have a small to moderate effect at improving resilience and other mental health outcomes ($r = 0.37$, 95% CI 0.18, 0.57 $p = .0002$; $I^2 = 41\%$; Leppin et al., 2014).

Mediated Resilience

Research that conceptualized resilience as being established through mediating factors continued to postulate that resilience could be learned and emphasized the role of culture (Wright, et al., 2013). However, the considerable shift in research from resilience as dynamic and learnable was the use of preventative interventions (Wright, et al., 2010). Much of this research used the strategy of protecting or fostering processes of emotional regulation, mastery, agency, and social engagement as a way to promote resilience (Wright et al., 2010). Researchers who conducted a

study that investigated the development of self-regulation abilities as a predictor of psychological adjustment across the first year of college provided an example of research where resilience (psychological adjustment) could be fostered by another factor, self-regulation (Park, Edmonson, & Lee; 2012). The study included a sample of 175 first-year students (65% women; with mean age of 17.9; .4% Native American, 10.9% Asian, 4.9% African-American, 3.5% Latino or Hispanic, 77.6% Non-Hispanic White, and 2.8 some other race or “bi-racial”); and used multiple regression to analyze data from four instruments that measured self-regulation (three) and adjustment outcomes (one; Park, et al., 2012). The study had two major findings: (a) on average, students did not increase in their constructive thinking or emotion regulation abilities and actually decreased in their sense of mastery ($p < .05$); and (b) change in self-regulation abilities predicted changes in adjustment (r s between .6 and .8; $p < .05$; Park, et al., 2012). Thus, within the current study, one would expect BMSM+ who are better able to self-regulate emotions, as reflected within the Emotions subtask of the Five Factor Wellness Inventory, to have higher levels of resilience.

Integrative Resilience

Integrative Resilience has been deemed the fourth wave of resilience research and is still very new (Grafton, et al., 2010; Wright, et al., 2013). Integrative resilience has incorporated the previous types of resilience investigated throughout research but also has emphasized brain development, non-genetic neurobiological process, and the interaction between systems that shaped development (Cicchetti & Curtis, 2006, 2007; Wright, et al., 2013). For example, researchers who conducted study that reviewed research on behavioral and cognitive strategies that cultivate resilience and change the brain discussed two major pathways to building a resilient brain

(Tabibnia & Radecki, 2018). The researchers found that the pathways that could build resilience; included: (a) learnable behaviors and habits, and (b) learnable cognitive and linguistic strategies (Tabibnia & Radecki, 2018).

Prior resilience research suggested that resilience has been covered in four different aspects relating to: (1) resilience as a static personality trait, (2) resilience as a dynamic process learned through facing adversity, (3) resilience through prevention, and (4) resilience integrated with neurobiological processes. However, the literature on the resilience of BMSM+ commonly focused on trait and dynamic resilience. An examination of literature specific to the resilience of BMSM+ and closely related populations are necessary in order to conceptualize the resilience of BMSM+, taking their unique navigation of society into consideration.

BMSM+ Resilience Research

Resilience is a construct that has been studied within the BMSM+ population quite frequently (Wilson et al. 2016b). Both quantitative and qualitative studies have supported the assertion that BMSM+ are resilient and that resilience aids them as they navigate life (Bruce & Harper, 2012; Emlet, et al., 2010; Emlet et al., 2016; van Eeden-Moorefield, 2008). Similar to research investigating the wellness of BMSM+, samples that were exclusively composed of BMSM+ within resilience research were infrequent, which may have limitations in terms of generalizability and transferability. Furthermore, researchers frequently used the term resilience to reflect the ability of avoiding HIV contraction, rather than being resilient in a way that represents withstanding and recovering from hardship (Peterson, et al., 2015). The latter is focused on in this literature review regarding the resilience of BMSM+, which is in alignment with the current

study's CRQD framework. Most studies that explored resilience involving BMSM+ samples could fit into two categories. The first category were studies that tried to establish the presence of resilience within BMSM+ and gauge its importance. The second category were studies that explored the relationship between resilience and other variables within BMSM+, such as mental health, support, community engagement, and hope.

Some studies have sought to understand resilience in a sample that contained BMSM+ and found that resilience was a multi-faceted construct for this population (Buttram, 2015; Emlet, et al., 2010; Harper et al., 2014). Researchers of one qualitative study found that factors of resilience included self-acceptance, optimism, will to live, generativity, self-management, relational living, and independence (Emlet, et al., 2010). However, the sample of this study was mostly White, half women, over 50, and 36% MSM (Emlet, et al., 2010). The uncertainty of the transferability of findings due to intersectionality is present here, similar to one of the criticisms of the wellness studies of BMSM+. Buttram's (2015) qualitative study of resilience included a sample inclusive of BMSM+, (African-American and Black MSM, whose HIV status was positive or negative). The results indicated that inner strength, social relationships, diversity of experience, religion/spirituality, altruism, and social experiences were factors of resilience. While some thematic similarity is present between the two studies, such as inner strength and social relationships, the differences highlight the need for intersectional research to explore the unique experience of BMSM+.

Harper, et al., (2014) conducted a qualitative study that used interviews that examined the health resilience processes among young gay and bisexual men living with HIV ($N = 54$). Fifty-seven percent of the participants were Black and from four different geographic locations. The

researchers found four themes reflective of the resilience process among the sample including: (a) health-promoting cognitive engagement, (b) using healthy behavioral practices, (c) recruiting social support, and (d) empowering other gay and bisexual men (Harper, et al., 2014). This study, provides information regarding a sub-group of BMSM+ that is relevant to informing the current study.

The other category of resilience studies that often used a sample that contained BMSM+ routinely investigated the relationship between resilience and another variable. In an examination of three studies that were selected because of the similarities between their research population and the one used in the current study, resilience had statistically significant relationships with a multitude of variables (See Table 2).

Table 2

Resilience Relationship Variable Matrix

Variable Associated with Resilience	Positive or negative association	Significance	Researchers
Social support	Positive	Beta = .22; $p < .01$	Emlet, et al., 2017
Community engagement	Positive	Beta = .19; $p < .01$	Emlet, et al., 2017
Depression	Negative	Beta = -.31; $p < .01$	Lyons & Heywood, 2016
Anxiety	Negative	Beta = -.16; $p = .004$	Lyons & Heywood, 2016
General stress	Negative	Beta = -.24; $p < .001$	Lyons & Heywood, 2016
Positive mental health	Positive	Beta = .40; $p < .001$	Lyons & Heywood., 2016
Active coping	Positive	Beta = .61; $p < .001$	Fang et al., 2014
Coping self-efficacy	Positive	Beta = .86; $p < .001$	Fang et al., 2014
Hope/Optimism	Positive	Beta = .75; $p < .001$	Fang et al., 2014
Social Support	Positive	Beta = .68; $p < .001$	Fang et al., 2014
Life stress	Negative	Beta = -.64; $p < .01$	Fang et al., 2014

While some of the variables did repeat across studies, the association type remains the same. Ultimately, the table revealed that the associations between resilience and other variables is what would be expected, a positive relationship among positive variables such as social support, coping, optimism, and community engagement, and a negative relationship between resilience and negative variables such as stress and depression. To some degree one would expect to see the same negative and positive associations if one were to put wellness in place of resilience, which would support the premise that resilience would be positively associated with wellness. While the samples in the studies included in the table similar to BMSM+, they were not exclusively BMSM+, which warrants the investigation of resilience among BMSM+ and its relationship to wellness. Still, the relationships established through resilience research has predominantly served to impact and inform clinical helping professions. Several associations that were established with resilience research involving BMSM+ have specific implications for the mental health field. While literature containing studies investigating the resilience of BMSM+ have helped to inform practice, it is not without critique.

Criticisms of BMSM+ Resilience Research

Although resilience as a research construct, has been studied among BMSM+ at a greater volume than wellness and empowerment, the literature is still scarce; and requires inferences to be made from samples with other identity markers. Similar to the criticism of wellness research, there may be identities that confound experiences, thus making the findings inappropriate to apply to BMSM+. However, the lack of studies that use BMSM+ as a sample is a trend seen across

constructs. Thus, the researcher offers one major, and two minor critiques of resilience research pertaining to BMSM+.

The major critique of research regarding the resilience of BMSM+ is the lack of representations of adults. Many studies that looked at resilience in BMSM+ commonly focused on adolescents and young adults or aging adults (Bruce, Harper, & ATN, 2012; Emler, Tozay, & Ravies, 2010; Emler, Shiu, Hyun-Jun, & Fredriksen-Goldsen, 2016; Fang, Vincent, Calabrese, Heckman, Sikkema, Humphries, & Hansen, 2014; Harper, Bruce, Hosek, Fernandez, Rood, & ATN, 2014; Reed & Miller, 2016). Such a narrow lens regarding age leaves a gap surrounding the resilience of adult BMSM+, which is necessary to explore given the rate of new HIV diagnoses among adults. In 2016, 64% of new HIV diagnosis among BMSM were 25 years of age or older (CDC, 2018c).

The minor critiques of resilience research pertaining to BMSM+ involve the dimension of resilience and the general method of assessment. Recurrently, the research that investigated the resilience of BMSM+ rarely did so on the individual level and instead, discussed resilience being shared, communal, environmental, or collective (Buttram, 2015). Consequently, an intrapersonal understanding of resilience among BMSM+ is needed. While resilience is one of the more frequently studied positive constructs in the literature, more studies pertaining to the resilience of BMSM+ are needed.

The Conceptualization of Empowerment as a Research Construct

Empowerment was the other variables explored in the current study and used to inform the experience of wellness among BMSM+. Empowerment is a concept that has appeared in literature

across disciplines, but recently has been used in studies pertaining to school settings, healthcare systems, and community. This section of the literature review briefly explores the research on empowerment in the domains related to the current study including healthcare systems and on the community level before discussing empowerment research in the context of Zimmerman's (1995) conceptualization. Empowerment research pertaining to school settings usually explored the implementation of empowerment programs within schools where the desired effects oftentimes did not have statistical significance, though participants of the interventions viewed the intervention as positive (Cleary, Velardi, & Schnaidman, 2017; Horn, 2017; Kirk, Lewis, Brown, Karibo, Scott, & Park, 2017; Zimmerman, et al., 2018). However, empowerment research in the school settings and systems domain were less relevant than empowerment research within the healthcare systems, and community domains. Thus, literature pertaining to empowerment is discussed in this section and was categorized within healthcare and community sectors. Next, literature within Zimmerman's conceptualization of empowerment is presented. This section of chapter two is concluded with research that explored empowerment among BSM+ and similar populations.

Healthcare Systems

Empowerment was routinely used as a construct in research regarding healthcare. Much of the empowerment research could be broken down into two categories, which focused on the experiences of nurses and consumers of healthcare (Lethbridge, Andrusyszyn, Iwasiw, Laschinger, & Fernando, 2011; Trus, Razbadauskas, Doran, & Suominen, 2012). Researchers who conducted a systematic review of studies focused on the empowerment of nurses, found empowerment to be positively correlated with job satisfaction, role satisfaction, perceived organizational support, and

managerial self-efficacy (Trus, et al., 2012) Furthermore, empowerment was negatively correlated with emotional exhaustion and health outcomes (Trus et al., 2010). Additionally, empowerment among consumers of healthcare has been researched frequently, with a great deal of attention given to people with chronic illnesses, especially cancer (Jorgensen, Eskildsen, Thomsen, Nielsen, & Johnsen, 2018). In a systematic review of qualitative studies about patient empowerment among cancer patients, after screening 2,292 papers, the researchers selected 38 articles, and found seven themes (Jorgeensen et al., 2018). Through the review of the studies, Jorgeensen et al., (2018) found that (a) empowerment was an ongoing process, (b) knowledge was empowering, (c) the process of empowerment was active, (d) empowerment required communication and interaction between patients and health care professionals, (e) group support was helpful for empowerment, (f) religion/spirituality could be empowering, and (g) gender played a role in one's sense of empowerment.

Community Level

Empowerment is often mentioned in research within the community level domain, which includes community organizations, social justice, and action (Barney, 2017; Batista & Johnson, 2015; Horn & Brysiewicz, 2014; Lardier, 2018). Research at the community level reflected the origins of empowerment, which was rooted in community organizing and social action (Freire, 1973). Paulo Freire, a Brazilian educator, is credited with the concept of empowerment (Freire, 1970, 1973). While Freire (1973) taught the poor of Brazil, he believed that the poor were denied basic human rights by their oppressors, Brazil's upper class. He believed that the only way that the poor could achieve their human rights and dignity was by becoming aware of self, looking

critically at their social situation, and taking action to change their society (Freire, 1973). A researcher who examined racism through the lens of psychological empowerment found that psychological empowerment contributed to a nuanced conceptualization of the relationship between experiences of everyday racism and mental health (Stovall, 1999). The findings of Stovall's (1999) study calls into question if empowerment's mediating effect on emotional wellness, and protective effect against racism will be consistent among BMSM+. The Sociopolitical Control Scale (Zimmerman, 1995), and the Emotions and Cultural Identity subtasks of the Five Factor Wellness Inventory (Myers, 2014) used in the current study could provide insight into that answer.

Zimmerman Psychological Empowerment Research

This section of chapter two discusses literature pertaining to Zimmerman's (1995) conceptualization of empowerment. The current study conceptualized empowerment closer to its community level origins and defined psychological empowerment as the process by which an individual gains mastery over issues of concern to them (Zimmerman, 1995). Within Zimmerman's conceptualization psychological empowerment included (a) a sense of control and motivation to control, (b) decision making and problem-solving skills, and (c) a critical awareness of one's sociopolitical environment and participatory behaviors (See Figure 3; Zimmerman, 1995). There were three domains that composed Zimmerman's conceptualization of empowerment, which included intrapersonal, interactional, and behavioral components (see Figure 1, Zimmerman, 2000).

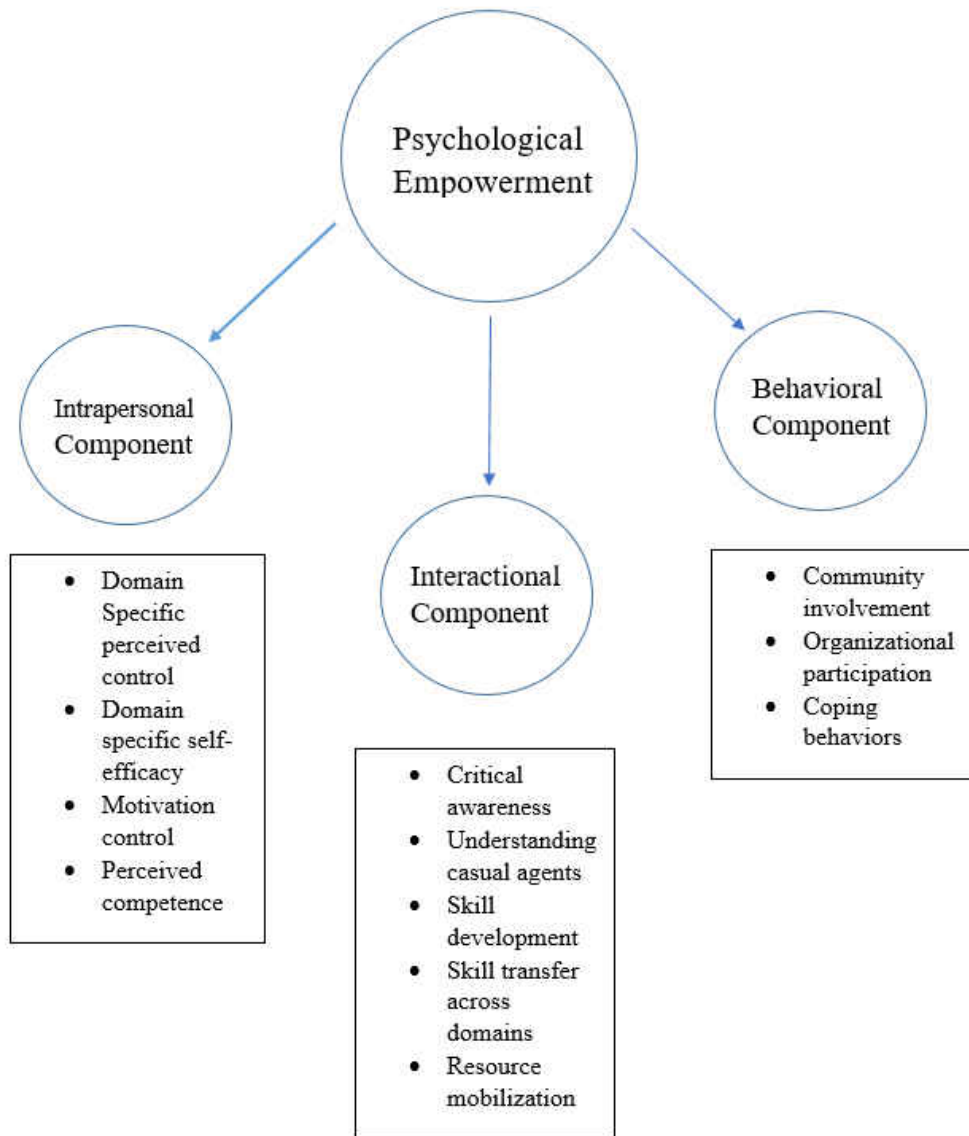


Figure 1. Nomological Network for Psychological Empowerment

Intrapersonal Component

The intrapersonal component, also known as sociopolitical control, refers to how people think about themselves and includes domain-specific perceived control and self-efficacy,

motivation to control, and perceived competence (Zimmerman, 1995). Domain-specific perceived control denotes beliefs about one's ability to influence different life domains such as family, school, work, or sociopolitical contexts (Paulhus, 1983). The intrapersonal component includes self-efficacy, motivation control, and perceived competence. Perceptions are included in the intrapersonal component because they are essential elements that provide people with the initiative to engage in behaviors for desired results (Strecher, DeVellis, Becker, & Rosenstock, 1986). Zimmerman (1995) believed that it was unlikely that people who do not believe that they possess the capability to achieve goals would either learn about what it takes to achieve those goals, or do what it takes to accomplish them. The intrapersonal component is the one of the more researched components of psychological empowerment due to the ease in measurement when compared to the other components (Cheryomukhin & Peterson, 2014; Christens, Krauss, & Zeldin, 2016; Peterson, Peterson, Agre, Christens, & Morton, 2011; Spreitzer, 1995). Researchers who conducted a study that investigated whether or not gender was a moderator of social cohesion and intrapersonal empowerment found effects of social cohesion on intrapersonal empowerment were different for females and males, where males had statistically significant higher scores than females on leadership competence $F(1, 508) = 14.35, p < .001$ (Peterson & Hughey, 2004). Within the current study BMSM+ may have a more nuanced relationship between social cohesion, gender, and intrapersonal empowerment when accounting for the intersectionality and the bifurcation of consciousness of BMSM+.

Two studies that researched populations more closely matched to the current study, included samples of young Black males and youth of color. A longitudinal study conducted by Zimmerman, Ramirez-Valles, and Maton in 1999 examined sociopolitical control as a protective

factor against helplessness and mental health (depression and anxiety symptomology, and self-esteem) among young Black males. The researchers found that sociopolitical control only served as a protective factor against helplessness (Zimmerman et al., 1999). Zimmerman's et al. (1999) study is limited in applicability to the current study given that identity markers relevant to the current study were not reported among participants and due to the timeliness of the study.

The other relevant study was conducted by Lardier, et al. (2017) and examined the interacting effects of psychological empowerment and ethnic identity on indicators of well-being among youth of color (Lardier, Garcia-Reid, Reid, 2017). The researchers stated that their results provide preliminary support for the relationship between empowerment and ethnic identity on factors of well-being. However, no measurements of well-being were actually used. The researchers examined perception of substance use to address well-being inversely, using a similar conceptually limiting approach as previous studies. Empowerment had statistically significant ($p < .01$) relationships with ethnic identity ($r = .32$) and perception of substance use ($r = .43$). Such an approach to measuring well-being was limited in that little information about well-being was actually provided. Additionally, the demographic of the sample used in the Lardier et al. (2017) study limits the study's relevance to the problem addressed by the current study. The sample used in the Lardier et al. (2017) study was heterogeneous racially, between the ages of 13-18, and the sexuality and HIV status of the participants was not reported. Consequently, the need to investigate the relationship between psychological empowerment at the intrapersonal level and wellness among BMSM+ is necessary.

Interactional Component

The interactional component of psychological empowerment refers to the understanding people have about their environments and related sociopolitical issues (Zimmerman, 1995). This component includes critical awareness, understanding casual agents, skill development, skill transferability, and resource mobilization (Zimmerman, 1995). Ultimately, the interactional component implies that people are conscious of appropriate behavioral choices to make in order to achieve the goals they set for themselves (Zimmerman, 1990). In order for this component of psychological empowerment to be actualized, people must learn about their options of choice to exert control in their environment in a given context (Zimmerman, 1995). Thus, individuals need to understand the norms and values of a particular context to navigate it successfully. Those norms and values may include decision making processes, culture type (ex. collectivist, individualistic), or existing supports (Zimmerman, 1995). The interactional component bridges perceived control, intrapersonal component, and taking action to exert control (behavioral component).

Petrovčič & Petrič, (2014) conducted a study purposed with exploring different forms and intensities of participation in health-related online support communities as associated with both dimensions of intrapersonal and interactional empowerment. The study had a sample of 616 participants in two health-related online support communities and the researchers found that online posters scored significantly higher in degree of interactional empowerment than online users who did not post (Petrovčič & Petrič, 2014). Additionally, the researchers found that there was no observed difference in terms of intrapersonal empowerment (Petrovčič & Petrič, 2014). Lastly, high posting frequency was significantly associated with a high level of interactional empowerment but not intrapersonal empowerment (Petrovčič & Petrič, 2014).

Behavioral Component

The behavioral component of psychological empowerment refers to the action an individual takes to directly influence outcomes (Zimmerman, 1995). Aspects of the behavioral component of psychological empowerment include community involvement, organizational participation, and coping behaviors. The behavioral component can also include behaviors that allow one to cope with the stress of trying to exert change or in adapting to change (Zimmerman, 1995). The behavioral component of psychological empowerment has been researched less frequently in a standardized manner than its counterparts. Researchers who studied employee empowerment by investigating the relationships between supervisors and supervisees suggested that feelings of empowerment were essential mindsets that need to be facilitated by supervisors to generate proactive behaviors (Boudrias, Gaudreau, Savoie, & Morin, 2009). Additionally, the researchers found a moderate correlation between psychological empowerment and behavioral empowerment measures, which suggested that the measures captured different facets of empowerment, consistent with the literature (Boudrias, et al., 2009). However, standardized methods of researching the behavioral component of empowerment are necessary. Research has supported the notion that higher levels of empowerment predict social and political activism (Albarracin, Munier, & Bail, 2017; Livingston, et al., 2017).

The three components of psychological empowerment interact and are expressed within an individual through that person's ability to enact change within a given context (intrapersonal component), while understanding the workings of context's systems (interactional component) and taking action to exercise control in that same context (behavioral component). All three components must be measured to fully capture all of psychological empowerment, however only

one psychometrically reliable and valid measure of psychological empowerment exists, which measures the interactional component. Zimmerman (1995) believed that further development of empowerment theory to examine how the intrapersonal, interactional, and behavioral components interact to form psychological empowerment was needed.

Psychological empowerment theory is rooted in agency in and social action. There are conceptualizations of empowerment that include education, community, gender, and other social identities and institutions. Psychological empowerment refers to empowerment at the individual level and integrates perceptions of personal control, proactive approaches to life as a member of society, and a critical understanding of the sociopolitical environment (Zimmerman, 1995). Yet, empowerment in this way, relating to social action and agency has rarely been studied on an individual level regarding BMSM+.

BMSM+ Empowerment Research

When it comes to empowerment in relation to HIV, many studies have focused on empowerment as a conduit toward HIV prevention. For example, Garcia, Parker, Parker, Wilson, Philbin, and Hirsch (2015) conducted an ethnographic study that identified the structural and environmental factors that influenced BMSM's vulnerability to HIV and HIV prevention services engagement. The researchers found that HIV prevention efforts must address the structural and environmental vulnerabilities of fear and mistrust of public institutions (i. e. churches, schools, police) to be successful (Garcia, et al., 2015). Additionally, the study found that community-based organizations can support HIV prevention efforts by empowering BMSM through the creation of safe spaces in response to the structural and environmental vulnerabilities of BMSM (Garcia, et al.,

2015). While studies like this do provide some insight into the lived experiences of BMSM, ultimately these studies rarely explore the experiences of BMSM+ in meaningful ways. Furthermore, empowerment studies focused on HIV prevention limit the understanding of the intrapersonal experience of empowerment among all BMSM to the scope of HIV prevention. Thus, this review of empowerment research pertaining to BMSM+ only included studies that focused on the role and understanding of empowerment in BMSM+ or similar samples. Many of the studies that investigated empowerment used a sample that had at least three of four (race, gender, sexual minority, HIV status) identity markers used to classify BMSM+, were mostly qualitative, or found empowerment to be an outcome or an implication of the study. Three specific studies are discussed below because of the similarities between the populations used by those researchers and the population used in the current study.

One exploratory study that included African American MSM as the sample found that religion had several implications for successful functioning (Foster, Arnold, Rebchook, & Kegeles, 2011). One of the roles that religion played in this population was helping them to feel empowered to effectively confront the challenges of life (Foster, et al., 2011). Another study that used narrative inquiry found that racial shelving (bracketing race in environments with a Black majority to work through sexual identity issues), thick skin, self-determination, defying/transcending stereotypes, and experiential evolution were strategies used by young Black men who have sex with men (YBMSM) to navigate through social institutions and spaces, while accepting and appreciating their blackness and sexuality (Bartone, 2017). Empowering YBMSM was an implication of the study as it helped them to navigate society (Bartone, 2017).

In another study, researchers analyzed neighborhood factors that may contextualize perceived discrimination from three intersecting stigmatized characteristics including race, HIV status, and sexual orientation among African-American MSM living with HIV by using multiple regression (Dale, Bogart, Galvan, Wagner, Pantalone, & Klein, 2015). This study reported two major significant findings: (1) greater neighborhood poverty was related to more frequent occurrences of hate crimes (homophobia-related: $b = 1.15$, $SE = .43$, $p < .008$); and (2) greater neighborhood-related stressors were related to more frequent discrimination (race-related: $b = .91$, $SE = .28$, $p = .001$; homophobia-related: $b = .71$, $SE = .29$, $p = .01$; and HIV-related: $b = .65$, $SE = .28$, $p = .02$) and hate crimes (race-related: $b = .28$, $SE = .14$, $p = .04$ and homophobia-related: $b = .48$, $SE = .13$, $p = .001$; Dale et al., 2015). Thus, higher neighborhood poverty and related stressors were associated with experiencing more discrimination and hate crimes for BMSM+ (Dale et al., 2015).

Criticisms of BMSM+ Empowerment Research

Akin to the other constructs studied there was little research that focused on the empowerment of BMSM+. As a result, individuals must be informed of the empowerment of BMSM+ by making inferences of heterogeneous samples, which may not be appropriate. While, there was a fair amount of research regarding the empowerment of populations similar to BMSM+, there were few studies that shared the racial, sexual minority status, and HIV status markers of BMSM+ exclusively. Consequently, inferences regarding the empowerment of BMSM+ from other studies may be less appropriate than doing so for wellness and resilience studies. Moreover, empowerment research pertaining to BMSM+ has other major criticisms that emphasized the need

for the current study beyond lack of BMSM+ sample. The researcher offers four major criticisms of empowerment research.

The first major criticism of empowerment research pertaining to BMSM+ is the lack of empirical research. There were several articles that discussed concepts or theoretical models to use when working with people who may share two or more identity markers with BMSM+ (Craig, Dentato, & Iacovino, 2015; Matthews & Salazar, 2012; Messinger, 2012; Jefferies, Sutton, & Eke, 2017; Payne & Smith, 2011). However, these pieces of literature failed to inform the field of the current state of BMSM+. The scarcity of empirical research does not inform the field of the actual status of empowerment in BMSM+ nor does it aid in better understanding empowerment in this population.

The second major criticism of empowerment research pertaining to BMSM+ is that many of the studies used a research design that relied on one person to be the expert, such as case studies and autoethnographies (D'Augelli, 2006; Young & McKibban, 2013). Such studies were limiting in terms of transferability to a greater understanding of how BMSM+ experience empowerment.

The third major criticism of empowerment research pertaining to BMSM+ was that the focus was generally on youth (D'Augelli, 2006; Matthews & Salazar, 2012; Wagaman, 2016). Several studies discussed the role of empowerment in young sexual minorities, which often included Black identities but not HIV positive identities. The negation of HIV status as a marker of identity was neglectful, especially given that gay and bisexual males aged 13 to 24 account for 92% of HIV diagnoses for all people in that age group (CDC, 2018d). Additionally, most of the literature on empowerment that focused on sexual minority youth were theoretical in nature and discussed empowerment in the context of school institutions.

The final criticism of empowerment research pertaining to BMSM+ is that empowerment was often interpreted as an outcome rather than a measured variable (Craig, Tucker, & Wagner, 2008; Dale, Bogart, Galvan, Wagner, Pantalone, & Klein, 2015; Foster, Arnold, Rebchook, & Kegeles, 2011; Gamarel, Walker, Rivera, & Golub, 2014; Young & McLeod, 2013).

Empowerment as an interpreted outcome in studies is a limitation because there is not standardized criteria of empowerment among the various conceptualizations researchers used, which limits the transferability and generalizability of the studies. This criticism warrants the current study, which sought to investigate the experience of empowerment of BMSM+ through an assessment with supported reliability and validity.

Conclusion

In chapter two, the researcher introduced the role of the CRQD framework in reviewing literature and then reviewed literature, starting with the identity markers of BMSM+ and ending with literature regarding the variables investigated within the current study. Research that specifically pertained to the wellness, resilience, and empowerment of BMSM+ was limited, which revealed the gap in literature and provided further rationale for the current study. The current study sought to add to the gap in literature surrounding the wellness, resilience, and empowerment of BMSM+, while addressing the limitations of past relevant studies such as sampling issues, variable selection, holistic approaches to wellness, and the use of appropriate research models.

CHAPTER III: METHODOLOGY

The following section outlines and describes the methodology for this study. The study sought to use a descriptive, correlational research design informed by a framework that integrated Critical, Race, Queer, and Disability (CRQD) theories. The CRQD framework allowed for a culturally appropriate investigation of the relationship among wellness, resilience, and empowerment in BSM+ through the use of standard multiple regression.

Introduction

While the HIV epidemic persists in the United States, some groups have been disproportionately affected by the spread of the disease. Gay and bisexual men (which include MSM), while only making up 2% of the population, are more severely affected by HIV than any other group in the United States (CDC, 2017g). Furthermore, while only 12% of the U.S. population, Black Americans account for the highest proportions of new HIV diagnoses, PLWHA, and individuals diagnosed with AIDS when compared to other races (CDC, 2017a). The ways HIV affects the intersection of both sexual minority identities and behaviors in combination with the racial/ethnic identity translates into BSM accounting for more HIV diagnoses than in any other subgroup in the U.S. One in two BSM will be diagnosed with HIV in their lifetime if current HIV transmission rates continue (CDC, 2017g). As a result of the disproportionately high rates of HIV, countless studies have been conducted in order to mitigate the HIV epidemic in the BSM community and to better understand various factors that make BSM susceptible. However, by only looking at the BSM through the lens of battling the HIV epidemic, extant literature provides

a myopic view of BMSM, especially BMSM living with HIV (BMSM+). In the current study the researcher sought to expand the literature regarding BMSM+, specifically in the area of wellness.

Furthermore, this study aimed to provide a preliminary investigation into the relationship among wellness, resilience, and empowerment within the BMSM+ population. A review of the literature displayed the dearth of research that has investigated the wellness, resilience, and empowerment of BMSM+ while using a culturally relevant research framework. The outcomes provided by this study have the potential to provide beneficial evidence to inform the work for researchers, mental health therapist and educators, and community-based organizations.

Research Questions

The aim of this descriptive, correlational study, was to examine how resilience and empowerment contribute to the wellness of BMSM+. Specifically, the study investigated whether or not resilience and psychological empowerment predicted wellness in BMSM+ and how much of the variance in wellness among BMSM+ could be explained by resilience and psychological empowerment. The research question and sub-question used to guide the study examined by the researcher follows.

RQ 1: Do resilience and psychological empowerment, as measured by the Resilience (Wagnild, 2009) and the Sociopolitical Control scales (Zimmerman, 1995) respectively, predict wellness as measured by the Five Factor Wellness Inventory (Myers, 2014) in Black Men who have Sex with Men living with HIV?

Sub RQ1: How much of the variance in wellness as measured by the Five Factor Wellness Inventory (Myers, 2014) among Black Men who have Sex with

Men living with HIV is explained by resilience and psychological empowerment as measured by the Resilience (Wagnild, 2009) and the Sociopolitical Control scales (Zimmerman, 1995) respectively?

Variables of the Study

The positive psychometric variables selected within the study are reflected within the CRQD framework, and provide an opportunity for countering the current narrative and queering what is assumed to be standard, which is that BMSM+ cannot be well. Additionally, the CRQD framework conceptualizes positive HIV status as an identity of difference rather than a defect.

Dependent Variable

In line with multiple regression this study had one dependent variable, wellness. Although wellness is a single variable the assessment used to measure it contains seventeen subthemes.

Wellness

The researcher selected wellness as the dependent variable in this study. Statistical evidence of the wellness of BMSM+ is necessary given that, conceptually, they have not been considered to be well (WHO, 1946). The lack of consideration regarding the wellness of BMSM+ is because of their chronic disease as well as other health disparities, which are due to sociocultural factors reflective of their racial identity and sexual minority statuses (Flenar, et al., 2017; OMH, 2014). For the sake of this study wellness was defined as a holistic approach in which mind, body, and spirit is integrated in a purposeful manner with the goal of living life more fully and measured by

using the Five Factor Wellness Inventory (Myers, 2014). The Five Factor Wellness Inventory (Myers, 2014) was developed from the Indivisible Self model of wellness, which is founded on holism, a concept aligned with the essence of intersectionality. Both holism and intersectionality emphasize that an individual cannot be understood by examining aspects of their personhood in isolation, because all aspects of an individual connect to all other aspects of that same person; both concepts are essential in the inquiry of wellness among BMSM+.

Independent Variables

The current study included two independent variables as predictors for the standard multiple regression model. The independent variables of the study were resilience and empowerment; each variable is discussed below.

Resilience

The researcher selected resilience as one of the independent variables in this study. Statistical evidence of the resilience of BMSM+ is necessary given that previous research does not use psychometric instruments to measure resilience in the general BMSM+ population. Instead, resilience appears in youth and older samples of BMSM+ or through qualitative research involving BMSM+ where resilience is theorized to be present (Bruce & Harper, 2012; Harper et al., 2014; Wilson; et al., 2016b). For the sake of this study resilience was defined as the ability to cope effectively when faced with adversity and connotes inner strength, competence, optimism and flexibility (Wagnild, 2009). The researcher used the Resilience Scale (Wagnild, 2009) to measure the level of resilience among BMSM+ in the current study.

Psychological Empowerment

The researcher selected empowerment as the other independent variable in this study. Statistical evidence of the empowerment of BMSM+ is necessary given that empowerment on an intrapersonal level is virtually absent from the literature regarding the BMSM+ population. Yet, empowerment does show up in the literature as an objective for community-based organizations that serve the BMSM+ community (Miller, Forney, Hubbard, & Camacho, 2012; Shelley, et al., 2017). For the sake of this study empowerment was defined as the process by which an individual gains mastery over issues of concern to them (Zimmerman, 1995). Empowerment can be grouped into three categories: intrapersonal, interactional, and behavioral (Zimmerman, 1995). This study used the Sociopolitical Control Scale (Zimmerman, 1995) to investigate the intrapersonal level of psychological empowerment among BMSM+. The intrapersonal level reflects the beliefs that individuals hold regarding their ability to overcome issues of concern to them within the environments in which they function (Zimmerman, 1995).

Instruments

There was a demographic questionnaire and three instruments, the Five Factor Wellness Inventory (DV; Myers, 2014), the Resilience Scale (IV; Wagnild, 2009), and the Sociopolitical Control Scale (IV; Zimmerman, 1995) used in the current study. Before the participants were able to access the demographic questionnaire and three instruments, they had to answer questions related to the inclusionary criteria of the study. The survey was distributed through an online Qualtrics survey and the participants' answers were recorded anonymously.

Inclusionary Criteria

After consenting to the study there were seven inclusionary criteria questions presented to respondents after the informed consent and before the demographic questionnaire and psychometric instruments in the current study. Respondents who did not meet the inclusion criteria were not able to continue through to the study and were thanked for their time. The inclusion criteria questions reflected the inclusion criteria of the study, which was (a) Black or African-American, (b) 18 years of age or older, (c) have engaged in sexual activity with a man, (d) be a cisgender male, (e) identify as HIV positive, (f) live in the U.S., and (g) have an adequate command of the English language.

Demographic Questionnaire

The demographic questionnaire was used to gather data from the sample and provided characteristics of the population. While BMSM+ are already a specific subgroup, exploring identity and experiential characteristics within groups can be necessary in order to understand the nuances of experiences (Young & Meyer, 2005). The demographic questionnaire was informed by research and the CRQD framework, and sought to further explore areas of intersectionality within the BMSM+ population. The demographic questionnaire was comprised of 38 questions, which could be classified into categories of social location, socio-economic status and career, upbringing and relationships, and substance use. Social location refers to the groups to which people belong, and takes historical relationships of power and privilege into account (Adams, Blumenfeld, Castaneda, Hackman, Peters, Zuniga 2010). Accordingly, people's social locations are defined by their age, race, gender, sexual orientation, ability, religion, geographic location, and social class (Adams, et

al., 2010). Many ($n = 9$) of the demographic questions were about the participants' social location and asked about age, ethnicity, nationality, sexual orientation, HIV diagnosis, spirituality, and geography of the participants. Socio-economic status and career demographic questions included questions about income, education and employment ($n = 5$). There were eight demographic questions related to upbringing and relationships. Upbringing and relationships demographic questions explored family make-up, relationship status, romantic relationship, sexual relationships, and social relationships. There was one multi-dimensional substance use question that asked about the frequency of use, given various substance, over the past 30 days.

The researcher ran two post hoc analyses that utilized six demographic variables including HIV viral load detectability, CD4 count, mode of contraction, level of religiosity/spirituality, education, and relationship status. Considerably unequal group sizes called for an effort to reduce the difference in proportion between groups of demographic variables. The education and relationship status demographic variables had considerable differences in group sizes, thus, the researcher adjusted both demographic variables by combining groups while considering the CRQD framework of the study. The adjusted demographic groups can be seen in Table 3.

Table 3

Demographic Variables Adjusted Groupings

Demographic Variable	Adjusted Grouping	<i>n</i>	Original Grouping	<i>n</i>
Education	High School Diploma/G.E.D. or less	68	Nursery to 8 th Grade	1
			Some High (no diploma)	3
			High School	62
			G.E.D.	2
	Trade School Experience	48	Trade/technical/vocation training (no certificate)	24
			Trade/technical/vocation training certificate	24
	Some College	103	Some College Credit (no degree)	103
	College Graduate	30	Associate's Degree	18
			Bachelor's Degree	10
			Master's Degree	1
Doctoral Degree			1	
Relationship Status	Single	105	Single (not dating)	105
			Single (dating one person)	51
	Dating	92	Single (dating multiple people)	41
			Partnered	52
	Partnered	52	Domestic partnership	16
			Legal partnership	8
			Married	21
Widowed			7	

Five Factor WEL

The Five Factor Wellness Inventory, Adult (FFWEL-A) was originally based off Adlerian theoretical foundations and was developed in 1998 through structural equation modeling. The Wellness Evaluation of Lifestyle (WEL) served as a precursor and data source to the Five Factor Wellness Inventory (Hattie et al., 2004). Originally, the WEL defined wellness as a holistic

approach in which mind, body, and spirit was central to the development of the Five Factor Wellness Inventory (Myers, 2014). Wellness was thought of as a way of life that was oriented toward optimal health and well-being (Myers, 2014). Thus, wellness was more than health, and absence of disease; wellness integrated a concern for optimal functioning (Myers, 2014).

In the original WEL, 29 of the 132 items were eliminated due to poor psychometric properties (Myers, 2014). A maximum-likelihood exploratory factor analysis was conducted based on the remaining 103 wellness items; resulting in 17 clear factors, subtasks, based on the original circumplex Wheel of Wellness model (Hattie, Myers, & Sweeney, 2004). Next, an exploratory factor analysis for the original 17 subtasks provided support for five life tasks, five selves.



Figure 2. The Indivisible Self

The five life tasks and subtasks include the Creative Self, which includes the third order factors of Thinking, Control, Positive Humor, Work, and Emotions; the Coping Self, which includes Realistic Beliefs, Leisure, Stress Management and Self Worth; the Social Self, which includes Friendship and Love; the Essential Self, which includes Spirituality, Self-Care, Gender and Cultural Identity; and the Physical Self, which includes Exercise and Nutrition (Myers, 2014).

In its most recent revision, the Five Factor Wellness Inventory contains 91 psychometric items and is on a four point Likert-type scale with the following choices: strongly agree, agree, disagree, and strongly disagree (Myers, 2014). Every response is converted to a numerical score from four (strongly agree) to one (strongly disagree) and the responses totaled for each subscale (Myers, 2014). The Realistic Beliefs scale and one of the items on the Local Context subscale are the only items worded negatively, and reverse scoring is applied to them to achieve consistency (Myers, 2014).

Each scale is converted to a score that ranges from 25 to 100 by dividing the mean score for each scale by the numbers of items and then multiplying by 25 in order to place all scales onto a common metric, which is useful for interpretation purposes (Myers, 2014). A minimum of three item responses per scale is required in order for a scale to be scored (Myers, 2014).

In terms of reliability Hattie, et al. (2004) reported alpha coefficients for the five second order factors as .93 (Creative Self), .92 (Coping Self), .94 (Social Self), .91 (Essential Self), and .90 (Physical Self), and .94 for Total Wellness. The sample in their study included 3,043 persons who had completed the Wellness Evaluation of Lifestyle, however, only the 73 items that comprise the FFWEL were examined in their reliability analysis (Hattie, et al., 2004). The participants included 54% males and 46% females, aged 18 to later adulthood. Eighty percent were Caucasian and 20%

were ethnic minorities, of whom 9.1% were African American (Hattie et al., 2004). Slightly less than half, 44%, had completed high school, 30% had a bachelor's degree and 15.7% held a master's degree (10.9%) or doctoral degree (4.8%; Hattie, et al., 2004).

Studies have provided evidence for the convergent and divergent validity of the FFWEL factors (Chang, 1998; Myers & Bechtel, 2004; Myers, Mobley, & Booth, 2003; Myers & Mobley, 2004; Sinclair, 2001). Where both the first and second order factors have been found to discriminate among a variety of populations related to variables including ethnic identity, acculturation, spirituality, moral identity, academic self-concept, mattering, self-esteem, transitions, chronological age, subjective age, and life satisfaction, family environment and adolescent delinquency and relationship self-efficacy (Myers, 2014).

Resilience Scale

Wagnild's (2009) Resilience Scale sought to measure the construct of resilience, which itself has been conceptualized and defined in various ways throughout research. For the sake of this study resilience was believed to incorporate an individuals' beliefs in their ability to cope, overcome, and bounce back.

The Resilience Scale was first published in 1993 and is the earliest published instrument designed to measure resilience (Wagnild, 2009). The scale has since been revised and contains 25 items and uses a Likert-type scale. The Likert-type scale goes from 1 to 7 which represents a spectrum from where 1 is disagree and 7 is agree. Only items 1 and seven are anchored scale items. A total score is produced which represents the test-taker's resilience, where a higher score indicates a higher level of resilience.

The scale initially was developed out of a qualitative study that used “older women” as the population for developing the instrument (Wagnild, 2009. p. 106.). However, later applications of the scale with more diverse populations in terms of gender, age, race, employments, and chronic disease have supported the instrument’s validity and reliability (Wagnild & Young, 1993). Cronbach’s alpha coefficient for the resilience scale has consistently been acceptable and moderately strong (.73 to .91) (Wagnild, 2009). Additionally, the Resilience Scale was supported in having construct validity through the scale’s positive association with life satisfaction and morale and negative association with depression (Wagnild, 2009).

Some of the original limitations of the Resilience Scale included a lack of racial diversity and possible adaptations based on religion or spirituality (Wagnild, 2009). However, since then the Resilience Scale’s reliability and validity have been supported among various racial and ethnic minority groups in several studies (Abiola, 2011; Bhamani, Omrana, Karmaliani, & Azam, 2015; Oladipo, & Idemudia, 2015). Additionally, Wagnild (2009) illustrates that language may present an issue regarding people with different religious and spiritual beliefs. One example of this is the item “I can depend on myself more than anyone else”, which some respondents disagreed (a negative resilience response) because God was who the respondents depend on the most. Though the resilience scale has some limitations, the scale items provides the most thorough application of resilience when compared to other resilience instruments. Thus, it seems most appropriate for a general measure of resilience within BMSM+.

Sociopolitical Control Scale

The Sociopolitical Control Scale was developed by Zimmerman (1995) and sought to measure sociopolitical control, which is the intrapersonal component of psychological empowerment. Within Zimmerman's (1995) measure, empowerment refers to the process by which an individual gains mastery over issues of concern to them. The Sociopolitical Control Scale was founded on the notion that perceived control includes personality, cognitive, and motivational variables. Zimmerman (1995) built all the constructs into the Sociopolitical Control Scale with the view that each construct differs across different life spheres (Fischer & Cochran, 2007). The Sociopolitical Control Scale instrument attempted to distinguish sociopolitical control from other types of perceived control. This scale has the potential to be especially useful for clinicians involved in some form of community practice because the scale can be used to measure empowerment in clients or help understand the experiences of volunteers, activists, and community isolates (Zimmerman, 1995).

The scale contains 17 items and uses a Likert-type scale. The Likert-type scale ranges from 1 to 6 which represents a spectrum from where 1 is strongly disagree and 6 is strongly agree. Only items 1 and 6 are anchored scale items, meaning that numbers between two through five do not have labels. The Sociopolitical Control Scale has two subscales including Leadership Competence and Policy Control. The combination of subscale items produce a total score that represents respondents' perceptions of their sociopolitical control, where a higher score indicates a higher level of perceived sociopolitical control. However, Zimmerman (1995) does not offer a discrete range for high or low scores.

The Sociopolitical Control Scale was initially normed using three different studies (Fischer & Corcoran, 2007), and demonstrated good internal consistency reliability with Cronbach's alpha being .75 to .78. Also, the Sociopolitical Control Scale was supported in having good construct validity with correlations in the predicted directions with locus of control measures, alienation measures, and measure of willingness to lead (Fischer et al., 2007). Furthermore, the construct validity of the Sociopolitical Control Scale was supported as levels of participation in community activities differed across groups and reflected appropriately in both subscales (Fisher et al., 2007). The norming sample was diverse in race, gender, and age (Zimmerman & Zahniser, 1991). More recent studies have provided a need to revise the negatively worded scale items, but still supported the Sociopolitical Control Scale strong reliability and validity (Peterson et al., 2006).

Research Design

The study sought to use a descriptive, correlational design rooted in an integrated CRQD and wellness framework (See Table 4) to investigate the relationship among resilience, empowerment, and wellness in BMSM+. Specifically, the CRQD framework of the current study guided the variable selection and reporting of the findings. Variables were selected to reflect and potentially provide a counter-narrative to the existing literature, which narrowly depicts BMSM+. Additionally, the CRQD framework employs researchers to consider the ways in which the reporting of findings will impact the community being researched. Thus, the findings are reported in a way that seeks to liberate rather than further marginalize the BMSM+ community. The design of the study required the use of a standard multiple regression to examine how the independent

variables, resilience and empowerment, contributed to the dependent variable, wellness, among BMSM+.

Table 4

Critical Race Queer Disability Framework Overview

Theory	Description
Critical Theory	Perspectives are concerned with empowering individuals to surpass the limitations put on them by race, class, and gender (Fay, 1987)
Racialized Discourses	Perspectives question the control and production of knowledge regarding communities of color (Ladson-Billings, 2000)
Queer Theory	Perspectives are concerned with cultural and political means and conveys the voices and experiences of lesbians, gay, bisexual, or transgender individuals without objectifying them (Gamson, 2000)
Disability Inquiry	Perspectives understand the sociocultural perspectives of people with disabilities and allows those individuals to take control over their lives beyond a biological understanding of their condition (Mertens, 2009)

Rationale for Correlational Design

Wilson et al. (2016b) asserted the need for more empirical research used for the BMSM population. Furthermore, there is a need for more empirical research regarding the wellness of BMSM+ specifically, given the scarce amount of research in this area. Quantitative research on BMSM+ is necessary to provide statistically significant information that is generalizable, to increase evidenced-based and informed practices, services, and policies.

Correlational Research Methodology

This study sought to utilize a standard multiple regression where wellness served as the dependent variable and resilience and empowerment were the independent variables. The correlation coefficients that resulted from the procedure served to inform the researcher of the

relationship among wellness, resilience, and empowerment. Additionally, the eta squared among the independent variables and dependent variables was used to explain the variance among the variables.

Employing a standard multiple regression was necessary to answer the research question, ‘Do resilience and psychological empowerment predict wellness in BMSM+?’ Additionally, the standard multiple regression answered the research sub-question and tested the null hypotheses. Multiple regression allows for the relationships between one dependent variable and two or more independent variables to be analyzed at once. Multiple regression can support whether or not the independent variables predict the dependent variables. The multiple regression analysis was selected as an appropriate method for data analysis in order to investigate if a relationship among wellness, resilience, and empowerment exists within BMSM+, and to discover if resilience and empowerment predict wellness in BMSM+.

While other statistical analyses were applicable to the study, multiple regression is most appropriate because the relationship among wellness, resilience, and empowerment within the BMSM+ population has yet to be established. Once, the relationship among wellness, resilience, and empowerment within the BMSM+ is established then more complex analyses can be run. Furthermore, multiple regression was selected in this study over analyses which have multiple regression embedded within them such as Structural Equation Modeling (SEM), because of the limitations of those analyses. For example, two major limitations of SEM are that various models can be modified to explain the results and the errors that exist from using multiple statistical methods (Jeon, 2015). The other major limitation of SEM is that the analysis requires a large sample, which could be difficult to obtain depending on the population of the study (Jeon, 2015).

Those limitations can discredit the strength of the study and are absent when using multiple regression.

Table 5

Research Question & Methodology Matrix

Research question	Data (type)	Data Collection Source	Data analysis
RQ 1: Do resilience and psychological empowerment, as measured by the sociopolitical control scale, predict wellness in Black Men who have Sex with Men?	Scores on Survey battery	Regression coefficients between scores on Five Factor Wellness Inventory, Resilience Scale, and Empowerment Scale.	Multiple Regression
Sub RQ1: How much of the variance in wellness among Black Men who have Sex with Men living with HIV is explained by resilience and psychological empowerment?	Scores on Survey battery	R^2 between scores on Five Factor Wellness Inventory, Resilience Scale, and Empowerment Scale.	Multiple regression

Population and Sampling

Black Men who have Sex with Men comprise the target population where the selection requirements for the sample included: (a) Black or African-American, (b) 18 years of age or older, (c) have engaged in sexual activity with a man, (d) be a cisgender male, (e) identify as HIV positive, (f) live in the U.S., and (g) have an adequate command of the English language. Sampling methods for the quantitative portion included having the survey distributed online through via community-based organizers who specialized in HIV prevention and helping services.

Additionally, sampling methods consisted of criterion and snowball sampling. Snowball sampling was used since HIV is an invisible identity and is socially stigmatized. Sampling procedures used methods to acquire a sample that reflected the BMSM+ population. Those methods are described below.

Sampling

To gather data, a survey was distributed using multiple methods to try to obtain a sample representative of BMSM+ living in the U.S. The researcher distributed an online survey via Qualtrics, which included an informed consent, participant inclusionary criteria, a demographic survey, the Five Factor Wellness Inventory (Myers), Resilience Scale (Wagnild, 2009), and the Sociopolitical Control Scale (Zimmerman, 1995). The researcher shared the link with various community-based organizers across the United States who provide HIV prevention and healthcare services. Criterion sampling was used as the organizers identified potential participants within their network of consumers and other organizations who provided the survey to people who were thought to meet the study's inclusion criteria. Then the organizers provided the survey link among their network of consumers and other organizations who provided the survey to people who were thought to meet the study's inclusion criteria. The term consumers refers to the people who use the services of community-based organizations. It is important to note that the link was shared with people who self-reported knowing their HIV status (positive or negative), for the purposes of not accidentally revealing someone living with HIV. Furthermore, organizations that serve BMSM were given the link so that participants could be reached. The materials containing the survey information and study link used snowball sampling and encouraged individuals to share the link

with people they knew or thought met the study's criteria. Additionally, a flyer and study website containing information about the study and the survey were posted and shared online as a way to recruit participants. The minimum number of participants for the study was determined by running an a priori G* Power analysis ($\alpha = .01$, power = .99, $f^2 = .15$) and was determined to be 187 participants, which infers a medium effect size.

Sites and Setting

While the data was collected online via Qualtrics survey, the researcher did have prior approvals from four community-based organizers who agreed to support the current study by advertising the flyer and sharing the study link to people who were believed to meet the criteria for the study. Each of the four sites are community-based organizations (CBO) that provide services to their respective communities with specialized programs for LGBTQ+ community and people affected by HIV. The sites offered a secured location that was convenient and safe for participants, where confidentiality can be maintained. For confidentiality purposes, the four locations are referred to as CBO I, CBO II, CBO III, and CBO IV.

CBO I

CBO I was located in a medium-sized, metropolitan Southeastern city and is housed within a larger community-based organization, which started as an assisted living facility in 1997 and now focuses on programs to prevent young people from contracting HIV or AIDS. The location offered a safe space for its clients and some of the services provided include: HIV Testing, STI screening, housing opportunity for persons with HIV/AIDS (HOPWA), nutrition services, Project AIDS Care

(PAC), and Ryan White Medical Case Management. CBO I was funded by federal and state grants as well as donations.

CBO II

CBO II was located in a large-sized, metropolitan Midwestern city and was a CDC funded program housed within a community-based organization. The mission of CBO II has been to be at the forefront of HIV prevention, education, and advocacy for the Black and Latino MSM communities. CBO II has focused on visibility, voice, and accountability with the goal of ending stigma and providing mental and social support for members of the aforementioned community.

CBO III

CBO III was located in a large-sized, metropolitan Northeastern city and was an interdisciplinary facility for research, training, education and policy development, focusing on national and international health issues. CBO III focuses on making life healthier for the LGBTQ+ community, PLWHA, and the site's respective community. The site believes in education and training, research and evaluation, and public health advocacy. The site offers a range of health services including HIV/STI counseling, testing, and referrals.

CBO IV

CBO IV is located in a medium-sized, metropolitan Mid-Atlantic city. CBO IV's mission is to end the HIV/AIDS epidemic in the U.S. through strategic grant-making, capacity building,

policy advocacy, technical assistance, and formative research. CBO IV offers several HIV/AIDS-related programs that focus on providing services to specific communities of color.

Data Collection

As previously stated the study utilized efforts to recruit a representative sample of BMSM+, given the context of participant criteria and accessibility to technology. The data was collected via Qualtrics, an online research management software. The following section includes a description of the data collection procedures for this study.

Data Collection Procedures

The data gathered through this study was obtained through the use of a Qualtrics online survey. The survey included an informed consent, participant criteria section, a demographic questionnaire, Five Factor Wellness Inventory (Myers, 2014), the Resilience Scale (Wagnild, 2009), the Sociopolitical Control Scale (Zimmerman, 1995). The survey took approximately 30 to 45 minutes with the average being approximately 15 minutes.

The instrumentation threat to internal validity is when there are changes that occur during the study in the way the dependent variable is measured (Michael. 2017). An example of this threat includes when there are different instructions or procedures given to participants. In this way, the order of the assessments given should remain constant to keep data collection procedures consistent. In doing so the researcher attempted to address the instrumentation internal threat to validity. Thus, the organization of the online survey remained consistent, and appeared in the following order: (1) informed consent, (2) inclusion criteria, (3) demographic questionnaire, (4)

Five Factor Wellness Inventory (Myers, 2014), (5) Resilience Scale (Wagnild, 2009), and the (6) Sociopolitical Control Scale (Zimmerman, 1995).

Participants were able to access the online survey via a link, which allowed participants to fill out the survey anonymously. The online survey began with an explanation of the research, an informed consent, a section that ruled out any participant who did not meet the inclusionary criteria, and a demographic survey. Next, the three psychometric instruments used to measure wellness (Five Factor Wellness Inventory; Myers, 2014), resilience (Resilience Scale; Wagnild, 2009), and empowerment (Sociopolitical Control Scale; Zimmerman, 1995) were included. Instructions for each instrument appeared at the beginning of each assessment and remained accessible to participants while answering the instrument questions. Each instrument appeared consecutively in the following order: Five Factor Wellness Inventory (Myers, 2014), Resilience Scale (Wagnild, 2009), Sociopolitical Control Scale (Zimmerman, 1995). The entire survey used forced responses so participants were not able to move throughout the survey before completing the section they were on. The force response process was used to ensure that all participants answered every question. Once the participants finished the three instruments they were thanked for their time.

Lastly, because the survey was extensive and contained 169 items in total, survey fatigue was a possible threat to internal validity. In order combat the threat of survey fatigue the researcher setup the Qualtrics survey so that participants could take a break and not be timed out of the study and allowed for participants to go back if they felt like they made an error.

Data Analysis

The purpose of this descriptive, correlational study, was to use standard multiple regression to determine if resilience and psychological empowerment contribute to the wellness of BMSM+.

Standard Multiple Regression

The aim of this portion of the current study was to investigate the degree to which resilience and psychological empowerment can predict the wellness of BMSM+. As such, the researcher used a standard multiple regression analysis to test the following hypotheses:

- Null Hypothesis 1: The wellness of Black men who have sex with men living with HIV cannot be significantly predicted by resilience.
- Null Hypothesis 2: The wellness of Black men who have sex with men living with HIV cannot be significantly predicted by psychological empowerment.
- Null Hypothesis 3: None of the variance in wellness of Black men who have sex with men living with HIV can significantly be explained by resilience and empowerment.

Multiple regression is a widely used correlational research design conducted to analyze the relationship between a single dependent variable and two or more independent variables (Allison, 2002). The current study used a multiple regression where wellness was the dependent variable (DV) and resilience and psychological empowerment were the independent variables. The researcher hypothesized that resilience and empowerment would predict wellness in BMSM+, thus requiring a multiple regression analysis. IBM Statistical Package for Social Sciences (SPSS) 25

was used to run the data analyses. In order to run a multiple regression assumptions must be checked first, next the regression model must be analyzed for fit, and then the results interpreted (Laerd, 2015a). Laerd (2015) identified eight assumptions that need to be checked for when running a multiple regression: (a) Continuous DV, (b) Continuous IVs, (c) Independence of observations, (d) Linearity, (e) Homoscedasticity, (f) Multicollinearity, (g) Unusual points, and (d) Normality. The first two assumptions require the dependent and independent variables to be continuous, though the independent variables can be categorical (Laerd, 2015a). Next, it is necessary to check for the independence of observations, which can be done by using a Durbin-Watson test or known if the study does not use multiple observations (Laerd, 2015a). The assumption of linearity can be checked by using scatterplot matrices and correlation coefficients. Correlation coefficients and scatterplot matrices are methods used to check for linearity between the DV and IVs. Next, the assumption of homoscedasticity needs to be checked and can be done by using a graph plotted from the studentized residuals against the unstandardized predicted values (Laerd, 2015a). Next, multicollinearity is checked by reviewing the Tolerance and Variation Inflation Factor (VIF; Laerd, 2015). Tolerance is a measure of multicollinearity and can be checked by reviewing the proportion of variance in one independent variable not explained by the remaining independent variables (Norusis, 2004). Here the tolerance should be no greater than 0.1 to be accepted (Laerd, 2015a). The VIF is checked by reviewing the calculation of 1 over the tolerance and should not be greater than 10 to be accepted (Laerd, 2015; Norusis, 2004). Next, one must check for unusual points in the data that may improperly influence the interpretation of the results and be detrimental to the model fit (Laerd, 2015a). The unusual points include outliers, high leverage points, and highly influential points (Laerd, 2015b). Outliers were cases that had a

standardized residual that was greater than ± 3 standard deviations (Laerd, 2015a). High leverage points were detected by using Leverage values, where cases that had a value of less than 0.2 were safe, 0.2-0.5 were risky, and 0.5 or greater were dangerous (Laerd, 2015a). Influential points were checked by sorting Cook's values, where distance values above 1 would be investigated and possibly deleted (Laerd, 2015a). The last assumption required that normality be checked using histogram and P-P plot of the model (Laerd, 2015a).

After checking the assumptions for multiple regression, it is necessary to fit the regression model. For multiple regression, a plane is fitted to data (Norusis, 2004). The fit of the multiple regression model can be assessed by the Coefficient of Multiple determination R^2 , which is a fraction that represents the proportion of total variation of y explained by the regression plane (Laerd, 2015; Norusis, 2004). The Coefficient of determination R^2 tells the amount of variance in the dependent variable explained by the independent variables overall (regression model; Laerd, 2015). Thus, the larger R^2 , the better model fits data. Generally, R^2 has to be greater than 30% to be considered significant (Laerd, 2015a).

Protection of Human Research Participants and Ethical Issues

This study was conducted after being granted approval by the Institutional Review Board at the University of Central Florida (UCF). All stipulations for conducting human behavioral research were followed, and the researcher handling the data was CITI trained to work with human subjects and data. The risks to this study were believed to be minimal because of the use of an anonymous survey. The use of anonymity was necessary in ensuring the minimization of risk and safety of participants given the sensitivity of health information, specifically HIV, which could have

negative social and legal ramifications. Data was stored on a computer that was two-time password protected. The data will be stored for five years following the study, given UCF's policy on de-identified data. The principal investigator, dissertation chairs, and dissertation committee had access to the data. The principal investigator was responsible for receipt and transmission of the data.

Summary

This chapter contained a detailed description of the research methods that were used in the current study. Following a CRQD framework, the researcher presented a descriptive, correlational design used to investigate the relationship among wellness, resilience, and empowerment in BSM+. The researcher's sampling strategy was designed to find an appropriate number of participants who met the criteria for the study and was informative on the research questions. The researcher described the data collection procedures and explained the rationale for those procedures. The researcher concluded this chapter by describing the data analysis process.

CHAPTER IV: DATA ANALYSIS

Chapter four includes statistical results of the primary and sub research questions used to guide the current study. The purpose of this study, which used a descriptive, correlational design, was to investigate whether resilience (as measured by the Resilience Scale Wagnild, 2009) and empowerment (as measured by the Sociopolitical Control Scale, Zimmerman, 1995) predict BMSM+'s wellness as measured by the Five Factor Wellness Inventory (Myers, 2014). The current study was informed by a CRQD framework, which guided the study's variable selection. The researcher set out to utilize a standard multiple regression to analyze the primary and subsequent research questions. The results of the current study are presented in the following order: (a) sampling procedures, (b) research questions, (b) data preparation, (c) descriptive statistics, (d) reliability of each scale, (e) checking for assumptions, (f) overview of findings, (g) post hoc analyses, and (h) a summary of the data and findings.

Research Questions & Null Hypotheses

To answer the research question, it was necessary to utilize a quantitative research methodology reflective of a correlational design. The following research question, complementary sub-question, and null hypotheses, informed by the CRQD framework, guided the current research study:

RQ 1: Do resilience and psychological empowerment, as measured by the Resilience (Wagnild, 2009) and the Sociopolitical Control scales (Zimmerman, 1995)

respectively, predict wellness as measured by the Five Factor Wellness Inventory (Myers, 2014) in Black Men who have Sex with Men living with HIV?

Sub RQ1: How much of the variance in wellness as measured by the Five Factor Wellness Inventory (Myers, 2014) among Black Men who have Sex with Men living with HIV is explained by resilience and psychological empowerment as measured by the Resilience (Wagnild, 2009) and the Sociopolitical Control scales (Zimmerman, 1995) respectively?

Null Hypothesis 1: The wellness of Black men who have sex with men living with HIV cannot be significantly predicted by resilience.

Null Hypothesis 2: The wellness of Black men who have sex with men living with HIV cannot be significantly predicted by psychological empowerment.

Null Hypothesis 3: None of the variance in wellness of Black men who have sex with men living with HIV can significantly be explained by resilience and empowerment.

Sampling

Criterion and snowball sampling procedures were used in the current study to obtain a sample that was reflective of the BSM+ population. An a priori G* Power analysis determined that the minimum number of participants needed for the study to have power with statistical significance was 187 ($\alpha = .01$, power = .99, $f^2 = .15$). The researcher distributed the online Qualtrics survey to various HIV prevention and treatment community-based organizers across the

United States (see chapter 3, page 107). At the end of data collection (21 days) there were 278 respondents who accessed the survey initially and after accounting for people who met the study's criteria the sample was $N = 249$.

The sample in the current study was fairly representative of the BSM+ population, and for the most part participants were in their late twenties ($M = 27.85$), African-American ethnically, virally suppressed, single, employed, most middle-class, with some college education. A little over one-third of participants ($n = 86, 34.5\%$) would technically have an AIDS diagnosis indicated by a CD4 count at or below 200 (CDC, 2018e). There was good representation across mode of HIV contraction, current income, and religion. The sample may have been underrepresented in regard to some age ranges and participants from the South. The sample may have been overrepresented in participants from the Northeast, Midwest, and West.

Data Preparation

The current study had 278 respondents and used an online Qualtrics survey to collect the responses from participants who met the study's inclusion criteria, which included (a) Black or African-American, (b) 18 years of age or older, (c) have engaged in sexual activity with a man, (d) be a cisgender male, (e) identify as HIV positive, (f) live in the U.S., and (g) have an adequate command of the English language. It was necessary to prepare the data collected through the online Qualtrics survey before running the primary data analyses. This section outlines the data preparation process employed by the researcher and included; (a) screening out the participants who did not meet the study's criteria, (b) entering in the data, and (c) screening and cleaning the data.

Participant Screening

Of the initial 278 people who responded to the survey, 29 respondents did not meet the inclusion criteria of the study (see Table 6).

Table 6

Participant Inclusion Criteria

Inclusion Criteria Statement	# of Respondents Who Did Not Meet Criteria	Cumulative # of Respondents Who Did Meet Criteria
“I consent to take part in this study.”	3	278
“I am at least 18 years of age.”	2	273
“I identify racially or ethnically as Black or African-American.”	3	270
“I identify as male and was assigned male at birth”	3	267
“In my lifetime, I have engaged in sexual activity with a man.”	3	264
“I am aware of my HIV status AND I have a positive HIV diagnosis.”	11	253
“I live in the United States.”	2	251
“I feel comfortable communicating in English.”	2	249

Additionally, six respondents were removed because they inputted an age younger than 18 on an open-ended demographic question asked later in the study. Although this may have been an entry error, the respondents were deleted as a way to maintain the integrity of the study’s inclusionary criteria.

Entering and Coding the Data

Qualtrics was created in 2002 and has enabled researchers to conduct survey research in traditionally hard to reach communities (Rosser et al., 2009). The online platform allows

researchers to develop surveys using Qualtrics software (Beymer, Holloway, & Grov, 2018).

Qualtrics was used primarily for administering the survey and the collection of responses.

There were three psychometric scales included in the survey, the Five Factor Wellness Inventory (Myers, 2014), the Resilience Scale (Wagnild, 2009), and the Sociopolitical Control Scale (Zimmerman, 1995). The Five Factor Wellness Inventory contained 91 Likert-type items, ranging from 1-4 (1-Strongly Disagree, 2-Disagree, 3-Agree, 4-Strongly Agree). Thus, items were coded so that the data value corresponded with the response entered. However, the Five Factor Wellness Inventory (Myers, 2014) did contain six reverse-scored items; in this case, items were re-coded in Qualtrics to the appropriate value (4-Strongly Disagree, 3-Disagree, 2-Agree, 1-Strongly Agree). The Resilience Scale (Wagnild, 2009) contained 25 Likert-type items, ranging from 1-7, where the anchors were “Strongly Disagree” with a value of one, and “Strongly Agree” with a value of seven. The values in between one and seven were not labeled on the survey and represented a subjective range between the anchors. The Resilience Scale (Wagnild, 2009) did not contain any reversely scored items. The Sociopolitical Control Scale (Zimmerman, 1995) contained 17 Likert-type items, ranging from 1-6, where the anchors were “Strongly Disagree” with a value of one and “Strongly Agree” with a value of six. The values in between one and six were not labeled and represented a subjective range between the anchors. Items were coded within Qualtrics so that the data value corresponded with the response entered. The further examination of the Sociopolitical Control Scale is provided in the “Instrument Reliability” section of this chapter. The psychometric items of the survey were coded within Qualtrics before transferring the collected responses to the Statistical Package for Social Sciences (SPSS) Version 25, where the data was screened, cleaned, and analyzed.

Screening and Cleaning the Data

Researchers have asserted the importance of screening and cleaning data before running analysis (Pallant, 2013; Tabachnick & Fidell, 2013). Screening and cleaning data is comprised of various processes that allow researchers to become aware of errors in the data. Raw data can have issues dealing with improper survey questions, the manner participants responded to questions, and data entry (Pallant, 2013; Tabachnick & Fidell, 2013). Errors left uncorrected during the data preparation process could create issues during the primary data analyses (Pallant, 2013; Tabachnick & Fidell, 2013). In the current study, the researcher checked for missing values and errors in order to prepare the data for primary analysis.

Missing Values

Qualtrics has a feature called “force response” where participants are forced to answer an item on the survey before moving on to the next item or question. The force response feature was used on every item in the current study. The current study only used data from participants who finished the entire survey and there were no missing values. Of the 278 respondents three did not complete the survey by the end of data collection and all of their data was expunged from the dataset.

Checking for Errors

The process of checking the data for errors refers to screening for values within the dataset that fall outside the range of viable values (Pallant, 2013). For example, the only possible values a participant could have been able to select when answering items on the Five Factor Wellness

Inventory ranged from 1-4, thus any value submitted outside of that range would be in error. It is necessary to check for errors because the presence of errors can distort the statistical analyses, and multiple regression can be sensitive to such errors (Pallant, 2013). Furthermore, one must check for errors and correct them before calculating the total scores of instruments (Pallant, 2013). The researcher checked for errors throughout the survey and employed different methods based on the type of data collected. While the data collected using the three psychometric instruments were continuous, several items within the demographic section of the survey were categorical. In order to check for errors among categorical variables the researcher inspected the frequency, minimum, and maximum of the variables for each item containing categorical variables. All values of items using categorical variables were within the range. In order to check for errors among continuous variables the researcher inspected each item's minimum and maximum values. All values of items using continuous variables were within the possible range. The same procedures used for error checking were used in order to get descriptive statistics regarding the study's sample.

Descriptive Statistics

Descriptive Statistics provide information about the sample of the study and helps to summarize the data in useful ways so that patterns may be seen (Laerd Statistics, 2013a). In order to calculate the descriptive statistics for items that collected categorical data, frequencies of the answer choices were calculated and a percentage given. Descriptive statistics for items that collected continuous data, calculated the mean, standard deviation, minimum value, maximum value. The following sections will discuss the descriptive statistics for the demographics and variables of the study. Additionally, this section will discuss the reliability of the psychometric

instruments and use descriptive statistics of the instruments to check for univariate and multivariate outliers before computing the descriptive statistics for the study's variables.

Demographic Descriptive Statistics

After accounting for the respondents who did not meet the inclusionary criteria (see Table 5), all of the participants in the current study reported that they were Black, cisgender males, engaged in sexual practices with men, HIV-positive, over the age of 18, living in the United States and had an adequate command of the English language ($n = 249$). Though demographics surrounding race, gender, and location were known, there was other demographic information deemed important to the study, which were also collected. The researcher collected descriptive demographic data that explored social location, socio-economic status and career, upbringing and relationships, and substance use, which are presented in this section. The full demographic statistics can be seen in Appendix J.

The mean age of participants was 27.85, with the youngest participant 20 years of age and the oldest participant 66 years of age. While all participants were Black racially, there was some variability among participants' ethnic identities (see Table 6). The majority of participants self-identified as gay or homosexual ($n = 215$; 86.3%), while almost 15% identified as straight, bisexual, pansexual, or fluid. There was bi-modal distribution among participants' CD4 count ranges, with about one-third reporting a CD4 count (T-cells, white blood cells reduced by HIV; CDC, 2018e) between 0-200 and about 1/3 between 401-600. According to the CDC a normal CD4 count range is from 500-1,600 cells (CDC, 2016b). The fact that the majority of participants had a CD4 count lower than the normal range yet 75.5% of participants had an undetectable viral load is

interesting and possibly indicative of early HIV diagnosis or an uncertainty surrounding their CD4 count. The plurality of participants indicated that they were “somewhat” religious or spiritual people ($n = 112$; 45.0%), with the second largest group indicating that they were “not at all” a religious or spiritual people ($n = 89$; 35.7%). Still, there was diversity regarding religious affiliation among participants (see Table 5). The geographic region with the most participants was the Mid-West region of the United States ($n = 61$; 24.5%), while other participants indicated that they lived in the Northwest ($n = 45$; 18.1%), Southeast ($n = 52$, 19%), North East ($n = 42$; 16.9%), Mid-Atlantic ($n = 28$; 11.2 %), Southwest ($n = 18$; 7.2), West ($n = 3$; 1.2%) regions. Full demographic statistics are provided in Table 7 below.

Table 7

Participant's Social Location Demographics

Characteristics	<i>n</i>	Total Percent
Ethnicity		
African/African American/Black	208	83.5%
Latino	34	13.7%
Afro-Caribbean	6	2.4%
Asian Pacific Islander	1	.4%
Sexual Orientation		
Homosexual/Gay	215	86.3%
Same Gender Loving	1	0.4%
Straight	15	6.0%
Bisexual	9	3.6%
Pansexual	6	2.4%
Fluid	2	0.8%
Queer	1	0.4%
HIV Viral Load Detectability		
Undetectable	188	75.5%
Not Undetectable	37	14.9%
Not Sure	24	9.6%
CD4 Count		
0-200	86	34.5%
201-400	39	15.7%
401-600	84	33.7%
601-800	34	13.7%
800+	6	2.4%
HIV Mode of Contraction		
Anal sex	99	39.8%
Vaginal intercourse	62	24.9%
Sharing needles	40	16.1%
Mother-to-child contact	8	3.2%
Unsure	40	16.1%
Level of Religiosity		
Not at all	89	35.7%
Not really	28	11.2%
Somewhat	112	45.0%
Very much	20	8.0%
Education		
High School	68	27.3%
Diploma/GED or Less	48	19.3%

Characteristics	<i>n</i>	Total Percent
Trade/technical/vocation training	103	41.4%
Some College Credit (no degree)	30	12.0%
College Graduate		
Employment Status		
Employed for wages	162	65.1%
Unemployed	87	34.9%
Current Income		
Less than \$15,000	37	14.9%
\$15,000 to \$24,999	47	18.9%
\$25,000 to \$34,999	76	30.5%
\$35,000 to \$99,000	85	34.1%
\$100,000 and above	4	1.6%
Geographic Location		
Mid-Atlantic	28	11.2
Midwest	61	24.5
North East	42	16.9
North West	45	18.1
South East	52	20.9
South West	18	7.2
West	3	1.2

Social class is considered a component of social location, descriptive statistics that are considered markers of social class and included income, education, and career. The plurality of participants indicated that they are currently middle class ($n = 85$; 34.1%; U.S. Centers for Medicare & Medicaid Services, n.d). Participants' had varied levels of education (see Table 7) but many indicated that they had some college credit but no degree ($n = 103$; 41.4%). The majority of participants indicated that they were employed for wages ($n = 162$; 65.1%) and had various types of employment.

Additionally, the researcher collected demographic information regarding the sample's upbringing, relationships, and substance use. Three aspects of the data collected on upbringing, relationships, and substance use deserve mention. On average participants grew up in a household with approximately four other people ($M = 3.80$, $SD = .967$), where primary caregiver type varied. When it came to relationship status many participants indicated that they were single and not dating ($n = 105$; 42.2%) and typically in romantic relationships with men. ($n = 226$; 90.8%). Additionally, over half of the sample engaged in some type of substance use in the past 30 days of them taking the survey, and substance use varied greatly among participants.

Ultimately, the descriptive statistics indicated that the sample in the current study was relatively young, gay, ethnically African-American, virally suppressed, employed, and had some college education. A considerable number of participants ($n = 86$, 34.5%) would technically have an AIDS diagnosis as indicated by the participants who reported that their CD4 count was below 200. There was good representation across modes of HIV contraction, current income, and geographical region, with representation from every U.S. region. There was diversity among religion. In addition to providing patterns among the characteristics of the sample in the current study, descriptive statistics were used to determine if the sample was representative of the population.

After reviewing national statistics from the CDC and previous research studies that included BMSM+ in their sample, the current study's sample is believed to be representative of the BMSM+ in several respects and provided a national sample. The CDC (2016) data are incomplete because they only report demographic data in the year that the person with HIV was diagnosed and does not track the demographics of people living with BMSM+. Still, the CDC

data on new HIV diagnosis among BMSM does provide insight given that new HIV diagnoses among BMSM from 2010-2016 represents 28% of the whole BMSM+ population (CDC, 2016a, CDC 2018a). The CDC data provides insight to possible age and region trends of BMSM+.

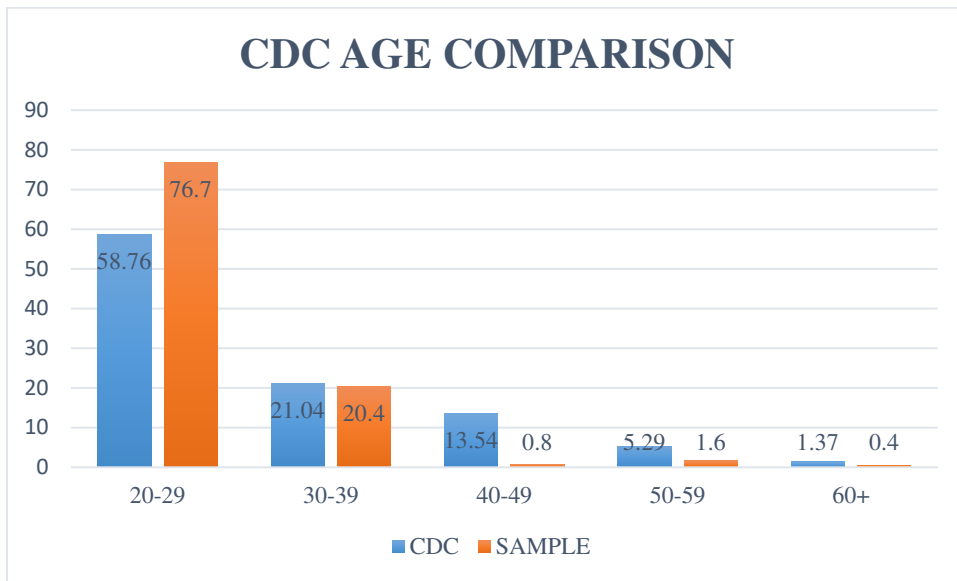


Figure 3. CDC Age at First Diagnosis Comparison Chart

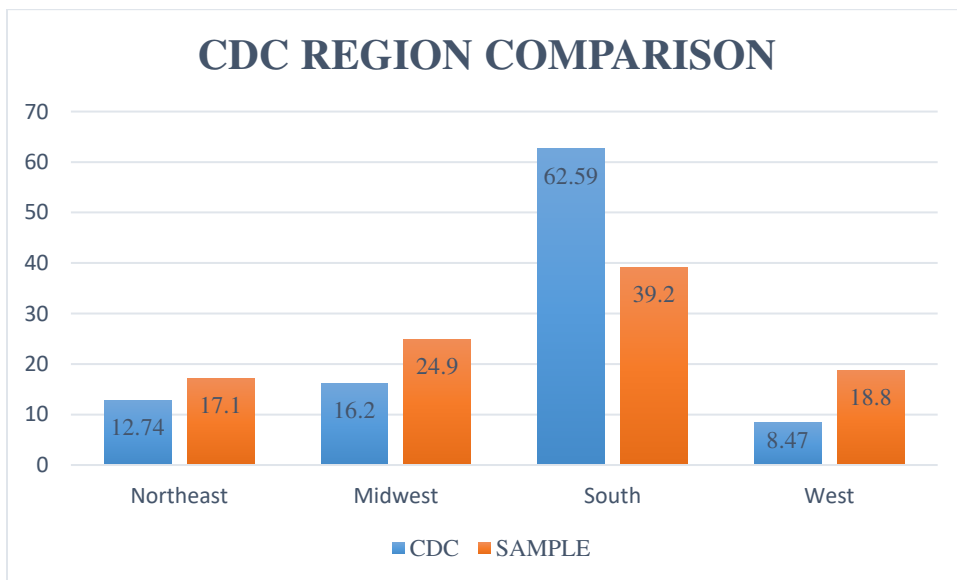


Figure 4. CDC Region at First Diagnosis Comparison Chart

Figures 3 and 4 compare age and region data after appropriately adjusting the demographic categories in the current study in order to contrast the percentages between CDC HIV new diagnosis data and the data from the current sample. Figures 3 and 4 display that BMSM+ aged 40 and over and of BMSM+ from the South may have been underrepresented among sample in the current study. Additionally, Figures 3 and 4 display that BMSM+ aged 20-29 and BMSM+ from the Midwest, and West were overrepresented.

In addition to CDC data, past studies help to inform how representative the current sample is of the national BMSM+ population. The difficulty in determining if the current study is representative of the BMSM+ population is that research rarely uses BMSM+ exclusively as the population. Prior research which included a sample of BMSM where at least 20% of the sample was BMSM+ were included as reference (Amola & Grimmert, 2015; Dale et al., 2015; Jerome & Halkitis, 2014; Peterson et al., 2014; Ports et al., 2017). The commonly collected demographic information included age, sexual orientation, education, and income. Compared to these other studies the current study's sample was overrepresented in the 20-29 age range. The younger sample could have been due to the online recruitment methods utilized by the researcher. Still, an overrepresentation of BMSM+ aged 20-29 may reflect those most impacted by HIV when considering the greater prevalence of HIV among BMSM between the age of 13-24 (CDC, 2018c). When considering data from the CDC and demographic statistics from previous studies, the current study is somewhat underrepresented of middle aged BMSM+ and BMSM+ living in the South. However, the current sample is believed to be somewhat representative of the BMSM+ population and provides a national sample.

Wellness, Resilience, & Empowerment Descriptive Statistics

Preliminary analyses were also run to give descriptive statistics regarding the variables being studied, which also allowed for the identification of outliers. Next, the reliability of each instrument was checked using Cronbach's alpha. The process of identifying and removing outliers and instrument reliability are discussed prior to the presentation of descriptive statistics regarding the variables of the current study.

Checking for Univariate and Multivariate Outliers

Regression analyses can be sensitive to extreme cases, thus it was necessary to identify and remove those extreme cases (Fox, 1991; Allison, 1999). Accordingly, in the current study, the researcher identified and removed univariate and multivariate outliers prior to running further analyses. Any z score over 3.00 would be more than three standard deviations away from the mean and considered to be a univariate outlier (Tabachnick & Fidell, 2013), though, z scores greater than or equal to 3.29 are considered to be very large and were used as the criteria for this study (Pallant, 2013; Tabachnick & Fidell, 2013). There were no cases in the current study that had a z score greater than 3.29 reflected in any of the subscales or total scores for the instruments.

Multivariate outliers are cases that have an unusual combination of scores on at least two variables and can be calculated using Mahalanobis distance (Laerd Statistics, 2013b).

Mahalanobis distance is a measure of multivariate distance and provides a conservative probability estimate for identifying an outlier when $p < .001$ for the chi-square value (Pallant, 2013; Tabachnick et al., 2013). In the current study, the researcher searched for multivariate

outliers by running a regression analysis of the independent variables to calculate the Mahalanobis distance, which did not result in the detection of outliers (chi square critical values with two degrees of freedom is 13.82; Pallant 2013).

Instrument Reliability

Cronbach's alpha was used to determine the reliability of the Five Factor Wellness Inventory (Myers, 2014), Resilience Scale (Wagnild, 2009), and the Sociopolitical Control Scale (Zimmerman, 1995). The researcher checked the reliability of the three psychometric instruments used in this study since the variables of wellness, resilience, and empowerment have rarely been used with the BSM+ population, especially not with the psychometric instruments used in this study. Cronbach's alpha can be used to determine to what extent all the items of a scale measure the same attribute (Pallant, 2013). A Cronbach alpha value ranges from -1 to 1 where values greater than or equal to .70 are accepted as internally consistent, where a larger Cronbach alpha values reflects greater consistency (Nunnally, 1978; Pallant, 2013). Scales with a Cronbach alpha values less than .70 are considered to lack internal consistency, which means the scale is not reliably and validly measuring what was intended.

Cronbach's alpha was also used to determine the internal consistency of each of the five major subscales, four contextual variables, and the overall Five Factor Wellness Inventory. The five major subscales of the Five Factor Wellness Inventory include Creative Self, Coping Self, Social Self, Essential Self, Physical Self; and the four contextual variables of the Five Factor Wellness Inventory include the Local Context, Institutional Context, Global Context, and the Chronometrical Context (Myers, 2014). The developer's alpha coefficient for the total Five

Factor Wellness Inventory was $\alpha = .98$, and the alpha coefficients for the five major subscales were as follows: Creative Self, $\alpha = .96$; Coping Self, $\alpha = .89$; Social Self, $\alpha = .96$; Essential Self, $\alpha = .95$; and the Physical Self, $\alpha = .90$ (Myers, 2014). The developer's alpha coefficients for the contextual variables of the Five Factor Wellness Inventory were Local Context, $\alpha = .74$; Institutional Context $\alpha = .73$, Global Context, $\alpha = .66$, and Chronometrical Context, $\alpha = .79$.

In the current study, the following subscales and contextual variables of the Five Factor Wellness Inventory had an acceptable Cronbach alpha value before adjusting items: Creative Self, Social Self, Essential Self, Physical Self, Global Context, Chronometrical Context (see Table 8).

Table 8

BMSM+ Wellness Scales with Acceptable Internal Consistency

Scale	Cronbach's Alpha	N of Items
Creative Self	.947	21
Social Self	.876	8
Essential Self	.907	16
Physical Self	.892	10
Global Context	.726	3
Chronometrical Context	.713	4
Total Wellness	.978	91

Additionally, the Five Factor Wellness Inventory had an acceptable Cronbach alpha overall.

The Coping Self, Local Context, and Institutional Context subscales had Cronbach alpha values that were less than .70. When comparing the developer's Cronbach alpha values of the Coping Self and Local Context variable there was a considerable difference (Myers, 2014), thus the researcher took steps to increase the internal consistency of these scales by removing items so that those measures were reliable and valid for the BMSM+ sample in the current study. The

Coping Self subscale consisted of 19 items and item 12, “I feel the need to keep people happy” was removed to increase the scale’s internal consistency above the acceptable level. The lack of internal consistency of this item could reflect a cultural difference in the role of other’s and their feelings on one’s own coping. The Local Context subscale consisted of five items and item 80, “I am afraid that my family will be hurt by terrorists” was removed to increase the scale’s internal consistency above the acceptable level. Though the Institutional Context variable did not have an acceptable Cronbach alpha, there was not much of a difference between the Cronbach alpha of the developer’s and the current study (Myers, 2014). Additionally, the Cronbach alpha value of the Institutional Context was approaching the acceptable level of internal consistency and removing items would have decreased the internal consistency of the scale, thus the researcher did not adjust the scale.

Table 9

Wellness Scales with Adjusted Internal Consistency

Scale	Cronbach’s Alpha Before Removal of Items	Cronbach’s Alpha After Removal of Items	# of Items Before Removal of Items	# of Items After Removal of Items
Coping Self	.641	.728	19	18
Local Context	.543	.784	5	4
Institutional Context	.691	.691	4	4
Total Wellness	.978	.980	91	89

Overall, after the removal of the two previously mentioned items, the Five Factor Wellness Inventory had a slightly stronger internal consistency that was the same ($\alpha = .98$) as the internal consistency of the developer of the instrument.

The Resilience Scale (Wagnild, 2009) also possessed strong internal consistency, $\alpha = .937$ and was not changed. Wagnild (2009) reported that the Cronbach alpha coefficient of the Resilience Scale norming groups fell within the range of .85-.94. Thus, the internal consistency of the Resilience Scale (Wagnild, 2009) in the current study fell within the expected range.

As discussed earlier in the section entitled “Entering and Coding the Data,” when the items for the Sociopolitical Control Scale were reverse coded none of the subscales produced a Cronbach alpha that demonstrated an acceptable level of internal consistency. The Cronbach alpha values for the subscales and total Sociopolitical Control Scale were: (a) $\alpha = -.136$ for the Leadership Competence subscale (b) $\alpha = .194$ for the Policy Control subscale, and (c) $\alpha = .378$ for the total score of the Sociopolitical Control Scale. The developer’s Cronbach alphas on the Sociopolitical Control subscales were $\alpha = .76$ for Leadership Competence and $\alpha = .75$ for Policy Control, which is a considerable difference from the Cronbach alphas of the current study. In order to increase the internal consistency to an acceptable level for each subscale, the researcher would have had to remove five items, which would have had a considerable effect on the 17-itemed measure. Because of the lack of internal consistency among the items of the Sociopolitical Control Scale, the instrument was deemed invalid for further use in the study.

Five Factor Wellness Inventory Descriptive Statistics

Wellness was measured using the Five Factor Wellness Inventory (Myers, 2014), where a total score was obtained along with five major subscales, four contextual variables, and an additional index that measured life satisfaction. There was a bi-modal distribution, two normal distribution within one set of data (see Figure 5) among total scores on the Five Factor Wellness

Inventory with mean of 73.28, a mode of 52.3 for the lower distribution, a mode of 81.46 for the higher distribution and a range from 46.07 to 87.64.

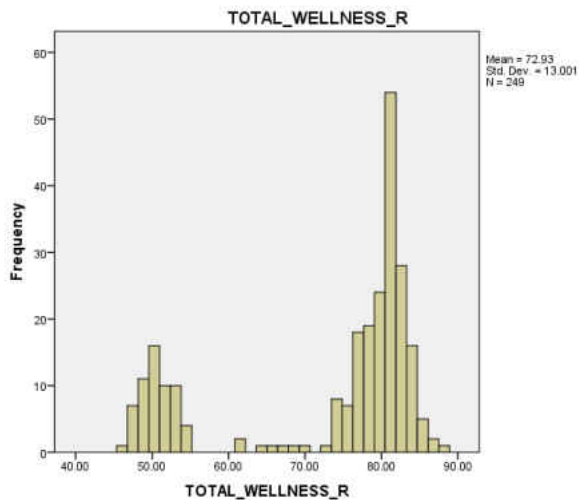


Figure 5. Wellness Bimodal Distribution

The subscales of the Five Factor Wellness Inventory (Myers, 2014) included the five Indivisible Self subscales, four context variables, and one life satisfaction subscale. Descriptive statistics regarding the Five Factor Wellness Inventory and subscales can be found in Table 10.

Table 10

Five Factor Wellness Inventory Descriptive Statistics

Scale	Mean	Minimum	Maximum	Std. Deviation
Creative Self	74.7418	36.90	91.67	15.10967
Coping Self	68.7082	41.67	87.50	8.95252
Social Self	75.3765	34.38	100.00	15.83824
Essential Self	73.5254	37.50	96.88	14.12300
Physical Self	73.1225	25.00	92.50	16.13683
Local Context	74.4980	31.25	100.00	15.79740
Institutional Context	74.6486	25.00	100.00	16.44623
Global Context	76.9076	25.00	100.00	18.02241
Chronometrical Context	69.1014	31.25	100.00	15.82141
Life Satisfaction Index	75.8032	25.00	100.00	22.54828
Total FFWEL	72.9277	46.07	87.64	13.00057

Myers (2014) did not suggest criteria for differentiating low and high scores on the Five Factor Wellness Inventory. Instead, Myers (2014) asserted the necessity of autonomy and that individuals should identify the areas of wellness (as measured by the Five Factor Wellness Inventory) that they would like change. In the context of this study, the subjectivity of Five Factor Wellness Score interpretation does not allow for a standardized way of evaluating the wellness (as measure by the Five Factor Wellness Inventory) of BMSM+. However, a comparison of the wellness of BMSM+ among norming groups used for the Five Factory Wellness Inventory does allow for comparison (Myers, 2014).

Table 11

A Comparison of Wellness Mean Scores

	BMSM+ N = 249	Population at-large N = 3,343	African- Americans N = 920	Males N = 746
Creative Self	74.74	73.18	73.66	65.72
Coping Self	68.71	68.73	69.29	65.08
Social Self	75.38	77.35	77.11	65.06
Essential Self	73.53	73.38	75.23	64.55
Physical Self	73.12	66.56	64.86	65.05
Total FFWELL	72.93	71.63	72.06	64.75

Table 11 allows the mean scores of the Five Factor Wellness Inventory (Myers, 2014) to be compared between BMSM+ and African-Americans, Males, and the population at large. There was no significant difference between the mean score for the current sample and the population at large on the Five Factor Wellness Inventory ($t(248) = 1.575, p = .12$). Compared to the population at-large, BMSM+ in the current study had a statistically significant higher mean score when examining the Physical Self subscale ($t(248) = 6.417, p = .000$). BMSM+ in the current

study had a statistically significant lower mean score when examining the Social Self subscale ($t(248) = -1.966, p = .050$). In sum, the overall wellness (as measured by the total Five Factor Wellness Inventory) of BMSM+ is similar to the general population, though there are statistically significant differences between the groups regarding their Physical and Social Selves, where BMSM+ have considerably better outcomes (Creative Self: $t(248) = 1.631, p = .104$; Coping Self: $t(248) = -.038, p = .969$; Essential Self: $t(248) = .162, p = .871$).

There was no significant difference between the mean score for the current sample and African-Americans on the Five Factor Wellness Inventory, ($t(248) = -1.444, p = .150$). There were no significant differences between BMSM+ in the current study and African Americans on multiple subscales of the Five Factor Wellness Inventory (Creative Self: $t(248) = 1.130, p = .260$; Coping Self: $t(248) = -1.026, p = .306$; Social Self: $t(248) = -1.727, p = .085$; Essential Self: $t(248) = -1.905, p = .058$). Though, on the Physical Self subscale, BMSM+ had a statistically significant higher mean score than African-Americans ($t(248) = 8.080, p = .000$).

When comparing the Five Factor Wellness Inventory mean scores of BMSM+ to males there were considerable differences that favor BMSM+. BMSM+ Five Factor Wellness Inventory total mean score was higher than males with statistical significance, ($t(248) = 9.926, p = .000$). BMSM+ had greater Five Factor Wellness Inventory mean scores on every subscale when compared to men (Creative Self: $t(248) = 9.422, p = .000$; Coping Self: $t(248) = 6.395, p = .000$; Social Self: $t(248) = 10.278, p = .000$; Essential Self: $t(248) = 10.028, p = .000$; Physical Self: $t(248) = 7.894, p = .000$).

Percentile scores of the Five Factor Wellness Inventory were available for African-Americans and Males and is the only norming data that contains the Local, Institutional, Global,

and Chronometrical subscales (see Table 12). There was no norming data available for the Life Satisfaction Index.

Table 12

A Comparison of Five Factor Wellness Scores at the 50th Percentile

	BMSM+ <i>N</i> = 249	African- Americans <i>N</i> = 920	Males <i>N</i> = 1,173
Creative Self	82.14	77.50	76.25
Coping Self	70.83	72.06	71.05
Social Self	81.25	87.50	81.25
Essential Self	79.69	79.69	75.00
Physical Self	80.00	65.00	65.00
Local Context	75.00	75.00	70.00
Institutional Context	81.25	68.75	50.00
Global Context	83.33	66.67	50.00
Chronometrical Context	68.75	75.00	50.00
Total FFWELL	78.30	76.39	74.66

The contextual variables incorporate systemic and environmental factors to provide a more holistic depiction of wellness (Myers, 2014). BMSM+ Five Factor Wellness Inventory scores at the 50th percentile were calculated by computing the median score through SPSS. When examining the contextual variables scores at the 50th percentile, BMSM+ in the current study had greater scores regarding the Institutional and Global Contexts; similar scores to African-Americans in regard to the Local context; and a Chronometrical Context score considerably higher than males and considerably lower than African-Americans. Similarly, BMSM+ 50th percentile score on the Local Context subscale is similar to the score of African-Americans, and both groups' scores are greater than the male group (see Table 12). Local Context refers to smaller systems in which one interacts most often, such as family and community. Lastly, BMSM+ Chronometrical Context 50th percentile score was considerably higher than the male population and considerably lower than the African-American population.

Resilience Scale Descriptive Statistics

Additionally, descriptive statistics for resilience as measured by the Resilience Scale (Wagnild, 2009) were within the acceptable range of scores 25.00-175.00. There was a bi-modal distribution (see Figure 6) of total scores on the Resilience Scale (Wagnild, 2009) with a mean of 123.39 ($SD = 22.87$), and a range from 70.00 to 161.00.

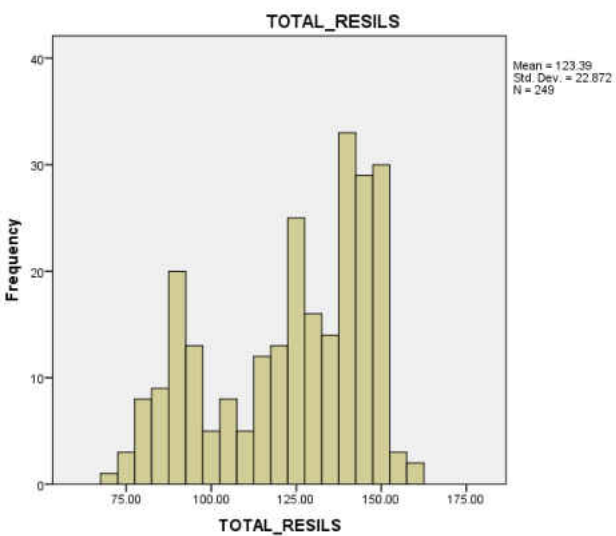


Figure 6. Resilience Bimodal Distributions

Table 13

Resilience Score Ranges and Levels

Score Range	Level of Resilience
25-100	Very Low
101-115	Low
116-130	Somewhat Low
131-145	Moderate
146-160	Moderately High
161-175	High

Wagnild (2009) differentiates six different ranges of scores from very low to high (see Table 13).

The mean Resilience Scale score ($M = 123.39$) indicated a somewhat low level of resilience

among participants in the current study (Wagnild, 2009). Participants had a Resilience Scale (Wagnild, 2009) median score of 129, suggesting that almost half of BMSM+ had a resilience level near or at moderate to high (see Figure 7).

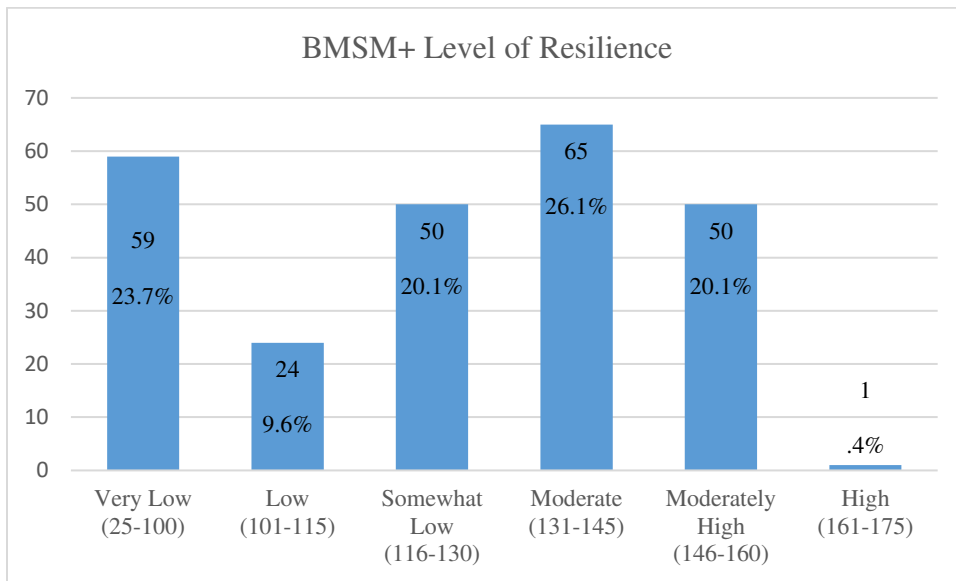


Figure 7. BMSM+ Level of Resilience

The mean for the norming group that was used to represent the United States population was 135.49 ($SD = 19.68$), with a range of 42 to 175. The mean for male norming group was 134.90 ($SD = 20.15$), with a range of 50 to 173. There was not norming information for racial groups. Participants in the current study had statistically lower levels of resilience when comparing their Resilience Scale (Wagnild, 2009) mean scores to the norming groups used to develop the instrument (population at-large: $t(248) = -8.345, p = .000$; males: $t(248) = -7.938, p = .000$).

Adjusted Research Question and Design

Because the Sociopolitical Control Scale (Zimmerman, 1995) had such low internal consistency there was not sufficient evidence that the instrument was a reliable and valid

measure of empowerment among the BMSM+ population, thus the use of the scale in the current study was deemed inappropriate by the researcher. The removal of the Sociopolitical Control Scale (Zimmerman, 1995) required that the original research questions and null hypotheses be adjusted. Thus, the adjusted research question, sub question, and null hypotheses were as follows:

RQ 1: Does resilience as measured by the Resilience (Wagnild, 2009) predict wellness as measured by the Five Factor Wellness Inventory (Myers, 2014) in Black Men who have Sex with Men living with HIV?

Sub RQ1: How much of the variance in wellness as measured by the Five Factor Wellness Inventory (Myers, 2014) among Black Men who have Sex with Men living with HIV is explained by as measured by the Resilience (Wagnild, 2009)?

Null Hypothesis 1: The wellness of Black men who have sex with men living with HIV cannot be significantly predicted by resilience.

Null Hypothesis 3: None of the variance in wellness of Black men who have sex with men living with HIV can significantly be explained by resilience.

The researcher ran a simple linear regression to address the adjusted research question, sub-research question and null hypothesis.

Checking Assumptions

Before analyzing the data to answer the research question it was necessary to address the assumptions of linear regression to ensure that it was an appropriate analysis for the data (Laerd,

2015b). Laerd (2015b) outlined seven assumptions to check for simple linear regression including; (1) continuous dependent variable, (2) continuous independent variable, (3) linear relationship between the dependent and independent variables, (4) independence of observations, (5) no significant outliers (6) homoscedasticity among variables, and (7) the residuals of the regression line are normally distributed.

The first two assumptions of simple linear regression required that the dependent and independent variables be continuous (Laerd, 2015b). Wellness, as measured by the Five Factor Wellness Inventory, was treated as a continuous variable. While the Five Factor Wellness Inventory was measured by a 4-point Likert-type scale the data can be treated as a continuous (Laerd, 2015). Thus, assumption number one was met.

Similarly, the second assumption of simple linear regression required that the independent variable is continuous (Laerd, 2015b). In the current study, resilience (as measured by the Resilience Scale; Wagnild, 2009) served as the independent variable and was continuous. The Resilience Scale (Wagnild, 2009) used Likert-type scaled items, which allowed the data to be treated as continuous (Laerd, 2015). Thus, assumption number two was met.

The third assumption of simple linear regression required that the independent variable is linear to the dependent variable (Laerd, 2015b). Linearity refers to a relationship between variables that is in the form of a straight line (Tabachnick & Fidell, 2013). Linearity can be assessed by using scatterplots and partial regression plots (Laerd, 2015). The linearity between resilience (as measured by the Resilience Scale; Wagnild 2009) and wellness (as measured by the Five Factor Wellness Inventory, Myers, 2014) appears to be linear (see Figure 8). Thus,

assumption number three was met.

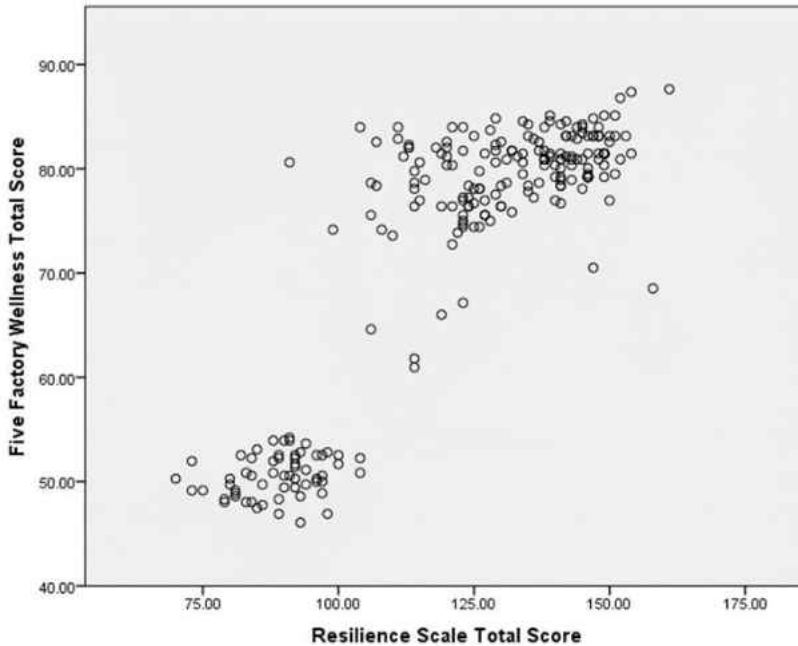


Figure 8. Wellness and Resilience Linearity Scatterplot

The fourth assumption of simple linear regression required that observations were independent of one another, meaning that errors cannot be related to one another (Laerd, 2015b). Due to the design of this study, one observation, this assumption was not an issue. Thus, the fourth assumption of multiple regression was met.

The fifth assumption of simple linear regression required the researcher to account for outliers (Laerd, 2015). While there were not any univariate or multivariate outliers previously detected, casewise diagnostics charts revealed the presence of three outliers, after two iterations of running a linear regression (See table 14).

Table 14

Simple Linear Regression Outliers

Case Number	Std. Residual	Total Wellness (FFWEL)	Predicted Value	Residual
184	3.136	83.99	63.4057	20.58306
185	3.595	80.62	57.0229	23.59508
139	-3.257	68.54	89.9189	23.59508

Laerd (2015b) has suggested that removing outliers should be a last resort and that one way to deal with outliers is by retaining them, especially if there is no appreciable difference in the results. The researcher decided to retain outliers after comparing the results of the linear regression with and without outliers and finding no considerable difference. Thus, the fifth assumption was met

The six assumption of simple linear regression, homoscedasticity, required equal residual values of the predicted dependent variable (Laerd, 2013). Homoscedasticity was assessed by interpreting a scatterplot that plotted the standardized residuals against the standardized predicted values. The scatterplot revealed that the data is heteroscedastic rather than homoscedastic (See Figure 9).

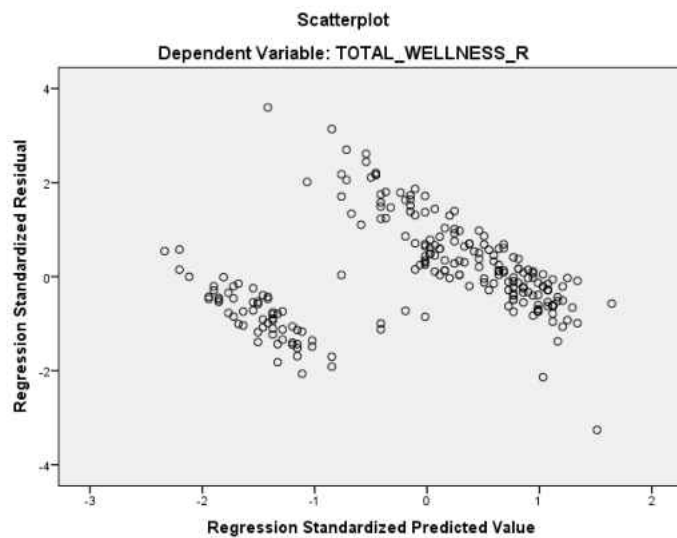


Figure 9. Simple Linear Regression Homoscedasticity Scatter Plot

Heteroscedastic data does not affect regression weights but will affect statistical inferences (Gujarati & Porter, 2009), changing the threshold p value from .05 to .01 reduces the chances of Type I error. While the sixth assumption of multiple regression was not met, the researcher changed the p value threshold to account for heteroscedastic data.

The final assumption of simple linear required that the residuals, or errors in the prediction, were normally distributed (Laerd, 2015). A histogram and P-P Plot of regression standardized residuals was used to assess the normal distribution of errors.

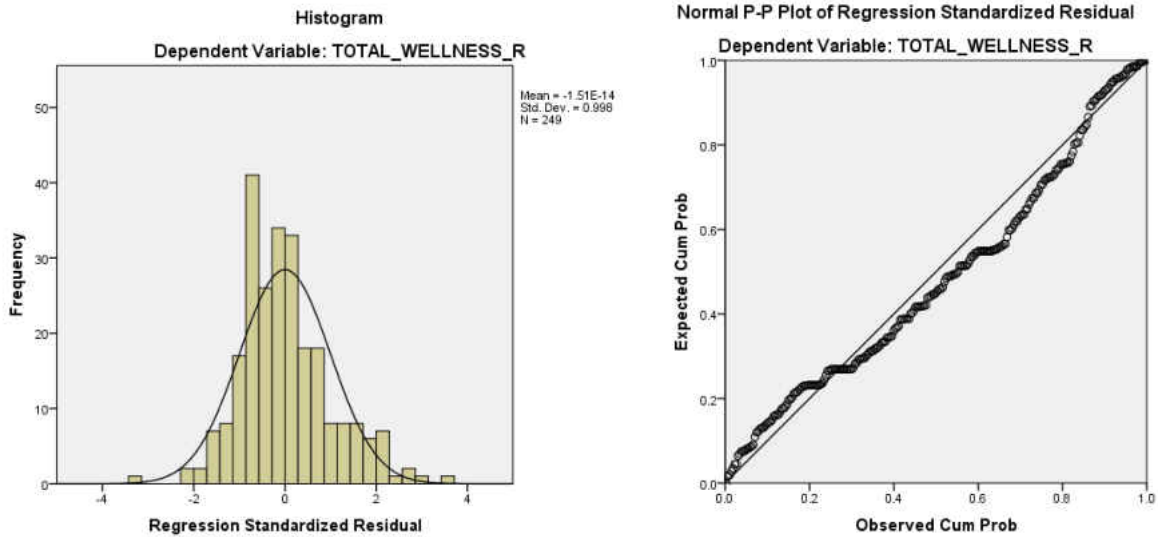


Figure 10 Histogram of Regression Standardized Residuals & P-P Plot of Regression Standardized Residuals

The histogram and P-P Plot of regression standardized residuals (See Figure 10) in the current study revealed that the errors were normally distributed, thus the eighth assumption of simple linear regression was met. Analysis of the data in this section showed that most of the assumptions required for linear regression were met. The threshold for statistical significance was changed because of heteroscedasticity of the data. The next section discusses the results of the simple linear regression.

Results of Simple Linear Regression

This section presents the findings from the study informed by the research questions and the hypotheses tested. The researcher's steps taken to check that the data met the assumptions of simple linear regression allowed for the data collected in the study to be analyzed via a simple linear regression and interpreted. The researcher ran a simple regression to investigate one

research question and one sub-research question. The first question sought to determine whether resilience (as measured by the Resilience Scale; Wagnild, 2009) could predict wellness (as measured by the Five-Factor Wellness Inventory; Myers, 2014) in BMSM+. The sub-research question examined how much of the variance in wellness (as measured by the Five-Factor Wellness Inventory; Myers, 2014) among BMSM+ could be explained by resilience (as measured by the Resilience Scale; Wagnild, 2009). The researcher tested two null hypotheses to investigate the research question and sub question of the current study.

Overview of Findings

This section presents the findings from the research question and sub-question presented in the current study.

Main Adjusted Research Question

RQ 1: Does resilience, as measured by the Resilience (Wagnild, 2009) predict wellness as measured by the Five-Factor Wellness Inventory (Myers, 2014) in Black Men who have Sex with Men living with HIV?

The linear regression model statistically significantly predicted wellness, $F(1, 247) = 726.012, p = .000$. The threshold of the p value for statistical significance was lowered to .01 to account for the violation of heteroscedasticity. The p value within the study was considerably lower than the threshold set, thus the researcher cautiously suggests that heteroscedasticity did not affect the results.

Table 15

Summary of Simple Linear Regression Analysis

Model	<i>B</i>	<i>SE_b</i>	β	<i>t</i>	Sig.
(Constant)	12.343	2.287	--	5.398	.000
Resilience (RS)	.491	.018	.864	26.945	.000*

Note. * $p < .01$; *B* = unstandardized regression coefficient; *SE_b* = Standard error of the coefficient; β = standardized coefficient

Resilience added statistically significantly to the prediction, $p = .000$, this result tests the first adjusted null hypothesis and allows for it to be rejected. Again, the p value is considerably lower than the $p < .01$ threshold to account for heteroscedasticity. The regression coefficient and standard errors can be found in Table 15. The regression model equation is:

$$\text{Wellness} = 12.34 + (0.491 * \text{Resilience})$$

The regression model equation means that for every one-point increase in resilience one can expect a .49 increase in wellness as measured by the Resilience Scale (Wagnild, 2009) and the Five Factor Wellness Inventory (Myers, 2014).

Adjusted Sub-Research Question

Sub RQ1: How much of the variance in wellness as measured by the Five-Factor Wellness Inventory (Myers, 2014) among Black Men who have Sex with Men living with HIV is explained by resilience the Resilience (Wagnild, 2009)?

Researchers have suggested using adjusted R^2 values when reporting variance explained over other indices such as the multiple correlation coefficient and the coefficient of determination (Laerd, 2015). The regression model had an adjusted R^2 value of .745 with an f^2 value of 2.92, which is indicative of a very large effect size (see Table 16). Thus, resilience (as

measured by the Resilience Scale; Wagnild, 2009) explained 74.5% of the variance in wellness (as measured by the Five Factor Wellness Inventory; Myers, 2014), this result allowed for the second adjusted null hypothesis to be tested and rejected.

Table 16

Linear Regression Study Model Summary

Model	<i>R</i>	<i>R</i> Square	Adjusted <i>R</i> Square	Std. Error of the Estimate
1	.864	.746	.745	6.56340

Note. $p < .01$; $f^2 = 2.92$

Additionally, the adjusted R^2 provides an estimate of the effect size according to Cohen’s (1988) classification. According to Cohen (1988) effect sizes (f^2) that are at least 0.02 are small, equal to 0.15 are medium, and equal to or greater than 0.35 are large. The regression model of the current study has an adjusted R^2 value of .745 and represents a very large effect size (Cohen, 1988).

Ultimately, the adjusted primary data analysis used a linear regression to establish that resilience can statistically significantly predict wellness, $F(1, 247) = 726.012$, $p = .000$ and resilience accounted for 74.5% of the variance explained in wellness.

Post Hoc Analyses

This section presents the results from two post hoc analyses that were conducted to examine how resilience and wellness varied based on demographic variables. Post hoc analysis refers to additional data analyses run to find patterns that were not primary objectives of the study, but can provide additional insights not evident from the primary analysis (Pallant, 2013). The researcher ran two post hoc analyses and utilized a multi-factor ANOVA analysis for both, testing only for main effects. Wellness and resilience were separately entered as the dependent

variables, and demographic variables pertinent to the framework of the study were entered as independent variables. Once again, the purpose of both post hoc analyses were to examine differences among the demographic variables with respect to wellness and resilience, which was aligned with the CRQD framework that asserted the need for acknowledging intersectionality within the sample.

Post Hoc Analysis One: Resilience and Demographics Multi-Factor ANOVA

The purpose of post hoc analysis one was to examine the differences among the demographic variables with respect to resilience, through the use of a multi-factor ANOVA. Resilience served as the dependent variable and CD4 count, HIV viral load detectability, mode of HIV contraction, level of religiosity/spirituality, and relationship status were entered into the multi-factor ANOVA as independent variables.

All the demographic variables entered into the model had been supported by research to have an association to resilience. Researchers have found that resilience plays a role in the health engagement behaviors of Black gay and bisexual men living with HIV, which could impact CD4 count and HIV viral load detectability (Harper, et al., 2014). Mode of contraction was relevant to the model because the modes of contraction imply different types of life stressors individuals may face and different coping styles, such as BMSM who contracted HIV through vaginal sex and sharing needles (Emlet, et al., 2010). Additionally, positive relationships among resilience, religiosity/spirituality, and social supports have been supported in research; thus, the religiosity/spirituality and relationship status demographics were entered into the model. (Buttram, 2015).

Before running the multi-factor ANOVA, the researcher checked the assumptions for a one-way ANOVA for each variable entered into the model since only the main effects of the multi-factor ANOVA were used. The following assumptions for one-way ANOVA were checked: (1) the dependent variable was continuous; (2) the independent variable was categorical, (3) there was an independence of observations, (4) there were no outliers, (5) the data was normally distributed, and (6) there was homogeneity of variances (Laerd, 2017). Every assumption for each factor was met, except for assumptions five and six. Though most factors violated the assumption of normal distribution, the researcher decided to continue on with the analysis as it has been established that ANOVA is quite robust against violations of normality and non-normality of data does not affect Type I error rate substantially (Maxwell & Delaney, 2004). Similarly, most of the demographic variables violated the assumption of homogeneity ($p < .05$), so Welch's ANOVA was interpreted and found to be acceptable for each factor ($p < .05$). Thus the violations of assumptions did not prevent the analysis, and a multi-factor ANOVA was an appropriate method for analyzing the data.

Detectability of viral load, CD4 count, mode of contraction, education, level of religiosity/spirituality, and relationship status were all entered into the multi-factor ANOVA model. The results for the original resilience multi-factor ANOVA can be seen in Table 17.

Table 17

Resilience Multi-Factor ANOVA Tests of Between Subjects

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	104535.918	18	5807.551	53.002	.000	.806
Intercept	439329.852	1	439329.852	4009.516	.000	.946
Detectability of Viral Load	1612.596	2	806.298	7.359	.001*	.060
CD4 Count	1514.050	4	378.512	3.454	.009*	.057
Mode of HIV Contraction	506.387	4	126.597	1.155	.331	.020
Level of Religiosity/Spirituality	439.543	3	146.514	1.337	.263	.017
Education	37093.060	3	12364.353	112.842	.000*	.595
Relationship Status	489.380	2	244.690	2.233	.110	.019
Error	25201.512	230	109.572			
Total	3921005.000	249				
Corrected Total	129737.430	248				

Note. * $p < .05$, R Squared = .806 (Adjusted R Squared = .791), alpha = .05

Only the detectability of viral load, CD4 count and education demographic variables were statistically significant in the model at $p < .05$, (see Table 17 for F ratios, eta squared, and p values). Mode of HIV contraction, level of religiosity/spirituality, and relationship status did not add significantly to the model ($p > .05$), but there were statistically significant group differences in respect to resilience. The model was re-run only using HIV viral load detectability, CD4 Count, and education ($p < .05$; see Table 18 for F ratios, eta squared, and p values). Additionally, partial eta squared can be used as reference for effect size where the effect sizes that are 0.01 are small, 0.06 are medium, and 0.14 are large (Cohen, 1988).

Table 18

Adjusted Resilience Multi-Factor ANOVA Tests of Between Subjects

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	102998.667	9	11444.296	102.293	.000*	.794
Intercept	894342.847	1	894342.847	7993.935	.000*	.971
HIV Viral Load Detectability	1157.857	2	578.929	5.175	.006*	.042
CD4 Count	3446.924	4	861.731	7.702	.000*	.114
Education	60371.340	3	20123.780	179.873	.000*	.693
Error	26738.763	239	111.878			
Total	3921005.000	249				
Corrected Total	129737.430	248				

Note. * $p < .05$, R Squared = .794 (Adjusted R Squared = .786), alpha = .05

The researcher describes the results of each demographic variable entered into the original multi-factor ANOVA model in the following sections.

HIV Viral Load Detectability

There were statistically significant differences in resilience between each HIV viral load detectability group $F(2, 230) = 7.36, p = .001, \eta_p^2 = .06$ (see Table 19).

Table 19

Multi-Factor ANOVA: Resilience & HIV Viral Load Detectability

HIV Viral Load Detectability	<i>n</i>	<i>M</i>	Mean Difference	
			Detectable	Unsure
Undetectable	188	129.67	$M_{\Delta} = 30.35^*$ $p = .000$	$M_{\Delta} = 18.34^*$ $p = .000$
Detectable	37	99.32	--	$M_{\Delta} = -12.01^*$ $p = .000$
Unsure	24	111.33	--	--

Note. * $p < .05$, Mean Square(Error) = 111.878

Participants who had a detectable HIV status had significantly lower ($p = .000$) resilience levels than people who were not sure about their HIV detectability who in turn had significantly lower ($p = .000$) resilience levels than participants who had an undetectable HIV viral load (see Table 18 for means and p values).

CD4 Count

There were statistically significant differences in resilience between CD4 count groups $F(4, 230) = 3.454, p = .009, \eta_p^2 = .06$ (see Table 20).

Table 20

Multi-Factor ANOVA: Resilience & CD4 Count

CD4 Count	<i>n</i>	<i>M</i>	Mean Difference			
			201-400	401-600	601-800	800+
0-200	86	118.00	$M_{\Delta} = 6.26^*$ $p = .020$	$M_{\Delta} = -13.62^*$ $p = .000$	$M_{\Delta} = -8.68^*$ $p = .001$	$M_{\Delta} = -24.67^*$ $p = .000$
201-400	39	111.74	--	$M_{\Delta} = -19.88^*$ $p = .000$	$M_{\Delta} = -14.93^*$ $p = .000$	$M_{\Delta} = -30.92^*$ $p = .000$
401-600	84	131.62	--	--	$M_{\Delta} = 4.94$ $p = .149$	$M_{\Delta} = -11.05$ $p = .101$
601-800	34	126.68	--	--	--	$M_{\Delta} = -15.99^*$ $p = .007$
800+	6	142.67	--	--	--	--

Note. * $p < .05$, Mean Square(Error) = 111.878

Means, mean differences, and p values for CD4 count can be seen in Table 20. Essentially, participants with a CD4 count above 800 had the highest levels of resilience. There was no

significant difference in resilience level between participants with a CD4 count of 401-600 and 601-800, and both groups of participants had a resilience level that was significantly different than participants who had CD4 counts of 0-200 and 201-400. Participants with a CD4 count of 201-400 had the lowest level of resilience.

Mode of HIV Contraction

Though mode of contraction was not statistically significant in the model, there were statistically significant differences in resilience between mode of HIV contraction groups $F(4, 230) = 1.16, p = .331, \eta_p^2 = .02$ (see Table 21).

Table 21

Multi-Factor ANOVA: Resilience & Mode of HIV Contraction

Mode of HIV Contraction	<i>n</i>	<i>M</i>	Mean	Difference		
			Vaginal Sex	Sharing Needles	Mother-to-Child	Not Sure
Anal Sex	99	125.39	$M_{\Delta} = -3.85$ $p = .159$	$M_{\Delta} = 8.62^*$ $p = .000$	$M_{\Delta} = 34.89^*$ $p = .000$	$M_{\Delta} = 2.82$ $p = .604$
Vaginal Sex	62	129.24	--	$M_{\Delta} = 12.47^*$ $p = .000$	$M_{\Delta} = 38.74^*$ $p = .000$	$M_{\Delta} = 6.67^*$ $p = .016$
Sharing Needles	40	116.78	--	--	$M_{\Delta} = 26.28^*$ $p = .000$	$M_{\Delta} = -5.80$ $p = .099$
Mother-to-Child	8	90.50				$M_{\Delta} = -32.08^*$ $p = .007$
Not Sure	40	122.58	--	--	--	--

Note. $p < .05$, Mean Square(Error) = 109.572

There were significant differences in resilience levels based on how participants contracted HIV (see Table 20 for means and p values). However, from the participants who knew how they contracted HIV there was not a significant difference ($p = .159$) in resilience levels with respect to mode of contraction that was via sex ($p = .159$). Participants who contracted HIV via mother-to-child had the significantly lowest levels of resilience, though this group was composed of only eight participants.

Level of Religiosity/Spirituality

Level of religiosity/spirituality was not statistically significant in the model, but there were statistically significant differences in resilience between groups $F(3, 230) = 1.34, p = .263, \eta_p^2 = .02$ (see Table 22).

Table 22

Multi-Factor ANOVA: Resilience & Level of Religiosity/Spirituality

Level of Religiosity/Spirituality	<i>n</i>	<i>M</i>	Mean Difference		
			Not Really	Somewhat	Very Much
Not at All	89	131.58	$M_{\Delta} = 31.80^*$ $p = .000$	$M_{\Delta} = 11.03^*$ $p = .000$	$M_{\Delta} = -4.31$ $p = .344$
Not Really	28	99.79	--	$M_{\Delta} = -20.77^*$ $p = .000$	$M_{\Delta} = -36.11^*$ $p = .000$
Somewhat	112	120.55	--	--	$M_{\Delta} = -15.35$ $p = .000^*$
Very Much	20	135.90	--	--	--

Note. $p < .05$, Mean Square(Error) = 109.572

Resilience levels varied significantly based on the level religiosity/spirituality of participants (see Table 21 for means and p values). There were significant differences in resilience mean scores

among every level of religiosity/spirituality groups, except for participants who were at the extremes of the variable (Not at All, Very Much; $p = .344$).

Education

There were statistically significant differences in resilience between education groups $F(3, 230) = 112.842, p = .000, \eta_p^2 = .595$ (see Table 23).

Table 23

Multi-Factor ANOVA: Resilience & Education

Education	<i>n</i>	<i>M</i>	Mean Difference		
			Trade School Experience	Some College	College Graduate
High School or Less	68	92.97	$M_{\Delta} = -28.93^*$ $p = .000$	$M_{\Delta} = -47.08^*$ $p = .000$	$M_{\Delta} = -44.08^*$ $p = .000$
Trade School Experience	48	121.90	--	$M_{\Delta} = -18.15^*$ $p = .000$	$M_{\Delta} = -15.67^*$ $p = .000$
Some College	103	140.05	--	--	$M_{\Delta} = 2.48$ $p = .671$
College Graduate	30	137.57	--	--	--

Note. * $p < .05$

Participants with more formal education had greater levels of resilience where there were no significant differences in resilience between participants who attended college, even if participants did not graduate, and participants who were college graduates (see Table 23 for means and p values).

Relationship Status

Though level of relationship status was not statistically significant in the model, there were statistically significant differences in resilience among every group $F(2, 230) = 2.23, p = .110, \eta_p^2 = .02$ (see Table 24).

Table 24

Multi-Factor ANOVA: Resilience & Relationship Status

Relationship Status	<i>n</i>	<i>M</i>	Mean Difference	
			Dating	Partnered
Single	105	134.89	$M_{\Delta} = 17.29^*$ $p = .000$	$M_{\Delta} = 24.44^*$ $p = .000$
Dating	92	117.60	--	$M_{\Delta} = 7.16^*$ $p = .000$
Partnered	52	110.44	--	--

Note. $p < .05$, Mean Square(Error) = 109.572

Participants who were single and not dating anyone had the significantly highest levels of resilience compared to people who were dating and partnered. Participants who were partnered had the lowest levels of resilience.

Post Hoc Analysis Two: Wellness and Demographics Multi-Factor ANOVA

The purpose of post hoc analysis two was to examine the differences among the demographic variables with respect to wellness, through the use of a multi-factor ANOVA.

Wellness served as the dependent variable and CD4 count, HIV viral load detectability, mode of

contraction, level of religiosity/spirituality, and relationship status were entered into the multi-factor ANOVA as independent variables.

All the demographic variables entered into the model had been supported by research to have a relationship to wellness. Both HIV viral detectability and CD4 count have been linked to aspects of physical wellness. Researchers have found that viral suppression allows the immune system to function properly and prevent illness (CDC, 2017c), and people with lower CD4 counts had more of a sedentary lifestyle. Mode of contraction was included because of differences that may occur among wellness when considering participants who contracted HIV through vaginal sex and sharing needles. When it comes to participants who contracted HIV via vaginal sex, research has shown that aspects of wellness may be difficult for BMSMW+ to obtain because of their discretion (Arnold, et al., 2017). Additionally, participants who contracted HIV via sharing needles may be using substances as coping mechanism, which may impact their wellness (Buttram, 2013). Lastly, level or religiosity/spirituality (Kendrick, 2017; Myers, 2014; Othieno, 2007; Sunil & McGhee, 2007) and relationship status (Arnold, et al., 2017) have been shown to have an association to wellness and are related aspects to subscales within the Five Factor Wellness Inventory (Myers, 2014).

Since only the main effects of the multi-factor ANOVA were used, the researcher checked the assumptions for a one-way ANOVA for each variable entered into the model before running the multi-factor ANOVA. The following assumptions for one-way ANOVA were checked: (1) the dependent variable was continuous; (2) the independent variable was categorical, (3) there was an independence of observations, (4) there were no outliers, (5) the data was normally distributed, and (6) there was homogeneity of variances (Laerd, 2017). Every

assumption for each factor was met, except for assumptions five and six. Though most factors violated the assumption of normal distribution, the researcher decided to continue on with the analysis as it has been established that ANOVA is quite robust against violations of normality and non-normality of data does not affect Type I error rate substantially (Maxwell & Delaney, 2004). Similarly, most of the demographic variables violated the assumption of homogeneity ($p < .05$), so Welch's ANOVA was interpreted and found to be acceptable for each factor ($p < .05$). Consequently, the violations of assumptions did not prevent the analysis post hoc analyses two, and a multi-factor ANOVA was an appropriate method for analyzing the data.

Detectability of HIV viral load, CD4 count, mode of HIV contraction, level of religiosity/spirituality, education, and relationship status were all entered into the multi-factor ANOVA model. The results for the original resilience multi-factor ANOVA can be seen in Table 25.

Table 25

Wellness Multi-Factor ANOVA Tests of Between Subjects

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	36680.242	18	2037.791	89.523	.000	.875
Intercept	160957.140	1	160957.140	7071.074	.000	.968
Detectability of Viral Load	259.025	2	129.513	5.690	.004*	.047
CD4 Count	375.332	4	93.833	4.122	.003*	.067
Mode of HIV Contraction	408.347	4	102.087	4.485	.002*	.072
Level of Religiosity/Spirituality	364.808	3	121.603	5.342	.001*	.065
Education	12643.913	3	4214.638	185.155	.000*	.707
Relationship Status	172.775	2	86.387	3.795	.024*	.032
Error	5235.434	230	22.763			
Total	1366208.339	249				
Corrected Total	41915.676	248				

Note.* $p < .05$, R Squared = .875 (Adjusted R Squared = .865), alpha = .05

Each factor entered into the model was statistically significant ($p < .05$). Again, partial eta squared was used as reference for effect size where effect sizes that were 0.01 were small, 0.06 were medium, and 0.14 were large (Cohen, 1988). The researcher discusses the results of each demographic variable entered into the multi-factor model in the following sections.

HIV Viral Load Detectability

There were statistically significant differences in wellness among each HIV viral load detectability group $F(2, 230) = 5.381, p = .005, \eta_p^2 = .05$ (see Table 26).

Table 26

Multi-Factor ANOVA: Wellness & HIV Viral Load Detectability

HIV Viral Load Detectability	<i>n</i>	<i>M</i>	Mean Difference	
			Detectable	Unsure
Undetectable	188	75.48	$M_{\Delta} = 19.04^*$ $p = .000$	$M_{\Delta} = -2.83^*$ $p = .018$
Detectable	37	56.45	--	$M_{\Delta} = -21.87^*$ $p = .000$
Unsure	24	78.31	--	--

Note. * $p < .05$, Mean Square(Error) = 22.763

Participants who had a detectable HIV viral load had the lowest level of the measured construct, wellness in this case. Additionally, participants with an undetectable viral load had significantly higher levels of wellness ($p < .000$), and participants unsure about the detectability of their HIV viral load had the highest significant levels of wellness.

CD4 Count

There were statistically significant differences in wellness among CD4 count groups $F(4, 230) = 4.051, p = .003, \eta_p^2 = .07$ (see Table 27).

Table 27

Multi-Factor ANOVA: Wellness & CD4 Count

CD4 Count	<i>n</i>	<i>M</i>	Mean Difference			
			201-400	401-600	601-800	800+
0-200	86	74.44	$M_{\Delta} = 9.52^*$ $p = .020$	$M_{\Delta} = -1.27$ $p = .417$	$M_{\Delta} = 3.70^*$ $p = .002$	$M_{\Delta} = -2.29$ $p = .787$
201-400	39	64.92	--	$M_{\Delta} = -10.79^*$ $p = .000$	$M_{\Delta} = -5.81^*$ $p = .000$	$M_{\Delta} = -11.81^*$ $p = .000$
401-600	84	75.71	--	--	$M_{\Delta} = 4.972^*$ $p = .000$	$M_{\Delta} = -1.02$ $p = .987$
601-800	34	70.74	--	--	--	$M_{\Delta} = -6.00^*$ $p = .039$
800+	6	76.73	--	--	--	--

Note. * $p < .05$, Mean Square(Error) = 22.763

The differences between CD4 count groups for wellness were not as straightforward as other demographic variables as can be seen in Table 27 above. Participants whose CD4 count was in the 401-600, and 800+ ranges had similar levels of wellness ($p = .987$), which were significantly higher levels of wellness than every other group. Participants whose CD4 count ranged from 0-200 did not have levels of wellness that significantly differed from participants whose CD4 count fell within the range of 400-600 ($p = .417$). Participants with a CD4 count of 201-400 had the significantly lowest levels of wellness.

Mode of Contraction

There were statistically significant differences in wellness between mode of HIV contraction groups $F(4, 230) = 4.527, p = .002, \eta_p^2 = .07$ (see Table 28).

Table 28

Multi-Factor ANOVA: Wellness & Mode of Contraction

Mode of HIV Contraction	<i>n</i>	<i>M</i>	Mean Vaginal Sex	Difference Sharing Needles	Mother-to-Child	Not Sure
Anal Sex	99	74.66	$M_{\Delta} = 2.44^*$ $p = .011$	$M_{\Delta} = 5.38^*$ $p = .000$	$M_{\Delta} = 22.81^*$ $p = .000$	$M_{\Delta} = -0.37$ $p = .604$
Vaginal Sex	62	72.23	--	$M_{\Delta} = 2.94^*$ $p = .016$	$M_{\Delta} = 20.37^*$ $p = .000$	$M_{\Delta} = -2.81^*$ $p = .025$
Sharing Needles	40	69.29	--	--	$M_{\Delta} = 17.43^*$ $p = .000$	$M_{\Delta} = -5.75^*$ $p = .000$
Mother-to-Child	8	51.85	--	--	--	$M_{\Delta} = 23.18^*$ $p = .000$
Not Sure	40	75.03	--	--	--	--

Note. * $p < .05$, Mean Square(Error) = 22.763

There were significant differences in wellness levels among every mode of HIV contraction group except for participants who were not sure how they contracted HIV and participants who contracted HIV via anal sex ($p = .604$). Among the participants who knew how they contracted HIV individuals who contracted HIV via anal sex had the highest levels of wellness. Participants who contracted HIV via mother-to-child had the lowest levels of wellness.

Level of Religiosity/Spirituality

There were statistically significant differences in wellness between level of religiosity/spirituality groups $F(3, 230) = 4.527, p = .002, \eta_p^2 = .07$ (see Table 29).

Table 29

Multi-Factor ANOVA: Wellness & Level of Religiosity/Spirituality

Level of Religiosity/Spirituality	<i>n</i>	<i>M</i>	Mean Difference		
			Not Really	Somewhat	Very Much
Not at All	89	75.72	$M_{\Delta} = 18.09^*$ $p = .000$	$M_{\Delta} = 3.82^*$ $p = .000$	$M_{\Delta} = -4.52^*$ $p = .001$
Not Really	28	53.44	--	$M_{\Delta} = -14.27^*$ $p = .000$	$M_{\Delta} = -22.62^*$ $p = .000$
Somewhat	112	72.12	--	--	$M_{\Delta} = -8.35^*$ $p = .000$
Very Much	20	80.23	--	--	--

Note. * $p < .05$, Mean Square(Error) = 22.763

There were significant differences between each level of religiosity/spirituality (see Table 29).

Participants with the highest level of religiosity/spirituality had the significantly highest levels of wellness. Participants with more moderate levels of religiosity/spirituality (Not Really, Somewhat) had lower levels of wellness, where individuals who were not really religious or spiritual had the significantly lowest levels of wellness.

Education

There were statistically significant differences in wellness between education groups $F(3, 230) = 182.26, p = .000, \eta_p^2 = .704$ (see Table 30).

Table 30

Multi-Factor ANOVA: Wellness & Education

Education	<i>n</i>	<i>M</i>	Mean Difference		
			Trade School Experience	Some College	College Graduate
High School Diploma/G.E.D. or Less	68	53.65	$M_{\Delta} = -26.05^*$ $p = .000$	$M_{\Delta} = -27.18^*$ $p = .000$	$M_{\Delta} = -24.99^*$ $p = .000$
Trade School Experience	48	79.70	--	$M_{\Delta} = -1.13$ $p = .526$	$M_{\Delta} = 1.06$ $p = .777$
Some College	103	80.83	--	--	$M_{\Delta} = 2.19$ $p = .123$
College Graduate	30	78.64	--	--	--

Note. * $p < .05$, Mean Square(Error) = 22.763

There were significant differences in wellness when comparing people with a high school diploma, G.E.D., or less education to every other education group. Thus, significant differences in wellness ceased to take place for participants after high school when compared to participants who sought formal education or training after high school even if they did not complete it.

Relationship Status

There were statistically significant differences in wellness among every relationship status group $F(2, 230) = 3.450, p = .000, \eta_p^2 = .03$ (see Table 31).

Table 31

Multi-Factor ANOVA: Wellness & Relationship Status

Relationship Status	<i>n</i>	<i>M</i>	Mean Difference	
			Dating	Partnered
Single	105	77.60	$M_{\Delta} = 4.55^*$ $p = .000$	$M_{\Delta} = 14.30^*$ $p = .000$
Dating	92	73.04	--	$M_{\Delta} = 9.74^*$ $p = .000$
Partnered	52	63.30	--	--

Note. * $p < .05$, Mean Square(Error) = 22.763

Participants who were single and not dating had significantly higher levels of wellness ($p = .000$) than single people who were dating; and both groups had significantly higher levels of wellness than BMSM+ who were partnered domestically, legally, or through marriage.

Chapter Summary

In chapter four, the researcher presented the results of the study after discussing the sampling procedures, research questions, data preparation, descriptive statistics, instrument reliability, assumption checking. Due to the lack of internal consistency of the Sociopolitical Control Scale (Zimmerman, 1995) used to measure empowerment, the researcher had to adjust the primary research question, sub-research question, null hypotheses. Consequently, the researcher ran a simple linear regression that examined the relationship between resilience and wellness. The researcher found that resilience (as measured by the Resilience Scale; Wagnild, 2009) statistically significantly predicted wellness (as measured by the Five Factor Wellness Inventory; Myers, 2014) with a very large effect size, $F(1, 247) = 726.012$, $p = .000$, adj. R^2

value of .745. Additionally, the researcher ran two post hoc analyses that examined the differences in resilience and wellness based off demographic. Both multi-factor ANOVAs revealed that demographic variables reveal significant differences in respect to the levels of resilience and wellness among the participants.

CHAPTER V: DISCUSSION

Chapter five discusses the current study in its entirety. In previous chapters, the researcher provided an overview of the study, reviewed the literature, described the study's methodology, and reported the results of the study. Chapter five serves as the final chapter of the dissertation and provides an overview of the study, a discussion regarding the results of the study, limitations of the current study, recommendations for future research, and implications of the current study.

Review of Study

Today, approximately 1.1 million people are living with HIV in the United States (CDC, 2017g). People who are most affected by HIV are at the intersection of minority racial and sexual identities (CDC, 2017a; 2017b). BMSM comprise the group that is the most affected by HIV in the U.S. (CDC, 2017d). Due to advances in medicine to prevent and treat HIV, and government policy purposed with combatting the HIV epidemic, research that has explored HIV prevention among BMSM is prevalent. However, researchers' focus on HIV prevention research among BMSM neglects nearly the half of the demographic that will be diagnosed with HIV in their lifetime if current HIV transmission rates continue (CDC, 2016c). Additionally, the CDC (2018f) has asserted that due to advances in HIV treatment, people living with HIV (PLWH) are living longer than ever before and have a better quality of life than those in the past. However, the lack of research done on the quality of life and wellness of BMSM+ calls into question if the CDC's assertion is true for all PLWHA. Furthermore, the absence of literature on the wellness of

BMSM+ has left helping professionals serving the BMSM+ community without culturally relevant and evidence informed practices. Consequently, research that investigates wellness among BMSM+ is fundamental for providing best practices to the BMSM+ community.

This study sought to fill the gap in the literature regarding the wellness of BMSM+ in order to inform practice and policy. The study applied an integrated Critical, Race, Queer, Disability (CRQD) framework that investigated if resilience (as measured by the Resilience Scale; Wagnild, 2009) and empowerment (as measured by the Sociopolitical Control Scale; Zimmerman, 1995) predict BMSM+'s wellness as defined by the Five Factor Wellness Inventory (Myers, 2014). It was necessary to check the internal consistency of the instruments used in the current study since none of the instruments had previously been used exclusively with BMSM+. The researcher removed two items from the 91-item Five Factor Wellness Inventory (Myers, 2014) in order to ensure that two subscales within the instrument were reliable and appropriate to use among the BMSM+ sample. The Resilience Scale (Wagnild, 2009) had strong internal consistency and was a reliable measure of resilience among BMSM+. The Sociopolitical Control Scale (Zimmerman, 1995) lacked internal consistency in the current study, which ultimately warranted the variable's exclusion from further analysis. Without a reliable and valid measure of empowerment the researcher was forced to adjust the original research question presented in the current study and used a simple linear regression to investigate the relationship between wellness and resilience. The researcher was able to address aspects of the original research question, sub-research question, and hypotheses and to further examine resilience as a contributor to wellness among BMSM+. Additionally, the study examined the differences in resilience and wellness separately, among various demographic variables.

Discussion of Findings

The findings from the descriptive statistics and two post hoc analyses that the researcher ran in the current study are discussed in this section. The researcher ran a simple linear regression to answer the adjusted research question, sub-research question, and null hypotheses and explored the relationship between resilience (as measured by the Resilience Scale; Wagnild, 2009) and wellness (as measure by the Five Factor Wellness Inventory; Myers, 2014). Additionally, the researcher ran a post hoc analysis that examined the relationship among demographic variables and resilience and wellness, separately. First the researcher discusses findings from the analyzing the descriptive statistics.

Descriptive Statistics

In the current study, descriptive statistics regarding the demographics of the sample and the variables were used to synthesize the data and observe patterns. The descriptive statistics of the demographics helped to determine that the sample was roughly representative of the BMSM+ population after comparisons with CDC data and previous studies. The sample included in the current study provided new information about the representation of the BMSM+ population and allows for the findings to be generalized to BMSM+. The descriptive statistics of the variables allowed for the levels of wellness (as measured by the Five Factor Wellness Inventory; Myers, 2014) and resilience (as measured by the Resilience Scale; Wagnild, 2009) among BMSM+ to be interpreted and compared. Again, the researcher discontinued to analyze empowerment (as measured by the Sociopolitical Control Scale; Zimmerman, 1995) further after the instrument was determined to lack internal consistency among the sample in the current study.

Demographic Descriptive Data

The inclusion criteria of the study required each participant to identify as Black or African-American, a cisgender man that has engaged in sexual activity with a man, HIV-positive, living in the United States, and comfortable communicating in English. Beyond that criteria participants varied in demography, which was discussed in chapter four. The mean age of participants was 27.85, where the majority identified as African, African-American, or Black ethnically (83.5%). On the demographic survey, sexual orientation was an open-ended question where the majority (86.3%) of participants self-identified as gay or homosexual. In fact, 55 participants identified as homosexual, which was interesting given that the term has been considered to be stigmatizing and rejected by sexual-minority men and women (Young & Meyer, 2005). One of the primary reasons homosexual has been viewed as stigmatizing is because the term was coined in scientific and clinical settings, not the sexual minority communities themselves (Young & Meyer, 2005). Furthermore, the homosexual label denoted same sex desires and sexual practices as epidemiological (Young & Meyer, 2005). Conversely, all the heterosexual participants, though small in size, identified themselves as “straight”. While the use of homosexual on the survey may be indicative of internalized stigma it could be an indicator that this population is accustomed to interacting with clinical settings where such terminology is used, and deemed this study as such a place. This could mean that many of my participants were connected to clinical medical or research institutions.

Many participants reported that they were single and not dating (42.2%); however, the majority of BMSM+ were engaged in some type of romantic relationship, which provided evidence that BMSM+ are able to locate social romantic relationships despite the hindrances of

internalized and externalized HIV stigma (Overstreet et al., 2013). Additionally, this statistic might indicate a shift from isolation, which has been documented as a common experience of PLWHA (Earnshaw, et al., 2013). BMSM+ in the current study, seem to be successful in negotiating their multiple cultural identities in order to navigate possibly oppressive healthcare systems given that the majority of participants had an undetectable HIV status (75.5%), varied in level of religiosity/spirituality, and were diverse among religious affiliations (Malebranche, et al., 2004; Othieno, 2007, Sunil & McGhee, 2007; Watson, 2014). Additionally, participants were spread through the United States, with the South having the greatest representation among the sample, though still lacking when compared to other statistics (CDC, 2016a). While the previously mentioned demographic descriptive statistics provide a general overview of the participants of the current study, there are several other additional descriptive statistics that are worth highlighting.

First, 34.5% of participants indicated that their CD4 count was between 0-200. The CDC has declared that people living with HIV whose CD4 count falls below 200 are in the third stage of HIV and technically have Acquired Immunodeficiency Syndrome (AIDS). Thus, over one-third of the current study's sample had AIDS.

Another demographic statistic worth noting is that almost half of the sample indicated that they were not really or not at all religious (46.9%). Furthermore, fewer than a quarter identified with the Christian faith. These two pieces of demographic information call into question the integration and focus on church and Christian faith in HIV prevention treatment research involving BMSM. For example, Foster et al. (2011) discussed the need to integrate spiritual practice into HIV programming as a way to be more culturally relevant. Based on the

diversity of religion/spirituality and lack thereof, it is not enough to include spirituality for the sake of cultural relevance, but to consider the diversity of religious/spiritual identities of all BMSM+ and how the incorporation of spiritual practices may hinder engagement.

Furthermore, one area of research pertaining to BMSM+ that has been prevalent in literature is the “down low” phenomenon. The “down low” has a negative connotation and refers to BMSM who also engage in sexual activity with women (BMSMW) usually involving deception. As a result of this terminology, much of the blame for the HIV epidemic among Black women has been placed on BMSMW (Bleich, et al., 2005; Lassiter, 2009). Thus, the examination of demographic descriptive statistics that provide insight on the “down low” phenomenon was worthwhile. In the current study, approximately nine percent (9.2%) of participants indicated that they are typically in romantic relationships with cisgender women, and cisgender men and women. Furthermore, on average participants reported having approximately one (.936) romantic relationship with a cisgender woman, with six romantic relationships being the highest number reported. Thus providing rationale for further research surrounding the role of BMSMW in the HIV epidemic among Black women. Additionally, within down low research there is an emphasis on Black women contracting HIV from BMSMW (Bleich & Taylor-Clark, 2005), however almost a quarter of the sample in the current study reported contracting HIV via vaginal intercourse. This statistic requires an expansion to the narrative of one-way HIV transmission, BMSMW to Black women, to a more complex understanding that also seeks to understand how BMSM contract HIV from women.

Lastly, the demographic statistics regarding the substance use of BMSM+ is concerning and somewhat inconsistent with the literature. Widespread substance use among BMSM has

been well documented in the literature and is usually in the context of behavior that puts one at risk of contracting HIV through shared drug paraphernalia (Wilson, et al., 2016b). Thus, it is somewhat in line with literature for BMSM who have contracted HIV to engage in substance use. However, the degree of substance use indicated by participants in some cases varies from what is found in literature. Researchers who examined substance use among BMSM over the last 90 days had higher rates of alcohol consumption, marijuana use, and crack/cocaine use among the participants when compared to the participants of the current study (Buttram & Surrat, 2013). The current study's sample had higher rates of substance use concerning ecstasy, methamphetamine, and opioids. Thus, the current study warrants continued investigation into the prevalence of alcohol, marijuana, and crack/cocaine use among BMSM+, and further exploration regarding ecstasy, methamphetamine, and opioids.

Wellness and Resilience Descriptive Data

The current study used the Five Factor Wellness Inventory (Myers, 2014) to measure wellness, the Resilience Scale (Wagnild, 2009) to measure resilience, and the Sociopolitical Control Scale (Zimmerman, 1995) to measure empowerment among BMSM+. The reliability of the scales used with BMSM+ were addressed in chapter four, but all scales demonstrated strong internal consistency as determined by Cronbach's alpha except for the Sociopolitical Scale (Zimmerman, 1995), which was removed from further analyses. The interpretation of the results for each instrument is discussed below.

Five Factor Wellness Inventory

There were some findings in the current study that differed from previous wellness literature, which may be best explained by the differences in wellness experiences of BMSM+ because of their intersectionality. The current study is one of few to use wellness as a construct of investigation, especially through the use of a holistic, psychometrically reliable and valid instrument (Ports, Lee, Raiford, Spikes, Manago, & Wheeler, 2017). The wellness of BMSM+ in the current study was similar and sometimes much better than other populations when compared to the mean for the total score on the Five Factor Wellness Inventory.

Through the descriptive statistics of the Five Factor Wellness Inventory (Myers, 2014), the narrative that BMSM+ cannot be well or are not well (Feldman, 2010; WHO, 1946) were directly countered in this study. At the very least BMSM+ are no less well than comparable demographics, including the population at large, African-Americans, and men in the U.S. There was no difference in the overall wellness among BMSM+ when compared to the U.S. population and African-Americans.

Additionally, BMSM+ had higher levels of wellness when compared to men. In fact BMSM+ had higher scores on each of the five major subscales of the Five Factor Wellness Inventory (Myers, 2014) when compared to men. Thus, BMSM+ generally have better levels of holistic wellness than men overall. Additionally, BMSM+ had higher levels of physical wellness as measured by the Physical Self subscale (Myers, 2014) than the U.S. population, African-Americans, and men. This is interesting given that this finding is in contrast with some of society's stigmatizing narratives surrounding PLWHA that associate HIV with mortality and poor physical health (Feldman, 2010).

BMSM+ had lower levels of wellness on the Social Self subscale when compared to the U.S. population and African-Americans, and on the Essential Self subscale when compared to African-Americans alone (Myers, 2014). The Social Self subscale refers to social support through connections with others through family ties, intimate relationships, friendships. BMSM+ could have lower social wellness in this aspect due isolating effects from HIV stigma; however, other findings in this study, like relationship status, somewhat counter that rationale (Evans et al., 2005; Myers, 2014; Vitiello, et al., 2003). It could be that the advantages and disadvantages of relationships among BMSM+ look different than other populations and was not captured on the Five Factor Wellness Inventory (Myers, 2014). This is especially the case given the differences in total wellness and resilience, among relationship status where BMSM+ with more established romantic relationships fared worse than their counterparts.

Additionally, BMSM+ had lower scores on the Essential Self subscale (Myers, 2014) when compared to African-Americans. The Essential Self subscale refers to meaning-making processes in life and includes aspects of Spirituality, Gender Identity, Cultural Identity, and Self-Care. The measurement of Self-Care largely depended on the absence of substance use, which was prevalent in the sample. BMSM+ may have had lower scores because many of them were not religious or spiritual at all. Yet, the participants who were not religious or spiritual at all had the second highest level of overall wellness when compared to participants with greater levels of religiosity/spirituality, which challenges the assumption of the instrument. Congruent with research, it could be that there is conflict between sexual minority status and Spiritual and Cultural Identities, which may indicate difficulty or tension in attempting to navigate them at times, bringing intersectionality to the fore (Kendrick, 2017; Othieno, 2007). Lastly, the

expression and relationship to gender among BMSM+ may differ greatly compared to African-Americans given the differences in how gender is socially constructed and performed across queer and non-queer spaces (Appelrouth & Edles, 2007).

Furthermore, results from the four contextual variables provide the field with new information in regard to the wellness of BMSM+ through the lens of environment. BMSM+'s greater median score on the Institutional Context provides support for the contention that BMSM+ are functioning within systems that they believe will most benefit their wellness, which is somewhat incongruent with literature. Researchers have noted that BMSM+ can benefit from government funded programs and spiritual institutions (Brown, 2015; Buttram, 2015; CDC, 2015); however, much of the literature indicated that the marginalized identities of BMSM+ are barriers to their wellness (Malebranche, et al., 2004, Watson, 2014).

The findings in the current study in regard to BMSM+'s score on the Local Context are contrary to prior research in which the experiences of BMSM+ are seen through the lens of HIV stigma (Eaton, et al., 2018). Local Context scores measure the smaller systems in which one interacts most often (i.e. family, community) and BMSM+'s scores on this scale could indicate that they are not public about their HIV status but could also be indicative of their ability to forge communities and spaces of safety.

The higher score that BMSM+ reported on the Global Context subscale when compared to norming groups may denote an appreciation of cultures different from their own by many BMSM+. Though, the BMSM+'s greater Global Context score could be the result of them being required to find worth in other cultures as they, at times, are forced to interact with and navigate a society dominated by other cultures.

BMSM+ Chronometrical Context median score was considerably higher than the male population and considerably lower than the African-American population. This finding draws on the unique experiences of BMSM+ based on their sexuality and HIV status that differ from the experiences of the African-American community at-large. The idea of aging among relatively young, mostly gay, and HIV positive individuals as they transition into new categories of adulthood, while grappling with stereotypes within their respective communities may be difficult.

Additionally, the bimodal distribution of total wellness scores did indicate that there are BMSM+ with relatively low overall wellness. In fact, nearly a quarter of the sample were among the low distribution of wellness scores, which makes wellness strengthening interventions necessary for BMSM+.

Resilience Scale

The current study is one of few that offers the field the ability to examine the personal resilience of BMSM+ through a psychometrically sound instrument. Thus, the current study provides a base regarding the resilience of BMSM+ and how their resilience compares to other populations.

The mean Resilience Scale (Wagnild, 2009) score among BMSM+ in the current study was 123.39, which would indicate a somewhat low level of resilience. The median score of BMSM+ was higher at 129, which means that almost half of BMSM+ had a resilience level near or at moderate to high. Still, the majority of BMSM+ had a Resilience Scale (Wagnild, 2009) considered to be on the lower ends of resilience.

Wagnild (2009) recognized low levels of resilience are not an absence of resilience and asserted that people who score on the low end of the Resilience Scale may be experiencing depression, lack of energy, isolation, anxiety, pessimism, a general sense of dissatisfaction, issues with control, and feeling unappreciated. Studies have shown that depression, lack of energy, anxiety, and isolation are commonly experienced by PLWHA (Evans et al., 2005; Vitiello, et al., 2003), which could explain the amount of low level Resilience Scale (Wagnild, 2009) scores. Additionally, the idea that some participants experience general dissatisfaction and feel unappreciated is congruent with other measures used in the current study. Furthermore, Wagnild's (2009) norming groups studies and Hu et al.'s 2015 study indicated that resilience can be strengthened over time with age, thus the overall levels of resilience in the current study could be indicative of the younger sample. Wagnild (2009) takes the stance of second wave resilience researchers who posit that resilience is not a fixed trait and things can be done to increase it. It is possible that BMSM+ are resilient in ways that were not captured by the Resilience Scale (Wagnild, 2009), given that other studies have found BMSM+ and similar populations to be resilient (Buttram, 2015; Emler, et al., 2010; Harper et al., 2014)

Primary Research Question

The researcher used a simple linear regression to determine if resilience as measured by the Resilience (Wagnild, 2009) could predict wellness as measured by the Five Factor Wellness Inventory (Myers, 2014) in BMSM+, and how much of the variance in wellness among BMSM+ could be explained by resilience. Results from the simple linear regression indicated that resilience (as measured by the Resilience Scale; Wagnild, 2009) predicted wellness (as measured

by the Five Factor Wellness Inventory) among BMSM+ with statistical significance $F(1, 247) = 726.012, p = .000$. Additionally, results from the first post hoc analysis indicated that resilience (as measured by the Resilience Scale; Wagnild, 2009) explained 74.5% percent of the variance wellness (as measured by the Five Factor Wellness Inventory) among BMSM+ with statistical significance ($p = .000$). Additionally, the adjusted R^2 statistic provides an estimation of effect size (Cohen, 1985), which in the current study would be very large.

The findings from the simple linear regression analysis were consistent with literature that has supported the beneficial nature of resilience for mental health or coping outcomes (El-Ghoroury, et al., 2012; Gao et al., 2017). However, many resilience studies have compartmentalized aspects of wellness such as emotional or social wellness, whereas the current study provides a depiction of the predictive relationship between resilience and a holistic construction of wellness (Strout, & Howard, 2015). The regression model indicated that for every one-unit increase in resilience one could expect a half-unit increase in wellness, which is substantial.

Resilience played a substantial role in predicting the wellness among BMSM+, more so than in previous studies measuring similar constructs, using different but similar research populations. Once again few studies investigated the relationship among wellness and resilience (Earnshaw, et al., 2013), so comparing the amount of variance explained is difficult. Still, looking at the amount of variance pertaining to wellness explained by resilience is necessary.

When examining studies that explored the relationship between resilience and wellness, two studies supported the idea that resilience explains approximately 44%-47% of the variance in wellness (Akbag & Ümmet, 2017; Gao, et al., 2017). However, it is necessary to note that

among three studies that examined the relationship between wellness and resilience, two of them used a well-being measure, and the other two did not use a holistic measurement of wellness but instead focused on emotional wellness (Akbag & Ümme, 2017; Bennett-Cattaneo & Goodman, 2010; Gao, et al., 2017). Furthermore, none of those studies used an exclusively homogenous population who shared the identities of BMSM+. Thus, the current study provides novel information to the amount of variance of wellness that is explained by resilience among BMSM+.

Because of the ability to predict wellness in BMSM+, interventions focused on strengthening resilience among BMSM+ would be helpful in also helping them to enhance their wellness (Leppin et al., 2014). This is particularly necessary for one out of the four BMSM+ who may have low levels of wellness as indicated in the current study. Simply, the strong positive correlational between resilience and wellness in this study suggests that helping professions could use resilience strengthening approaches with BMSM+ to increase and protect their wellness.

Post Hoc Analyses

The post hoc analysis allowed the researcher to investigate the differences among resilience and wellness levels among the intersectionality of BMSM+. In order to do so, the researcher ran two multi-factor ANOVAs that utilized resilience and wellness as separate dependent variables and demographic variables as independent variables. HIV viral load detectability, CD4 count, mode of contraction, level of religiosity/spirituality, education, and

relationship status were the demographic variables entered into each multi-factor ANOVA model.

The first ANOVA used the Resilience Scale (Wagnild, 2009) total score as the dependent variable and the demographic variables as the fixed factors. HIV viral load detectability, CD4 count, and education were demographic variables that were significant in the model between subjects ($p < .05$). The second ANOVA used the Five Factor Wellness Inventory (Zimmerman, 1995) total score as the dependent variable and the demographic variables as the fixed factors. HIV viral load detectability, CD4 count, level of religiosity/spirituality, and relationship status, were demographic variables that were significant in the model between subjects ($p < .05$). The interesting findings from both post hoc analyses are discussed below and organized by demographic variable.

HIV Viral Load Detectability and CD4 Count

In the current study, participants with highest levels of resilience had higher CD4 counts and an undetectable viral load. Thus, resilience for the participants in the current study may have been an indicator of medication adherence or reflected participants' ability and resourcefulness in obtaining their HIV treatment needs despite difficulty (Malebranche, et al., 2004; Watson, 2014). Previous research has stated that minorities' personal identities can be barriers to wellness because of discriminatory and marginalizing practices within healthcare systems that can make it difficult for individuals like BMSM+ to access the healthcare they need (Malebranche, et al., 2004; Watson, 2014). Thus, the results that indicated that participants with higher CD4 counts and undetectable HIV viral loads had higher levels of resilience could indicate that those

participants were more readily able to overcome the adversity they faced in the healthcare system and obtain the care they needed. There were significant differences among CD4 count and wellness; however, there was not a straightforward understanding of those differences. This finding is aligned with the principle of disability theory that asserts an understanding of HIV counter to and outside of the biological sense. In fact, participants who would have had a clinical AIDS diagnosis had a higher level of wellness when compared to participants with a CD4 count ranging from 601-800.

Participants who had a CD4 count that ranged from 201-400 had the lowest levels of resilience and wellness. The low viral load of these participants could be indicative of difficulty getting their health needs met, which may mean it is difficult for them to get their needs met in other areas of their life. Additionally, these participants might be feeling pressure that affects their resilience and wellness as their CD4 count range is close to an AIDS diagnosis on one end and a normal CD4 count on the other. Further, the mean score on the Resilience Scale (Wagnild, 2009) for those participants with a CD4 count ranging from 201-400 would put them in the “very low” category of resilience and their mean score on the Five Factor Wellness Inventory would put them in the lower distribution of scores for wellness. Along similar lines, participants who had a detectable HIV status had the lowest levels of resilience and wellness. Similar to participants with a CD4 count between 201-400, the detectable viral load of participants could indicate that they live within a gap where it is difficult to get their health needs met, which may suggest difficulty for them to get their needs met in other areas of their life

Mode of HIV Contraction

There were also interesting findings when it came to mode of contraction. Of the participants who knew how they contracted HIV, those who contracted the virus via sex had higher levels of resilience and wellness than their counterparts. Among the participants who contracted HIV via sex there were no differences in resilience levels whether they contracted it through anal or vaginal sex. However, there was a significant difference in wellness where those who contracted HIV via anal sex reported higher levels of wellness than those who contracted the virus via vaginal sex. This difference could be due to greater HIV prevalence and resources targeting MSM communities, which may make HIV less stigmatizing (CDC, 2018d; Miller, et al., 2012). Furthermore, participants who contracted HIV via sharing needles may still engage in substance use which may be the reasoning for those participants' lower levels of resilience and wellness. Lastly, participants who contracted HIV via mother-to-child transmission, had the lowest levels of both resilience and wellness. This finding could be indicative of a difference in experience, adversity, lifestyle, when living with HIV since birth. While there were only eight participants in the current study who reported that they contracted HIV via mother-to-child transmission, the findings indicate a need to address the disparities among resilience and wellness within this subgroup of BMSM+ to increase their levels of resilience and wellness.

Level of Religiosity/Spirituality

There were two demographic variables entered into both multi-factor ANOVA analyses that reflected religion. Level of religiosity/spirituality was significant in the multi-factor ANOVA for wellness but not for resilience, meaning that level of religiosity was not as

significant in the resilience model when compared to other variables. The fact that level of religiosity/spirituality did not have a significant effect in the resilience model contradicts previous research that tied religion and spirituality to resilience among BMSM (Buttram, 2015). It is important to note that previous studies used qualitative approaches to research these constructs where there were significant differences in resilience among levels of religiosity/spirituality. However, level of religiosity/spirituality was significant in the wellness multi-factor ANOVA. The difference in number of significant variables in both models could reflect the notion that resilience is less influenced by external forces (Grafton, et al., 2010) when compared to wellness. Previous research has not been able to determine whether religion and spirituality are barriers or catalysts to positive psychological aspects and adaptive functioning among BMSM (Foster, et al., 2011, Kendrick, 2017). Similar incongruent findings were found in this study. In the current study, participants who indicated that they were “very much” religious or spiritual had the highest levels of wellness and participants at the lowest end of religiosity/spirituality had the next highest levels of wellness. Furthermore, participants who had the highest levels of religiosity/spirituality also had the highest levels of resilience; however, their levels of resilience were not significantly different from participants who were not religious or spiritual at all. In fact, it was people with more moderate levels of religiosity/spirituality who possessed lowest levels of resilience and wellness. Thus, it could be that the extent which an individual is religious or spiritual matters in that it is beneficial for BMSM+ who are very religious and spiritual or not at all, and a hindrance for BMSM+ with more moderate amounts of religiosity/spirituality. This could be reflective of the intersectionality of BMSM+ and their possible experience of role conflict as they grapple with their religious/spiritual identity and their

sexual minority behaviors or identity (Collins & Bilge, 2016). Thus, BMSM+ with more moderate levels are unsure of how to navigate their conflicting identities and maybe in environments where either identity is not accepted.

Education

Out of all the variables entered into each model, education had the largest effect size for both resilience and wellness. In both models the more formal education BMSM+ had the more resilience or wellness they had. Though in both models there was a point of plateau, where the significant differences between groups ceased to exist. Differences in levels of resilience ceased to be significant among participants after college experience. Differences in levels of wellness stopped taking place after high school. In both cases, participants did not have to complete the next level of formal education, they just had to experience it. Thus, this finding could be indicative of a difference in socioeconomic status, opportunity, or resources. Where participants who come from a higher socioeconomic status and resources have more opportunities to access higher levels of education or even that participants with more education acquired a higher socioeconomic status and more resources to better their wellness and resilience.

Relationship Status

Lastly, the findings regarding relationship status in both post hoc analyses provided information that contradicts the literature. First, relationship status was significant in the wellness multi-factor ANVOA but not the resilience multi-factor ANOVA. Though within both models there were significant differences among relationship status groups, though there were small

effects for both wellness and resilience. The significant differences among relationship status groupings that were incongruent with literature. Previous literature has discussed the positive role of social support on characteristics such as wellness and resilience (Emlet, et al., 2016, Roscoe, 2009). However, in the current study BMSM+ who were not in romantic relationships had higher levels of resilience and wellness. In fact, the more sanctioned participants' relationships were, the less resilient and well they were, where the lowest levels of resilience and wellness were among participants who were in domestic or legal partnerships or were married. These findings indicate that romantic relationships among BMSM+ may not be analogous to social support, and there may be a need for a focus on recognizing, building, and maintaining healthy relationships for BMSM+.

Implications (Summary of Study)

As BMSM continue to contract HIV at disproportionate rates, there is a need to better support the wellness of BMSM+. Counseling practitioners, counselor educators, researchers, and community-based organizations all have a unique role in safeguarding the wellness of BMSM+. The implications for counselor practitioners, counselor educators, researchers, and community-based organizations based off the findings of the current study are discussed in this section.

Counselor Practitioners

Implications for counselor practitioners from the current study focus on wellness and resilience strengthening interventions, and improving social justice advocacy. In the resilience

field of study, researchers believe that resilience is a learnable and dynamic trait, although that was debated in the past (Wright & Masten, 2005). Intervention studies have been able to strengthen the resilience among participants (Leppin et al., 2014). Thus, counselors should attempt to adapt effective resilience building interventions to fit the needs of their BMSM+ clients. Such interventions could be incredibly useful for all BMSM+ who, in the current study had overall low resilience as measured by the Resilience Scale (Wagnild, 2009), which could in turn increase the client's wellness as indicated in the current study. However, it is possible that BMSM+ are resilient in ways that were not reflected in Wagnild's Resilience Scale, especially given previous research that found BMSM+ or similar populations to be resilient (Buttram, 2015; Emler, et al., 2010; Harper et al., 2014). Consequently, counseling practitioners should use strength-based approaches to demonstrate the resilience of their BMSM+ clients. Wagnild (2009) indicated that lower resilience scores could be reflective of depression or lack of optimism, so it might be necessary for counselor practitioners to use depression interventions in session and instill hope in their BMSM+ clients. For example, counselor practitioners can point out the times that their clients have been resilient and use those instances to instill hope in the client that he will overcome the adversity he is facing similar to as he had done in the past. Nevertheless, interventions focused on strengthening the resilience of BMSM+ could lead to better wellness outcomes, based on the results in the current study which substantiated resilience as a predictor of wellness.

In addition to strengthening wellness through resilience, counselors can also use interventions that directly impact the wellness of BMSM+. While BMSM+ had high levels of wellness overall as indicated by the Five Factor Wellness Inventory, the data also showed that

there are some BMSM+ who could benefit from counseling interventions focused on building wellness. About 24% (n = 59) of the current study's sample had a total wellness score below 60. Once again the researcher suggests using strength-based approaches, which has been proposed by other researchers (Orsulic-Jeras, et al., 2003), to strengthen wellness among BMSM+.

Lastly, counselors should consider broaching topics of identity such as religion and relationships. Religion was complex in its relationship with wellness where it could serve either as a great tool in helping a BMSM+ client achieve resilience and wellness or a barrier. Additionally, BMSM+ in romantic relationships had the worst resilience and wellness outcomes, which may highlight a need for relationship psychoeducation or couple and family therapy interventions. Counselor practitioners should consider the unique needs of BMSM+ that are grappling with relationship issues such as discussing HIV stigma, disclosure of status, and intersectionality of identities.

Counselor Educators

Counselor educators play a unique role in bettering the wellness of BMSM+ through the content they teach, how they teach, and who they teach. The need for intersectional approaches used in the current study carries through a similar need to use intersectional approaches in counseling and teaching. Counselor educators must teach their students how to develop an intersectional lens when looking at clients, social issues, and society as a whole, which is aligned with the Council for Accreditation of Counseling and Related Educational Programs' (CACREP) standards, the American Counseling Association's ethical code, and Association for Multicultural Counseling and Development's multicultural and social justice counseling

competencies. Without intersectional lenses, the experiences and needs of people in the marginalized subgroups, such as BMSM+, get lost. Thus, counselor educators should find ways to discuss BMSM+ in all core counseling courses so that counselors in training can learn about the unique needs of BMSM+ and provide appropriate counseling services to them in the future. For example, counselor educators teaching techniques courses may use strategies of teaching that incorporate BMSM+ clients to demonstrate how to effectively balance counseling, psychoeducation, and linkage to resources for BMSM+ clients who may be newly diagnosed with HIV. Such teaching strategies could include using case studies, role plays, or multi-media. The need of incorporating BMSM+ in coursework is paramount given that past studies have indicated that counselors-in-training feel unprepared to work with PLWHA, which would include BMSM+, and need more knowledge (Joe et al., 2018a; 2018b).

Additionally, given the prevalence of HIV in general, but especially among BMSM, counselor educators should consider that PLWHA and BMSM+ specifically may be a part of their student body. Accordingly, counselor educators should consider the unique needs of those students and should promote and enable self-care among students while creating an empowering environment. The results of this study show that some BMSM+ may have lower levels of resilience. Thus, counselor educators should create opportunities for their BMSM+ students to increase their resilience and build agency. Examples of such opportunities may include autonomy in class projects and allowing their voices to be heard in class. Additionally, the educational experience may look different for BMSM+, and those students may need different levels of encouragement or resources given that their low levels of resilience may be reflective of pessimism and depression they may experience. Counselor educators should also be aware of

the unique needs of their BMSM+ students in terms of self-care and health, such as medication adherence and doctors' visits which may require breaks during class or student absences (CDC, 2017c).

Finally, while advocacy for and with BMSM+ is needed at the counseling practitioner level, it is also need from counselor educators. Beyond advocacy efforts to promote the social welfare of BMSM+, counselor educators should also focus on equipping their students with proper advocacy skills. Many intersections of the identity of BMSM+ are politicized in some way. Consequently, counselor educators should teach and model social justice. As Joe (2017) asserted there is great need to increase counselors' cultural competence when working with clients affected by HIV, and that currently counselors-in-training believe more knowledge about PLWHA would be helpful in providing them with appropriate services. Furthermore, counselor educators should also model appropriate advocacy.

Advocacy for BMSM+ should include micro and macro level advocacy. Micro level advocacy could be necessary in clinical settings that may discriminate against BMSM+ for any of their marginalized identities. Thus, equipping counseling students with the tools to be able to identify, challenge, and change discriminatory practices is necessary to ensure the resilience of BMSM+ through preventative measures and create access to wellness. Additionally, the marginalized identities of BMSM+ are tied to politics which may requires citizen participation to bring about change and safeguard the social welfare of BMSM+. Thus counselor educators should prepare and model macro level advocacy efforts at local, state and national levels as well, which is aligned with counselor's ethical code to be promoters of social justice (ACA, 2014).

Researchers

Researchers should continue to conduct research where the sample is exclusively BMSM+, so that the unique experiences of BMSM+ do not get overshadowed or erased, as in previous research. Recording demographic information among BMSM+ is necessary as there was heterogeneity among the sample, which was reflective in considerable differences among levels of wellness and resilience. Additionally, collecting demographic information from samples that are exclusively composed of BMSM+ could be beneficial in establishing a reference of what is representative of the BMSM+ population. Furthermore, assuming normal distributions among BMSM+ may be questionable given the bimodal distributions found in this study. The bimodal distributions found in the current study could be because of varying reasons. The bi-modal distributions could be reflective of how BMSM+ answer questions where BMSM+ perceive their lives to be at the extreme, rather some middle ground. It is also possible that there is not a lot of middle ground in their experiences and their perception is an accurate interpretation of those extreme experiences. Lastly, it could be that there is a great disparity among BMSM+ that explains the difference in the distribution of scores.

Additionally, future research should seek to understand the experiences of BMSM+ through intersectional, culturally relevant lenses as attempted by the current research study. The collection of demographic variables among BMSM+ allows for the intersectionality within the population to be accounted for and explored. Furthermore, when conducting research that uses BMSM+ it is important to include theoretical or conceptual framework and models that incorporate intersectionality so that the findings of the study are culturally relevant.

Lastly, researchers should conduct more balanced research when studying BMSM+,

through the incorporation of positive psychological variables. More balanced research may play a role in destigmatizing the BMSM+ population and help mitigate the marginalization and oppression of the BMSM+ population that is oftentimes reproduced by research narratives. The incorporation of the positive psychology variables will also aid in providing a more holistic picture of BMSM+.

Community-Based Organizations

The current study provides three major implications for community-based organizations that serve BMSM+. The implications revolve around the settings of community programming and the focus of programs for BMSM+.

The demographic survey used in the current study demonstrated that almost 47% of BMSM+ are not either really religious/spiritual or are not religious/spiritual at all. Specifically, nearly 45%, of the BMSM+ sample in the current study identified as Agnostic, Atheist, or having no religion at all. Research has asserted that Christian churches have been or should be involved in addressing HIV disparities in Black populations (Foster, et al., 2011). However, about 24% of BMSM+ in the current study's sample were Christian. Thus, community-based organizations should consider using religiously neutral spaces when the programming is specifically for BMSM+.

Currently, many community organizations facilitate Mpowerment Projects, one of the oldest, national CDC evidence-based programs (Miller, et al., 2011). The Mpowerment Project is purposed with creating a stronger and healthier community of young gay men through empowerment and often focuses on engaging BMSM and BMSM+ (Keagles, et al., 2011). The

current study suggests that focusing on resilience instead of or in conjunction with empowerment may be a better method to support young gay men, specifically BMSM+ in enhancing their health and wellness (see Table 17). This may look like giving BMSM+ a voice through empowerment, but also equipping them with ways to be resourceful if their voice goes unheard so that they may still fulfill their needs. Furthermore, current programs which target BMSM, such as Mpowerment Projects generally focus on HIV and STI prevention, which is a limiting approach to health and wellness. Thus, community-based organizations should consider expanding programs like Mpowerment Projects or making new programs that focus on building resilience and holistic wellness.

Community-based organizations should consider all types of modes of contractions when creating programs for BMSM+. Prior research has suggested that there are barriers that prevent BMSM+ from accessing the care they need (Bleich & Taylor-Clark, 2005), given that almost a quarter of the sample reported that they contracted HIV via vaginal intercourse special attention should be paid to the unique programmatic needs of that BMSM+ subgroup. Additionally, unique interventions for BMSM+ who contracted HIV via mother-to-child contact should also be established within community-based organizations as well. While the current study only had eight participants who contracted HIV via mother-to-child contact there should be supports and resources available to improve their lower levels of resilience and wellness.

Limitations of Study

There were several limitations of the study related to research design, sampling and data collection methods, and instrumentation used. There were limitations inherent to linear

regression and ANOVA research designs including the possible presence of an unacknowledged co-founding variable or possible type I and II error. The research design limitation was countered by the procedures used by the researcher to check that the data met the necessary assumptions for simple linear regression and ANOVA, and by doing so while accounting for violations with statistically significant results, the researcher believes the presence of a co-founding variable was minimal. Additionally, type I and type II errors can be limitations of a linear regression and ANOVA research design. Although, checking for assumptions and obtaining a statistically significant result should assuage type I or type II error, the researcher did violate the assumption of homoscedasticity and found that the data was heteroscedastic. At the juncture of homoscedastic violation, type I error is believed to be of greater possibility. Thus, the researcher increased the threshold of statistical significance from .05 to .01 in order to lessen the possibility of type I error. The p value within the results of the study was considerably lower than the threshold set ($p = .000$), therefore the researcher cautiously suggests that heteroscedasticity did not affect the results and the type I error is not believed to be an issue. Additionally, the researcher accounted for the assumptions of normality and homogeneity of variances in both multi-factor ANOVAs thus the occurrence of type I error is believed to be minimal.

Another limitation of the study was fundamental to the sampling and data collection methods used. The study required participants to be at least 18 years of age, leaving out BMSM aged 14-18, defined by the CDC as those most affected by HIV (CDC, 2018c). Additionally, participants had to have a device capable of using internet to be able to access the survey since it was through an online platform. Thus, the study may have been

unintentionally biased in excluding members of the BMSM+ community who lack resources to internet capable devices. However, 14.9% of the sample would be considered near the federal poverty line for a single individual (U.S. Centers for Medicare & Medicaid Services, n.d.).

The last limitations of the current study involved instrumentation and were reflected in the data collection process. The surveys contained 146 items and relied on self-report. Survey fatigue was expected to be an issue given the length of the survey even though only three participants did not complete the survey. Additionally, the Sociopolitical Control Scale (Zimmerman, 1995) was removed from the study after the researcher determined that the instrument was not a reliable measure of empowerment for the sample in the current study due of the lack of internal consistency within the instrument. Thus, resulting in an inability for the researcher to answer the original research question, sub-research question, and null hypotheses.

Recommendations for Future Research

The current research study set out to examine the relationship among wellness (as measured by the Five Factor Wellness Inventory; Myers, 2014), resilience (as measured by the Resilience Scale; Wagnild, 2009), and empowerment (as measured by the Sociopolitical Control Scale) in BMSM+. As a result of the removal of an instrument, the researcher examined the relationship between wellness and resilience among BMSM+ and also the relationship among demographic variables and wellness and resilience separately. Based on the issues of the current

model, the researcher intends to address some design elements in a future study through using different, adequate instruments.

While the Five Factor Wellness Inventory provides a holistic picture of the wellness among BMSM+. The instrument has 91 items, which alone could have the limitation of survey fatigue. Thus, a different instrument may decrease survey fatigue and allow for more instruments to be given during data collection procedures. Additionally, it is difficult to conjecture the coding and internal consistency issue of the Sociopolitical Control Scale (Zimmerman, 1995), thus, using another instrument to capture empowerment or aspects of empowerment such as locus of control or community engagement may be necessary. Additionally, a structural equation model analysis may be helpful in determining the appropriateness of using the instruments within a study with BMSM+.

Another way to understand the appropriateness of the instruments that were used in the current study is by using a qualitative research design. Such a design would be culturally appropriate and aligned with the CRQD framework, allowing BMSM+ to share how they conceptualize and experience wellness, resilience, and empowerment. Such data may reveal if the instruments that were used in the study were sufficient.

Some of the results of the study aligned with the results found in other studies that used a BMSM+ population or a population with shared characteristics. Researchers have noted that one of the difficulties in creating intervention programs among BMSM is their heterogeneous make-up (Wilson et al., 2016b), the same principle of diversity within subgroup is present for BMSM+. Thus, the researcher may want to investigate other demographic variables related to BMSM+, such as age of diagnosis, length of time living with HIV, openness about status, and

comorbidity. That way the researcher could get a greater understanding of the role that time plays in the wellness of BMSM+ as it relates to their unique experiences with HIV.

Additionally, qualitative research would also provide a greater understanding of wellness, resilience, and empowerment among BMSM+ and is a necessary next step following the current study. When taking into account how some of the findings in the current study challenged the assumptions within the wellness instrument used and the surprisingly low resilience scores in the current study further exploration is necessary. Using qualitative inquiry to expand on the current study's findings could provide greater understanding of BMSM+'s experience of wellness, resilience, and empowerment.

Additionally, given the results of this study, the creation and effectiveness of resilience interventions among BMSM+ should be studied. Due to the low scores on the Resilience Scale (Wagnild, 2009) it may be necessary to help BMSM+ increase their resilience through targeted interventions. Past research has indicated that it is possible to increase one's level of resilience through interventions, however such an intervention specifically for BMSM+ has not been widely researched (Leppin, et al., 2014). Thus, there is a need for future research to explore and develop resilience-strengthening interventions tailored to the unique needs of BMSM+.

Also, comparisons among BMSM+, African Americans, and males establish that BMSM+ have adequate levels of wellness (see Figure 8). However, the bimodal distribution among wellness scores does indicate that there are BMSM+ in serious need of wellness interventions. Similarly to resilience, future researcher should also investigate effective wellness targeted interventions for BMSM+. Furthermore, the high levels of wellness among BMSM+ were also in the presence of consistent substance use for over half of the participants. The

counseling field which has historically focused on abstinence only, substance use targeted interventions need to be explored.

Outside of the current study, future research should explore wellness, resilience, and empowerment among BMSM+ youth aged young than 18. This study excluded BMSM+ younger than 18 from participating, yet the reality is that BMSM between the ages of 13-24 have the second highest new HIV diagnosis rate when grouped by age. Thus, a considerable proportion of BMSM+ were left out of the study, and given their age, they would experience, wellness, resilience, and empowerment differently than their adult-aged counterparts.

Summary and Conclusion

The original purpose of this study was to investigate the relationship among wellness (as measured by the Five Factor Wellness Inventory; Myers, 2014), resilience (as measured by the Resilience Scale; Wagnild, 2009), and empowerment (as measured by the Sociopolitical Control Scale; Zimmerman, 1995) in BMSM+. However, due to issues with internal consistency the Sociopolitical Control Scale (Zimmerman, 1995) was removed and the relationship between wellness and resilience was examined. In chapter five, the researcher compared the findings from the current study to existing literature. The results of the current study established that resilience predicted wellness among BMSM+, while explaining 74.5% of the variance. Additionally, some demographic variables were significant indicators of resilience and wellness. Counseling practitioners, counselor educators, researchers, and community-based organizations should use the findings of this to inform their practices when supporting BMSM+. Each plays a unique role in supporting BMSM+ in obtaining wellness. Given the fact that

approximately half of all BMSM will diagnosed with HIV in their lifetime, the current study also serves for continued efforts to better counseling and research practices focused on the wellness of BMSM+.

APPENDIX A: UNIVERSITY OF CENTRAL FLORIDA INSTITUTIONAL
REVIEW BOARD APPROVAL LETTER



University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Human Research

From: UCF Institutional Review Board #1
FWA00000351, IRB00001138

To: Nevin J. Heard

Date: March 29, 2018

Dear Researcher:

On 03/29/2018 the IRB approved the following human participant research until 03/28/2019 inclusive:

Type of Review: UCF Initial Review Submission Form
Expedited Review
Project Title: More Than a Statistic: A Mixed Methods Approach to
Understanding Wellness, Resilience, and Empowerment Among
Black Men who have Sex with Men Living with HIV.
Investigator: Nevin J. Heard
IRB Number: SBE-18-13874
Funding Agency:
Grant Title:
Research ID: N/A

The scientific merit of the research was considered during the IRB review. The Continuing Review Application must be submitted 30 days prior to the expiration date for studies that were previously expedited, and 60 days prior to the expiration date for research that was previously reviewed at a convened meeting. Do not make changes to the study (i.e., protocol, methodology, consent form, personnel, site, etc.) before obtaining IRB approval. A Modification Form **cannot** be used to extend the approval period of a study. All forms may be completed and submitted online at <https://iris.research.ucf.edu>.

If continuing review approval is not granted before the expiration date of 03/28/2019, approval of this research expires on that date. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

Use of the approved, stamped consent document(s) is required. The new form supersedes all previous versions, which are now invalid for further use. Only approved investigators (or other approved key study personnel) may solicit consent for research participation. Participants or their representatives must receive a copy of the consent form(s).

All data, including signed consent forms if applicable, must be retained and secured per protocol for a minimum of five years (six if HIPAA applies) past the completion of this research. Any links to the identification of participants should be maintained and secured per protocol. Additional requirements may be imposed by your funding agency, your department, or other entities. Access to data is limited to authorized individuals listed as key study personnel.

In the conduct of this research, you are responsible to follow the requirements of the [Investigator Manual](#).

This letter is signed by:



Signature applied by Gillian Morien on 03/29/2018 01:29:26 PM EDT

Designated Reviewer

APPENDIX B: QUALTRICS INFORMED CONSENT



Title of research study: Countering the Narrative: Exploring the Relationship among Wellness, Resilience, and Empowerment Black Men Who Have Sex with Men Living with HIV

Principal Investigator(s): Nevin J. Heard, MA.

*Faculty: Jacqueline Joe, PhD
M. Ann Shillingford-Butler, PhD*

*Investigational Site(s): University of Central Florida
Counselor Education Department
College of Education and Human Performance*

Permission to Take Part in a Human Research Study

Page 2 of 4

Why am I being invited to take part in a research study?

Hello, we invite you to take part in a research study because you are a Black man who has sex with men, 18 years of age or older, and are living with HIV. The purpose of this study is to better understand the relationship among of resilience, empowerment, and wellness of Black Men who have Sex with Men living with HIV (BMSM+). In this study we want to learn how do you live a full life taking care of your mind, body and spirit. We know that it's not always easy and that's why we are interested. We want to learn about if or when you've felt in control of your own life and if you've ever had to overcome something to live more fully. The study consists of an anonymous online survey. Through learning about your experience, we will be able to help others like you by impacting public policy and improving the practices of agencies serving your community.

What should I know about a research study?

- Someone will explain this research study to you.
- Whether or not you take part is up to you.
- You can choose not to take part.
- You can agree to take part and later change your mind.
- Your decision will not be held against you.
- You can ask all the questions you want before you decide.

Who can I talk to?

If you have questions, concerns, or complaints, or think the research has hurt you, talk to the research principal investigator at nevin.heard@gmail.com or the faculty advisors at Jacqueline.joe@ucf.edu or dr-s@ucf.edu. *Additionally, and if you have any questions, doubts, or need clarification please feel free to call the principal investigator 262-342-6760.*

This research has been reviewed and approved by an Institutional Review Board ("IRB"). You may talk to them at 407-823-2901 or irb@ucf.edu if:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research subject.
- You want to get information or provide input about this research.

Why is this research being done?

1 in 2 Black Men who have Sex with Men (BMSM) will be diagnosed with HIV in their lifetime if current HIV transmission rates continue. While research focused on HIV prevention within the BMSM community is needed; equally important is the need for research which explores the experiences of BMSM living with HIV. Thus, the purpose of this study is to understand the experience of resilience, empowerment, and wellness of HIV positive Black Men who have Sex with Men (BMSM+) and how resilience and empowerment contribute to their wellness. In this study wellness refers to the combination of one's state of mind, body, and, spirit and how they are purposely mixed with a goal of living life more fully.

How much time is needed from you?

This study uses an anonymous online survey, which will take approximately 30-45 minutes to complete.

How many people will be studied?

We expect about 100 people to take part in the first portion of the study that uses an anonymous online survey. The findings of this research will lead to publication and further research.

What happens if I say yes, I want to be in this research?

If you agree to partake in this research you will be given a Qualtrics link to an anonymous online survey which will take about 30-45 minutes to complete.

What happens if I do not want to be in this research?

Participation in research is completely voluntary. You can decide to participate or not to participate. You will not be pressured to participate in the study in any way. You can choose to remove yourself from this study before submitting your survey. However, due to the anonymity of the survey once your survey has been submitted, you cannot remove yourself from the study.

What happens if I say yes, but I change my mind later?

You can leave the research at any time and it will not be held against you. Once again you can choose to remove yourself from this study before submitting your survey. However, due to the anonymity of the survey once your survey has been submitted, you cannot remove yourself from the study.

Is there any way being in this study could be bad for me?

There are no foreseeable risks of participating in this research.

Will being in this study help me in any way?

We cannot promise any direct benefits to you from your taking part in this research.

What happens to the information collected for the research?

In this study, you will never be asked to reveal your identity in any way. Once all the data from the anonymous online surveys are collected the principal investigator will analyze the data and make conclusions about the findings. The principal investigator will be the only one to handle any information collected. Organizations that may inspect and copy your information include the IRB and other representatives of this organization. Data collected during this study will be stored on a two-time password protected laptop; and a flash drive which will be stored behind two locks.

Can I be removed from the research without my OK?

The person in charge of the research study or the sponsor can remove you from the research study without your approval. The researcher wants to protect you from any harm that may occur, so your removal from the research process may be necessary. Additional conditions for removal include incomplete online survey answers.

Permission to Take Part in a Human Research Study

Page 4 of 4

I consent to take part in this study.

I do not want to be a part of this study.

APPENDIX C: COMMUNITY BASED ORGANIZATIONS PRIOR
APPROVALS

AIDS United

2/16/2018

RE: BMSM+ Wellness, Resilience, & Empowerment Study - Nevin Heard

RE: BMSM+ Wellness, Resilience, & Empowerment Study

Adrian Neil, Jr <aneil@aidsunited.org>

Thu 2/15/2018 3:06 PM

To: Nevin Heard <nevin.heard@Knights.ucf.edu>;

Good afternoon Nevin,

Thank you for reaching out to me. I will be more than willing to assist you with this. Looking forward to working with you.



Adrian Neil Jr.
CBA Specialist, Getting to Zero
Pronouns: He, Him, His
AIDS United
(202) 876-2850 Direct
www.aidsunited.org

AIDS United's mission is to end the AIDS epidemic in the United States. We will fulfill this mission through [policy and advocacy](#), [strategic grantmaking](#), and [capacity building](#) assistance.

** Don't miss the [26th Anniversary of AIDSWatch](#), March 26-27, 2018 in Washington, DC. Registration opens December 4 **

From: Nevin Heard [mailto:nevin.heard@Knights.ucf.edu]
Sent: Thursday, February 15, 2018 2:16 PM
To: Adrian Neil, Jr <aneil@aidsunited.org>
Subject: BMSM+ Wellness, Resilience, & Empowerment Study

Hello Adrian!

It was great to talking about my dissertation study, *More than Statistic: A Mixed Methods Approach to Understanding Wellness, Resilience, & Empowerment in Black Men who have Sex with Men Living with HIV*. I appreciate your time and I am excited that you're willing to help. I wanted to confirm that you are willing to aid with my study, as a Community Based Organization Stakeholder/Contact of AIDS United by a) helping with recruitment by posting/sharing my flyer and sharing information on the study; and b) offering a space within your Community Based Organization for the focus group portion of the study.

<http://outlook.office.com/owa/?viewmodel=ReadMessageItem&ItemID=AAMLADMwMzYINGZkLTY0MGRhNGUxMS1hNWY3LWBIINDFZWFjMmMyZABQ...> 1/2

Miracle of Love Inc.

2/19/2018

RE: BMSM+ Wellness, Resilience, Empowerment Study - Nevin Heard

RE: BMSM+ Wellness, Resilience, Empowerment Study

Lester Burgos <LBurgos@miracleofloveinc.org>

Fri 2/16/2018 11:13 AM

To: Nevin Heard <nevin.heard@knights.ucf.edu>;

Hello Nevin,

Hope all goes well. YES, I'm more than happy to help in however I can. Thanks so much. ☺

Lester

From: Nevin Heard [mailto:nevin.heard@knights.ucf.edu]
Sent: Thursday, February 15, 2018 2:34 PM
To: Lester Burgos <LBurgos@miracleofloveinc.org>
Subject: BMSM+ Wellness, Resilience, Empowerment Study

Hello Lester!

It was great to talking about my dissertation study, *'More than Statistic: A Mixed Methods Approach to Understanding Wellness, Resilience, & Empowerment in Black Men who have Sex with Men Living with HIV'*. I appreciate your time and I am excited that you're willing to help. I wanted to confirm that you are willing to aid with my study, as a Community Based Organization Stakeholder/Contact of Miracle of Love by a) helping with recruitment by posting/sharing my flyer and sharing information on the study; and b) offering a space within your Community Based Organization for the focus group portion of the study.

Best,
Nevin

Nevin J. Heard, MA, LPC (OH), NCC
The University of Central Florida
AACTE Holmes Scholar
SEC Mentoring Project Coordinator-UCF
Doctoral Candidate/Graduate Research Assistant
Counselor Education · College of Education & Human Performance
Mobile: 513-348-4446 Email: nevin.heard@knights.ucf.edu
<http://heardn4.wixsite.com/nevinheard>

"What lies behind us and what lies before us are small matters compared to what lies within us. And when we bring what is within us out into the world, miracles happen." -Ralph Waldo Emerson

"Emotions don't scare me" -Rupaul

<http://outlook.office.com/owa/?viewmodel=ReadMessageItem&ItemID=AAMEADMcMxYINGZkLTY0MGRhNGUxMS1hNWY3LWBIINDkZWF0MmMyZABQ...> 1/1

Fenway Health

RE: BMSM+ Wellness, Resilience, & Empowerment Study

Dwayne Steward <DSteward@fenwayhealth.org>

Thu Jul 4/2018 4:23 PM

To: Kevin Heard <kevinheard@highlights.edu>

From: Dwayne Steward

Subject: BMSM+ Wellness, Resilience, & Empowerment Study

Attachments: BMSM+ Wellness, Resilience, & Empowerment Study

Dwayne Steward | Director of Community Affairs
The Fenway Institute | Ansin Building | 1340 Boylston St. | Boston, MA | 02215
Office: 857.313.6630 | www.thefenwayinstitute.org



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From: Dwayne Steward
Sent: Thursday, July 4, 2018, 4:23 PM
To: Kevin Heard
Subject: BMSM+ Wellness, Resilience, & Empowerment Study

Attachments: BMSM+ Wellness, Resilience, & Empowerment Study

More than Static: A Mixed Methods Approach to Understanding Wellness, Resilience, & Empowerment in Black Men who have Sex with Men Living with HIV

Attachments: BMSM+ Wellness, Resilience, & Empowerment Study

APPENDIX D: RECRUITMENT FLYER

It's time for your story to be heard!

An opportunity to take part in a research study



1

ARE YOU A BLACK MALE
OVER THE AGE OF 18?

2

HAVE YOU HAD SEXUAL
CONTACT WITH A MALE?

3

DO YOU KNOW YOUR HIV
STATUS?

Parts of Study:



Anonymous Online
Survey

Approximately 30-45
minutes

Why this study?

1 in 2 Black Men who have Sex with Men (BMSM) will be diagnosed with HIV given current HIV transmission rates (CDC, 2017). BMSM research usually focuses on HIV prevention, but what about the people already living with HIV?

In this study we want to learn how do you live a full life taking care of your mind, body and spirit. We know that it's not always easy and that's why we are interested. We want to hear your stories about if or when you've felt in control of your own life and if you've ever had to overcome something to live more fully. The study uses an anonymous online survey to explore the relationships among your wellness, resilience, and empowerment. We believe that your experiences are an essential piece to providing better services to your community & others like you!

For more info contact the Researcher or your Community Based Organizer

Researcher
Nevin Heard
Call or Text: (262) 342-6760
Email: nevin.heard@gmail.com

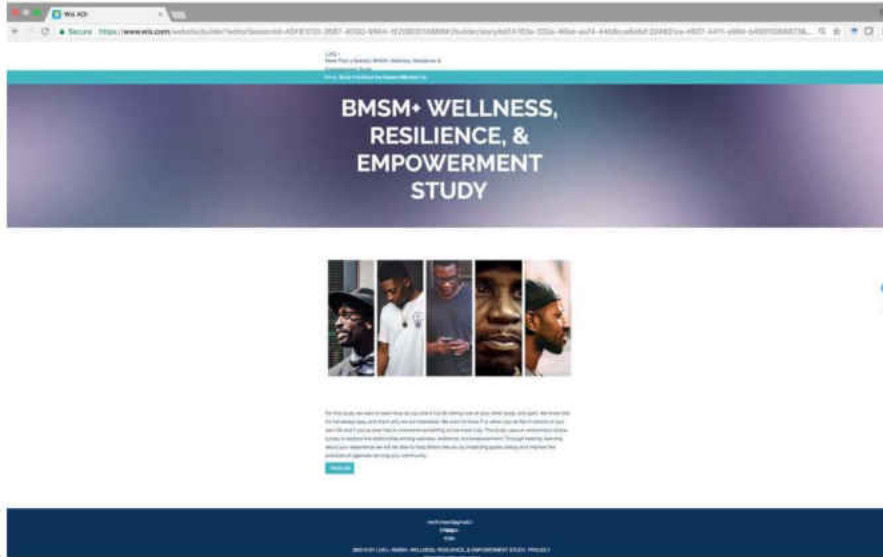
Organizer
***Insert Name**
***Insert Room Number**
Call: ***Insert Number**

Visit Study Website *insert url

APPENDIX E: STUDY RECRUITMENT AND INFORMATION WEBSITE

BMSM+ Survey Recruitment Website

Homepage:



Study Info Page:

About the Researcher Page:

LIVE • More Than a Statistic: DASH: Wellness, Resilience, & Engagement Study


Home Study Site About the Researcher Contact Us

NEVIN J. HEARD, MA, LPC IDHOL, NCC

Principal Investigator

Hi I am a postmaster education doctorate candidate at the University of Central Florida in Orlando but I am originally from Cincinnati, Ohio. My purpose is rooted in social justice, where my calling is to create spaces, and a society for marginalized voices to be heard and empowered. I have developed my expertise through my research interests. The gaps which persist in addressing multiculturalism impeded the well-being of our work. Specifically, I am interested in HIV/AIDS, people from disadvantaged backgrounds, issues affecting Black communities, and social justice. I am conducting the Systemic Wellness, Resilience, & Engagement Study for my dissertation in comparison of INQ.

[Get to Know Me](#)



Contact Us Page:

LIVE • More Than a Statistic: DASH: Wellness, Resilience, & Engagement Study

Home Study Site About the Researcher Contact Us

CONTACT US

Thank you for your interest in our research. Get in touch with us for any questions, comments or for participation regarding our work. We'd love to hear from you!

It is not necessary to leave your name. Feel free to leave that section blank or enter a pseudonym.

Physical Address:
University of Central Florida
College of Education and Human Performance
1680 University Blvd., Orlando, FL 32816

Mailbox Address:
PO Box 16000, Orlando, FL 32816
nevin.heard@ucf.edu
nevin.heard@ucf.edu


©2022 UCF

Name

Email

Subject

Message



APPENDIX F: FIVE FACTOR WELLNESS INVENTORY

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	A. Strongly Agree	B. Agree	C. Disagree	D. Strongly Disagree	
1.	I engage in a leisure activity in which I lose myself and feel like time stands still.	A	B	C	D
2.	I am satisfied with how I cope with stress.	A	B	C	D
3.	I eat a healthy amount of vitamins, minerals and fiber each day.	A	B	C	D
4.	I often see humor even when doing a serious task.	A	B	C	D
5.	I am satisfied with the quality and quantity of foods in my diet.	A	B	C	D
6.	Being a male/female is a source of satisfaction and pride to me.	A	B	C	D
7.	When I have a problem, I study my choices and possible outcomes before acting.	A	B	C	D
8.	I do not drink alcohol or drink less than two drinks per day.	A	B	C	D
9.	I get some form of exercise for 20 minutes at least three times a week.	A	B	C	D
10.	I value myself as a unique person.	A	B	C	D
11.	I have friends who would do most anything for me if I were in need.	A	B	C	D
12.	I feel like I need to keep other people happy.	A	B	C	D
13.	I can express both my good and bad feelings appropriately.	A	B	C	D
14.	I eat a healthy diet.	A	B	C	D
15.	I do not use tobacco.	A	B	C	D
16.	My cultural background enhances the quality of my life.	A	B	C	D
17.	I have a lot of control over conditions affecting the work or schoolwork I do.	A	B	C	D
18.	I am able to manage my stress.	A	B	C	D
19.	I regularly get enough sleep.	A	B	C	D
20.	I can take charge and manage a situation when it is appropriate.	A	B	C	D
21.	I can laugh at myself.	A	B	C	D
22.	Being male/female has a positive effect on my life.	A	B	C	D
23.	My free time activities are an important part of my life.	A	B	C	D
24.	My work or schoolwork allows me to use my abilities and skills.	A	B	C	D
25.	I have friends and/or relatives who would provide help for me if I were in need.	A	B	C	D
26.	I have at least one close relationship that is secure and lasting.	A	B	C	D
27.	I seek ways to stimulate my thinking and increase my learning.	A	B	C	D
28.	I am often unhappy because my expectations are not met.	A	B	C	D
29.	I look forward to the work or schoolwork I do each day.	A	B	C	D
30.	I usually achieve the goals I set for myself.	A	B	C	D

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	A. Strongly Agree	B. Agree	C. Disagree	D. Strongly Disagree	
31.	I have sources of support with respect to my race, color, or culture.	A	B	C	D
32.	I can find creative solutions to hard problems.	A	B	C	D
33.	I think I am an active person.	A	B	C	D
34.	I take part in leisure activities that satisfy me.	A	B	C	D
35.	Prayer or spiritual study is a regular part of my life.	A	B	C	D
36.	I accept how I look even though I am not perfect.	A	B	C	D
37.	I take part in organized religious or spiritual practices.	A	B	C	D
38.	I am usually aware of how I feel about things.	A	B	C	D
39.	I jump to conclusions that affect me negatively, and that turn out to be untrue.	A	B	C	D
40.	I can show my feelings at any time.	A	B	C	D
41.	I make time for leisure activities that I enjoy.	A	B	C	D
42.	Others say I have a good sense of humor.	A	B	C	D
43.	I make it a point to seek the views of others in a variety of ways.	A	B	C	D
44.	I believe that I am a worthwhile person.	A	B	C	D
45.	I feel support from others for being a male/female.	A	B	C	D
46.	It is important for me to be liked or loved by everyone I meet.	A	B	C	D
47.	I have at least one person who is interested in my growth and well-being.	A	B	C	D
48.	I am good at using my imagination, knowledge, and skills to solve problems.	A	B	C	D
49.	I can start and keep relationships that are satisfying to me.	A	B	C	D
50.	I can cope with the thoughts that cause me stress.	A	B	C	D
51.	I have spiritual beliefs that guide me in my daily life.	A	B	C	D
52.	I have at least one person with whom I am close emotionally.	A	B	C	D
53.	I am physically active most of the time.	A	B	C	D
54.	I use humor to gain new insights on the problems in my life.	A	B	C	D
55.	I can put my work or schoolwork aside for leisure without feeling guilty.	A	B	C	D
56.	I have to do all things well in order to feel worthwhile.	A	B	C	D
57.	I feel a positive identity with others of my gender.	A	B	C	D
58.	I am appreciated by those around me at work or school.	A	B	C	D
59.	I plan ahead to achieve the goals in my life.	A	B	C	D
60.	I like myself even though I am not perfect.	A	B	C	D
61.	I am satisfied with my free time activities.	A	B	C	D
62.	I do some form of stretching activity at least three times a week.	A	B	C	D
63.	I eat at least three meals a day including breakfast.	A	B	C	D
64.	I do not use illegal drugs.	A	B	C	D

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65.	I believe in God or a spiritual being greater than myself.	A	B	C	D
66.	I can experience a full range of emotions, both positive and negative.	A	B	C	D
67.	I view change as an opportunity for growth.	A	B	C	D
68.	I eat fruits, vegetables and whole grains daily.	A	B	C	D
69.	My spiritual growth is essential to me.	A	B	C	D
70.	When I need information, I have friends whom I can ask for help.	A	B	C	D
71.	I am proud of my cultural heritage.	A	B	C	D
72.	It is important for me to be physically fit.	A	B	C	D
73.	I have at least one person in whom I can confide my thoughts and feelings.	A	B	C	D
74.	I am satisfied with my life.	A	B	C	D
75.	I have enough money to do the things I need to do.	A	B	C	D
76.	I feel safe in my home.	A	B	C	D
77.	I feel safe in my workplace or school.	A	B	C	D
78.	I feel safe in my neighborhood.	A	B	C	D
79.	I feel safe in my daily life.	A	B	C	D
80.	I am afraid that I or my family will be hurt by terrorists.	A	B	C	D
81.	I am optimistic about the future.	A	B	C	D
82.	My government helps me be more well.	A	B	C	D
83.	My education has helped me be more well.	A	B	C	D
84.	My religion helps my well-being.	A	B	C	D
85.	I know I can get a suitable job when I need one.	A	B	C	D
86.	I watch TV less than two hours each day.	A	B	C	D
87.	World peace is important to my well-being.	A	B	C	D
88.	Other cultures add to my well-being.	A	B	C	D
89.	I look forward to growing older	A	B	C	D
90.	I like to plan the changes in my life.	A	B	C	D
91.	Changes in life are normal.	A	B	C	D

92. What is your current marital status?

- A. Married
- B. Single
- C. Separated
- D. Divorced
- E. Widowed
- F. Prefer not to answer

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APPENDIX G: RESILIENCE SCALE

RESILIENCE SCALE™

Date _____

Please read each statement and circle the number to the right of each statement that best indicates your feelings about the statement. Respond to all statements.

Circle the number in the appropriate column	Strongly Disagree					Strongly Agree	
	1	2	3	4	5	6	7
1. When I make plans, I follow through with them.	1	2	3	4	5	6	7
2. I usually manage one way or another.	1	2	3	4	5	6	7
3. I am able to depend on myself more than anyone else.	1	2	3	4	5	6	7
4. Keeping interested in things is important to me.	1	2	3	4	5	6	7
5. I can be on my own if I have to.	1	2	3	4	5	6	7
6. I feel proud that I have accomplished things in life.	1	2	3	4	5	6	7
7. I usually take things in stride.	1	2	3	4	5	6	7
8. I am friends with myself.	1	2	3	4	5	6	7
9. I feel that I can handle many things at a time.	1	2	3	4	5	6	7
10. I am determined.	1	2	3	4	5	6	7
11. I seldom wonder what the point of it all is.	1	2	3	4	5	6	7
12. I take things one day at a time.	1	2	3	4	5	6	7
13. I can get through difficult times because I've experienced difficulty before.	1	2	3	4	5	6	7
14. I have self-discipline.	1	2	3	4	5	6	7
15. I keep interested in things.	1	2	3	4	5	6	7
16. I can usually find something to laugh about.	1	2	3	4	5	6	7
17. My belief in myself gets me through hard times.	1	2	3	4	5	6	7
18. In an emergency, I'm someone people can generally rely on.	1	2	3	4	5	6	7
19. I can usually look at a situation in a number of ways.	1	2	3	4	5	6	7
20. Sometimes I make myself do things whether I want to or not.	1	2	3	4	5	6	7
21. My life has meaning.	1	2	3	4	5	6	7
22. I do not dwell on things that I can't do anything about.	1	2	3	4	5	6	7
23. When I'm in a difficult situation, I can usually find my way out of it.	1	2	3	4	5	6	7
24. I have enough energy to do what I have to do.	1	2	3	4	5	6	7
25. It's okay if there are people who don't like me.	1	2	3	4	5	6	7

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APPENDIX H: SOCIOPOLITICAL CONTROL SCALE

SOCIOPOLITICAL CONTROL SCALE

The following statements concern attitudes and feelings you might have about yourself and a variety of situations. Please indicate how strongly you agree or disagree with each of the statements below using the following rating scale:

- | | Strongly
disagree | | | | | Strongly
agree |
|--|----------------------|---|---|---|---|-------------------|
| | 1 | 2 | 3 | 4 | 5 | 6 |
- LC 1. I would prefer to be a leader rather than a follower.
- PC 2. Sometimes politics and government seem so complicated that a person like me can't really understand what's going on. (R)
- PC 3. I feel like I have a pretty good understanding of the important political issues which confront our society.
- LC 4. Other people usually follow my ideas.
- PC 5. It hardly makes any difference who I vote for because whoever gets elected does whatever he wants to do anyway. (R)
- LC 6. I like to wait and see if someone else is going to solve a problem so that I don't have to be bothered by it. (R)
- PC 7. So many other people are active in local issues and organizations that it doesn't matter much to me whether I participate or not. (R)
- LC 8. I would rather not try something I'm not good at. (R)
- PC 9. A good many local elections aren't important enough to bother with. (R)
- LC 10. I am often a leader in groups.
- PC 11. I enjoy political participation because I want to have as much say in running government as possible.
- LC 12. I would rather someone else took over the leadership role when I'm involved in a group project. (R)
- LC 13. I can usually organize people to get things done.
- PC 14. People like me are generally well qualified to participate in the political activity and decision making in our country.
- LC 15. I find it very hard to talk in front of a group. (R)
- PC 16. There are plenty of ways for people like me to have a say in what our government does.
- PC 17. Most public officials wouldn't listen to me no matter what I did. (R)

(Zimmerman & Zahniser, 1991) "Refinements of Sphere-Specific Measures of Perceived Control: Development of a Sociopolitical Control Scale. JOURNAL OF COMMUNITY PSYCHOLOGY 19:189-204, 1991.

APPENDIX I: DEMOGRAPHIC QUESTIONNAIRE

BMSM+ DEMOGRAPHIC QUESTIONNAIRE

Q1

Please identify your age:

Q2

How would you describe your ethnicity? (Example: African, African-American, Afro-Caribbean, Latino, Asian Pacific Islander, etc.)

Q3

Please identify your nationality: (Example: United States, Nigeria, Jamaica, Haiti, etc.)

Q4

Which of these most closely describes the annual income of your family of origin?

- Less than \$15,000
- \$15,000 to \$24,999
- \$25,000 to \$34,999
- \$35,000 to 99,999
- \$100,000 and above

Q5

Which of these most closely describes your current annual income?

- Less than \$15,000
- \$15,000 to \$24,999
- \$25,000 to \$34,999
- \$35,000 to \$99,999
- \$100,000 and above

Q6

Who primarily raised you?

- One biological parent
- Two biological parents (married)
- Two biological parents (not married)
- Other family member(s)
- Two non-biological parents (married)
- Two non-biological parents (not married)
- Other-please specify

Q7

How many people lived in your household growing up?

BMSM+ DEMOGRAPHIC QUESTIONNAIRE

Q8

Which option most closely represents your current relationship status?

Single (not dating)

Single (dating one person)

Single (dating multiple people)

Domestic partnership

Legal partnership

Married

Widowed

Divorced

Q9

Who are you typically in romantic relationships with? Check all that apply.

Men

Women

Trans-women

Trans-men

Trans-persons

Q10

Are you a religious or spiritual person?

Not at all

Not really

Somewhat

Very much

BMSM+ DEMOGRAPHIC QUESTIONNAIRE

Q11

What religion or faith do you associate with?

None

Agnosticism

Atheism

Baha'i

Buddhism

Christianity

Hinduism

Islam

Judaism

Paganism

Santeria

Taoism

Wicca

Spiritual but no formal religion

Other (Please Specify)

Q12

How would you describe your sexual orientation?

Q13

Please check your level of education completed.

No schooling

Nursery school to 8th grade

Some High School, no diploma

High school diploma

GED

Some trade school

Trade/technical/vocational training, no certificate

Skilled Trade/technical/vocational certificate

Some college credit, no degree

Associate's degree

Bachelor's degree

Specialist degree

Master's degree

Professional degree (e.g. JD, MD, DDS, etc.)

Doctoral degree (e.g. Ph.D., Ed.D., Psy.D.)

BMSM+ DEMOGRAPHIC QUESTIONNAIRE

Q14

What is your employment status?

Employed for wages

Self-employed

Out of work and looking for work

Out of work but not currently looking for work

Homemaker

Student

Military

Retired

Unable to work

Q15

Which most closely characterizes your occupation type?

Management occupations

Business and financial operations occupations

Computer and mathematical occupations

Architecture and engineering occupations

Life, physical, and social science occupations

Community and social service occupations

Legal occupations

Education, training, and library occupations

Arts, design, entertainment, sports, and media occupations

Healthcare practitioners and technical occupations

Healthcare support occupations

Protective service occupations

Food preparation and serving related occupations

Building and grounds cleaning and maintenance occupations

Personal care and service occupations

Sales and related occupations

Office and administrative support occupations

Farming, fishing, and forestry occupations

Construction and extraction occupations

Installation, maintenance, and repair occupations

Production occupations

Transportation and material moving occupations

BMSM+ DEMOGRAPHIC QUESTIONNAIRE

Q16

Military Affiliation

None

Active Duty

Reserves

Veteran

Q17

How many people do you know who are living with HIV?

0

1-4

4-7

8-10

10+

Q18

How many of your friends do you think are living HIV?

0

1-4

4-7

8-10

10+

Q19

During the past 30 days on how many days did you use the following substances:

0 days 1 or 2 days 3 to 5 days 6 to 9 days 10 to 19 days 20 to 29 days All 30 days

Alcohol

Cocaine

Crack

Ecstasy

Heroin

Marijuana

Methamphetamine

Opioid

Tobacco

Other (Please Specify, Mark "0 days" if not applicable)

Other (Please Specify, Mark "0 days" if not applicable)

BMSM+ DEMOGRAPHIC QUESTIONNAIRE

Q20

How many romantic relationships have you had with _____.

Insert Number (Put "0" if not applicable)

Males

Females

Transpersons

Q21

How many sexual partners have you had who were _____. (If "0" move marker to)

010

20

30

40

50

60

70

80

90

100

Black MSM

MSM of color (not Black)

White MSM

Q22

How many friends do you have who are _____.

Insert Number (Put "0" if not applicable)

Black MSM

MSM of color (not Black)

White MSM

Q21

How old were you when you had your first consensual sexual experience? (Put "0" if not applicable)

BMSM+ DEMOGRAPHIC QUESTIONNAIRE

Q22

Before your 18th birthday did a household member(s)/caregiver(s).... (Check all that apply)
often swear at you, insult you, put you down, or humiliate you?

or

often act in a way that made you afraid that you might be physically hurt?

often Push, grab, slap, or throw something at you?

or

ever hit you so hard that you had marks or were injured?

an adult or person at least 5 years older than you touch or fondle you or have you touch their
body in a sexual way?

or

try to or actually have oral, anal, or vaginal sex with you?

make you feel unloved, unimportant or not special?

or

like the family didn't look out for each other, feel close to each other, or support each other?

not provide enough to eat, or wear clean clothes, and protection to you?

or

were too drunk or high to take care of you or take you to the doctor if you needed it?

ever get separated or divorced?

often pushed, grabbed, slapped, or had something thrown at them?

or

sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

or

ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

who was a problem drinker or alcoholic or who used street drugs?

depressed or mentally ill or did a household member attempt suicide?

went to prison?

× N/A

Q23

Rate your ability to take all your HIV medications as prescribed:

Very poor

Poor

Fair

Good

Very good

Excellent

BMSM+ DEMOGRAPHIC QUESTIONNAIRE

Q24

In your most recent HIV lab work was your viral load undetectable?

Yes

No

I am not sure

Q25

In your most HIV lab work what was the range of your CD4 count?

0-200

201-400

401-600

601-800

800+

Q168

How did you contract HIV?

Anal sex

Vaginal sex

Sharing needles

Mother to child (pregnancy, birth, breastfeeding)

Not sure

Other

Q26

What region of the United States do you live in?

Mid-Atlantic

Mid-West

North East

North West

South East

South West

West

APPENDIX J: DEMOGRAPHIC STATISTICS

Social Location

Characteristics	<i>n</i>	Total Percent
Ethnicity		
African/African American/Black	208	83.5%
Latino	43	13.7%
Afro-Caribbean	6	2.4%
Asia Pacific Islander	1	.4%
Nationality		
United States	246	98.8%
Haiti	11	0.4%
Jamaica	1	0.4%
Dual	1	0.4%
Sexual Orientation		
Homosexual/Gay	215	86.3%
Straight	15	6.0%
Bisexual	9	3.6%
Pansexual	6	2.4%
Fluid	2	0.8%
HIV Viral Load Detectability		
Undetectable	188	75.5%
Not Undetectable	37	14.9%
Not Sure	24	9.6%
CD4 Count		
0-200	86	34.5%
201-400	39	15.7%
401-600	84	33.7%
601-800	34	13.7%
800+	6	2.4%
HIV Mode of Contraction		
Anal sex	99	39.8%
Vaginal intercourse	62	24.9%
Sharing needles	40	16.1%
Mother-to-child contact	8	3.2%
Unsure	40	16.1%
Religion/Spirituality		
No religion	93	37.3%
Christianity	60	24.1%
Islam	25	10.0%
Agnosticism	12	4.8%
Hinduism	10	4.0%
Buddhism	8	3.2%
Judaism	7	2.8%
Taoism	7	2.8%

Characteristics	<i>n</i>	Total Percent
Atheism	7	2.8%
Santeria	4	1.6%
Wicca	4	1.6%
Baha'i	3	1.2%
Paganism	2	.8%
Level of Religiosity		
Not at all	89	35.7%
Not really	28	11.2%
Somewhat	112	45.0%
Very much	20	8.0%
Geographic Location		
Mid-Atlantic	28	11.2
Midwest	61	24.5
North East	42	16.9
North West	45	18.1
South East	52	20.9
South West	18	7.2
West	3	1.2

Socioeconomic Status and Career Demographics

Characteristics	<i>n</i>	Total Percent
Family of Origin Income		
Less than \$15,000	17	6.8%
\$15,000 to \$24,999	21	8.4%
\$25,000 to \$34,999	56	22.5%
\$35,000 to \$99,000	128	51.4%
\$100,000 and above	27	10.8%
Current Income		
Less than \$15,000	37	14.9%
\$15,000 to \$24,999	47	18.9%
\$25,000 to \$34,999	76	30.5%
\$35,000 to \$99,000	85	34.1%
\$100,000 and above	4	1.6%
Education		
Nursery to 8 th grade	1	0.4%
Some High School (no diploma)	3	1.2%
High School Diploma	62	24.9%
GED	2	0.8%
Trade/technical/vocation training (no certificate)	24	9.6%
Trade/technical/vocation training certificate	24	9.6%
Some College Credit (no degree)	103	41.4%
Associate's degree	18	7.2%
Bachelor's degree	10	4.0%
Master's degree	1	0.4%
Doctoral degree	1	0.4%
Employment Status		
Employed for wages	162	65.1%
Self-employed	19	7.6%
Out of work and looking for work	18	7.2%
Out of work but not looking for work	16	6.4%
Homemaker	9	3.6%
Student	7	2.8%
Military	9	3.6%
Retired	7	2.8%
Unable to work	2	0.8%
Occupation Type		
Management occupations	24	9.6%
Business and financial operations occupations	24	9.6%
Computer and mathematical occupations	32	12.9%
Architecture and engineering occupations	14	5.6%
Life, physical, and social science occupations	10	4.0%
Community and social service occupations	19	7.6%
Legal occupations	6	2.4%

Characteristics	<i>n</i>	Total Percent
Education, training, and library occupations	6	2.4%
Arts, design, entertainment, sports, and media occupations	14	5.6%
Healthcare practitioners and technical occupations	6	2.4%
Healthcare support occupations	6	2.4%
Protective service occupations	3	1.2%
Food preparation and serving related occupations	16	6.4%
Building and grounds cleaning and maintenance occupations	13	5.2%
Personal care and service occupations	5	2.0%
Sales and related occupations	17	6.8%
Office and administrative support occupations	8	3.2%
Farming, fishing, and forestry occupations	5	2.0%
Construction and extraction occupations	4	1.6%
Installation, maintenance, and repair occupations	11	4.4%
Production occupations	2	0.8%
Transportation and material moving occupations	4	1.6%

Upbringing and Relationships

Variable Type	Characteristics	<i>n</i>	Total Percent
Categorical Variables			
Primarily raised by	One biological parent	112	45%
	Two biological parents (married)	73	29.3%
	Two Biological parents (not married)	20	8.0%
	Other family member(s)	9	3.6%
	Two non-biological parents (married)	18	7.2%
	Two non-biological parents (not married)	17	6.8%
Relationship Status	Single (not dating)	105	42.2%
	Single (dating one person)	51	20.5%
	Single (dating multiple people)	41	16.5%
	Domestic partnership	16	6.4%
	Legal partnership	8	3.2%
	Married	21	8.4%
	Widowed	7	2.8%
Typical Romantic Relationship	Men	226	90.8%
	Women	15	6.0%
	Men and Women	8	3.2%
Continuous Variables		<i>Mean/SD</i>	<i>Min./Max.</i>
	# of people in household growing up	3.78/.967	1.00/9.00
	# of romantic relationships with males	2.63/3.27	.00/40.00
	# of romantic relationships with females	.936/1.33	.00/6.00
	# of romantic relationships with transpersons	.237/.632	.00/3.00
	Age of first consensual sexual experience	11.21/7.56	.00/20.00
	# of BMSM sexual partners	22.78/26.90	.00/91.00
	# of MSM of color (not Black) sexual partners	18.36/23.45	.00/84.00
	# of White MSM sexual partners	19.28/25.19	.00/89.00
	# of BMSM friends	3.61/13.63	.00/200.00
	# of MSM of color (not Black) friends	1.06/2.03	.00/20.00
	# of White MSM friends	.843/1.66	.00/14.00

Participants' Substance Use Demographics

Characteristics	<i>n</i>	Total Percent
Alcohol		
0 days	58	23.3%
1 or 2 days	30	12.0%
3 to 5 days	61	24.5%
6 to 9 days	72	28.9%
10 to 19 days	13	5.2%
20 to 29 days	15	6.0%
Crack/Cocaine		
0 days	114	45.8%
1 or 2 days	27	10.8%
3 to 5 days	65	26.1%
6 to 9 days	24	9.6%
10 to 19 days	7	2.8%
20 to 29 days	12	4.8%
Ecstasy		
0 days	123	49.4%
1 or 2 days	19	7.6%
3 to 5 days	48	19.3%
6 to 9 days	30	12.0%
10 to 19 days	19	7.6%
20 to 29 days	10	4.0%
Marijuana		
0 days	102	41.0%
1 or 2 days	34	13.7%
3 to 5 days	53	21.3%
6 to 9 days	24	9.6%
10 to 19 days	20	8.0%
20 to 29 days	13	5.2%
	3	1.2%
Methamphetamine		
0 days	102	41.0%
1 or 2 days	34	13.7%
3 to 5 days	53	21.3%
6 to 9 days	24	9.6%
10 to 19 days	20	8.0%
20 to 29 days	13	5.2%
All 30 days	3	1.2%
Opioids		
0 days	107	43.0%
1 or 2 days	38	15.3%
3 to 5 days	63	25.3%
6 to 9 days	17	6.8%
10 to 19 days	12	4.8%
20 to 29 days	12	4.8%
Tobacco		

Characteristics	<i>n</i>	Total Percent
0 days	29	11.6%
1 or 2 days	67	26.9%
3 to 5 days	53	21.3%
6 to 9 days	38	15.3%
10 to 19 days	36	14.5%
20 to 29 days	22	8.8%
All 30 days	4	1.6%

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