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YOUNG BLACK GAY MEN'S ACCESS TO QUEER SPACE AND LGBTQ SERVICES: A CHICAGO-BASED EXAMINATION

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For young Black gay men and the broader Black LGBTQ community

Introduction to the Dissertation

This dissertation is an empirical investigation that qualitatively examines Chicago Black gay men's perceptions and experiences of the existing LGBTQ health infrastructure in the city of Chicago. In addition to examining the social and contextual factors that men perceived as motivating or inhibiting their ability to access the city's LGBTQ health infrastructure, the researcher was interested in centering Chicago Black gay men, their narratives of their lives, as well as the community contexts in which they are situated. Contrary to current sexual health and prevention scholarship, upon entering the field, I encountered multiple narratives about Black gay men and their relationships to Chicago's LGBTQ health institutions. In short, I encountered risk-related personal and structural narratives that were much broader than HIV. In my qualitative examination of Chicago Black gay men's lives, their processes and experiences of navigating Chicago's LGBTQ health infrastructure, it was clear to me that the multiple and intersecting forms of adversity these Black gay men negotiated and experienced were salient.

Chapter one is the conceptual chapter and literature review that frames my dissertation. This chapter is fundamentally concerned with the question of problem definition. Throughout, I examine the current public health and biomedical literature on Black gay men (and "Black MSM") to address how prevailing risk and prevention discourses continue to both define and constrain the research focus in relation to Black gay men—including limiting conceptualizations of risk. Throughout, I attempt to show that despite a gradually shifting paradigm that bears greater recognition of the social and structural production of risk, for the most part, an epistemological divide between individual (i.e., individual behavior change) and social paradigms (i.e., social and structural change) remains. As I illustrate in the dissertation, however, it is the interplay of individual and social factors that produces multiple forms of risk for

intersectionally marginalized populations, such as Chicago Black gay men. This requires greater consideration in social work scholarship and practice given the profession's commitment to social justice.

Chapter two includes a discussion of the methods used in the dissertation. A qualitative and inductive research methodology—i.e., constructivist grounded theory—was used in conducting the investigation. The chapter details the research design, setting, sampling, and data collection strategies. A detailed description of the methods used to analyze the data, as well as to enhance and ensure methodological rigor are also discussed. Finally, the membership role and positionality of the researcher are also addressed.

Chapter three presents empirical findings from the in-depth interviews conducted with a sample of Chicago Black gay men (n = 30). The in-depth interviews demonstrate how broader forms of social and structural oppression manifest in individual Black gay men's lives, contributing to their interconnected and interwoven experiences of trauma (e.g., familial rejection/non-acceptance; the sudden or gradual loss of home; involvement in sex work and its interrelated heath social consequences; sexual assault/rape; mental health disorders). In this chapter, I develop a novel theoretical concept I label, intersectional trauma. Consistent with constructivist grounded theory methodology, this concept is informed by sensitizing theories including intersectionality, insidious trauma, and complex trauma. These critical theoretical frameworks guide and inform the generation of this theoretical concept.

Chapter four discusses the empirical findings from the shadowing observations conducted with a sample of Chicago Black gay men (n = 3). In shadowing observations, I observed three Chicago Black gay men as they engaged in LGBTQ service utilization with LGBTQ organizations located on the city's North Side, where the city's LGBTQ health infrastructure

remains disproportionately located. This mode of data collection facilitated gathering empirical data demonstrating these Chicago Black gay men's perceptions and experiences of spatial marginalization within the broader context of accessing LGBTQ-related services within the context of the city of Chicago. Throughout this chapter, I develop the concept of spatial marginalization. I draw on Sibley's (1995) concept of the geographies of exclusion to inform the development of the concept.

Research Question

The research question guiding the dissertation project is: What are the social and contextual factors that motivate or inhibit access to or engagement with LGBTQ human service organizations among Chicago Black gay men ages 18 to 25? To investigate the research question, the investigator completed a one-year qualitative investigation exploring Chicago Black gay men's perceptions and experiences of Chicago's LGBTQ health infrastructure using constructivist grounded theory as the methodology.

Chapter One

The Trouble with Black MSM

Introduction

I begin the conceptual chapter that frames my dissertation by reciting the recent statistics that demonstrate the continued impact of HIV on Black gay men. In absolute terms, HIV incidence in the United States (U.S.) has declined by five percent since 2011 (CDC, 2016). In relative terms, incidence rates are on the rise, and continue to disproportionately impact Black gay men. A recent CDC report estimates that 1 in 2 Black gay or bisexual men will be diagnosed HIV positive in their lifetime (CDC, 2016). The fastest growing rates currently are witnessed among young Black gay men ages 13-29 (CDC, 2016). I mention these statistics at the risk of undermining my central argument, because it warrants consideration. While these data do demonstrate the epidemic's continued impact on Black gay communities, the figures also make clear that current responses—framed by limited visions of risk and prevention—have largely failed to address the comprehensive risks confronting populations of vulnerable young Black gay men, particularly those who reside in urban contexts.

Current prevention approaches relating to Black gay men in the health sciences and in clinical practice broadly frame diverse population of Black gay or bisexual men as "Black men who have sex with men" ("Black MSM"). This umbrella category makes them legible to health institutions as a community collectively 'at-risk,' particularly in the domain and discourses of sexual health and prevention. This framing which historically has largely focused on the domain of the sexual, overlooks exogenous structural and institutional barriers to health care. This functions because public health commonly conceptualizes risk as located in the individual as opposed to structural.

In this conceptual chapter, I argue 'Black MSM,' as a risk category, which focuses on risk at the level of the individual, perpetuates further marginalization of Black gay men. I argue this is facilitated through its incorporation into a racialized paradigm of risk reduction. A model that racializes Black gay men and does not racialize other groups of gay men (e.g., White gay men). I argue that this framing limits the scope of health sciences research and practice interventions with Black gay men to the sexual domain. Moreover, this racialized model paradoxically treats 'Black MSM' as a key population while simultaneously marginalizing them through risk and prevention discourses that routinely reaffirms their risk for HIV.

Social, structural, and institutional factors contribute to the widening health disparities disproportionately impacting Black gay men. Urban contexts in particular present unique challenges for Black gay men between the ages of 18 and 25. Extant studies suggest that urban residing Black, lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations often negotiate multiple challenges within various life domains (Pettiway, 1996; Bailey, 2013; Andersson, 2015; McCready, 2004). One such challenge includes Black gay men's spatial exclusion from culturally competent and accessible LGBTQ health infrastructures within urban environments (Rosentel et al. 2019). Presently, strategies addressing the collective impact of structural and institutional marginalization on Black gay men's health are limited and are primarily focused at the level of the individual.

To date, few studies have sought to understand how spatial inequity of LGBTQ human services in urban contexts, functions as a dimension of structural vulnerability for Black gay men, and importantly, a structural barrier that may inhibit access to services to one of the most HIV-vulnerable groups (e.g., Black gay men). This study seeks to contribute to this literature, as this feature of LGBTQ urban life remains an overlooked dimension of 'risk,' and

vulnerability, particularly for Black LGBTQ community members, and may serve as a potential focus of intervention. Given this context, the broader dissertation investigates a single guiding research question: What are the social and contextual factors that motivate or inhibit LGBTQ health infrastructure access or engagement for Chicago Black gay men ages 18 to 25?

Context

In Chicago, the post-industrial urban context where the dissertation research unfolded, Black gay men navigate multiple forms of marginalization and exclusion everyday (Harper et al. 2004; Daniel-McCarter, Orne, 2017). Despite research documenting the enduring impact of various forms of social marginalization and exclusion within their lives (Konrad, 2014; Bailey, 2013), scholarship on Black gay men emphasizes their risk for HIV acquisition and transmission (see Wade & Harper, 2017). Given this context, the current dissertation challenges HIV-centered prevention research and practice approaches. It is my contention that this focus has failed to allocate the necessary attention to the social and contextual characteristics of the urban contexts in which socially marginalized Black gay men are often situated. From the standpoint of theoretical intervention, the dissertation study develops more expansive theory—e.g. intersectional trauma and spatial marginalization—by deploying an inductive qualitative methodology, to challenge prevailing definitions and 'risk' and 'prevention,' with hyper-marginalized Black gay men (Comfort et al. 2015).

Purpose of the Study

The dissertation project is both empirical analysis and theoretical intervention. It is intended to fulfill three aims. Aim one is to challenge and reframe current 'risk' and 'prevention' discourses as the guiding paradigms for research, practice, and healthcare with

Black gay men. Like Black gay men in general, Black gay men in Chicago experience multiple social, structural, and institutional difficulties beyond navigation of racial, gender, and sexual differences. Prevailing approaches, however, confine 'risk' and 'prevention' to the sexual domain. Aim two is to present qualitative findings gathered through a year-long constructivist grounded theory study to examine the perceptions and experiences of Chicago Black gay men ages 18 to 25. During a year of fieldwork, 30 Chicago Black gay men were interviewed about the social and contextual factors that facilitated or served as barriers to their access to LGBTQ human service organizations within the city of Chicago. I conducted shadowing observations with Chicago Black gay men (n = 3) and conducted participant observation at two South Side LGBTQ youth organizations to contextualize these narratives. Aim three is to address the implications of employing Black gay men's perspectives about their lived experiences to design, inform, and guide future research, practice, and health policy interventions. Although prior efforts have incorporated participant, client, and service user perspectives to inform research, clinical practice, and primary healthcare, policy agendas continue to be framed predominantly by professionals.

Findings presented from the current study support the assertions of race, gender, sexuality, and social work scholar Laurens Van Sluytman (2014) that in fact social interventions "…require attention to methods and policies that are contextually driven" (p. 13). The current study supports the conclusion that prevention strategies within social and health services settings tailored to meet the holistic health and social development of emerging adult Black gay men must encompass context-driven modalities that not only seek to minimize HIV acquisition, but also address broader interpersonal, social, structural, and institutional concerns present in their lives. For instance, familial rejection, exposure to trauma, mental health,

substance abuse, and racial disparities in access to culturally responsive LGBTQ health infrastructure. Crafting prevention strategies responsive to these overlapping and multidimensional layers of risk is an ethical imperative for social work and public health researchers, clinical practitioners, HIV outreach workers, and primary care providers concerned about the ways in which social inequality disproportionately impacts the lives and health of Black gay men, and Black LGBTQ communities more generally.

Literature Review

The first chapter of my dissertation is a conceptual chapter and literature review that troubles prevailing risk and prevention discourses surrounding the behavioral category 'Black MSM.' The acronym MSM groups together a heterogeneous group of Black gay, bisexual, and other Black men who have sex with men. Numerous scholars have noted that its routinized and uncritical incorporation into research, clinical, and service provision contexts portray Black gay men as a community of individuals always already at-risk (Truong et al. 2016; Parker et al, 2016; Young & Meyer, 2005; Bailey, 2016) In the first section, I review this history, discussing how the marginal and 'at-risk' statuses constructed by and through the term Black MSM function to affirm institutional surveillance of their bodies, sexual activities, and health statuses, as Bailey (2016) and others have argued (see Williams, 2012; Robinson, 2008). Such minoritizing discourse and logic reinforcing hierarchical divisions between majority (i.e., 'normal') and minority (i.e., 'abnormal') groups assigns 'Black gay men' to a 'risk' category (via Black MSM), perpetuating their further marginalization. I contend use of Black MSM perpetuates the marginalization of Black gay men, and trace how this process is facilitated through its incorporation into a racialized paradigm of risk reduction. In tracing this process, I

also show how this model paradoxically treats 'Black MSM' as a key population[1] within institutional contexts of research, clinical practice, and primary care, while simultaneously marginalizing them through a narrative that foregrounds and routinely reaffirms their risk for acquiring and transmitting HIV. In so doing, I find that this paradigm also universalizes White gay men (i.e., whiteness) as the normative, normal, and compliant sexual subject within mainstream sexual health and prevention discourses. Conversely, constructing Black gay men as the non-normative, abnormal, and deviant subject—thus shaping the scope and contours of 'risk' and 'prevention' within scholarly discourse and service provision to Black gay men.

This first chapter is attentive to the marginalizing power of language of the expert and critiques its role in the social construction of behavioral health categories. Drawing on Rosaline Petcheskey's (2009) critique of expert discourse in producing 'categories of deviance,' like Black MSM, the current study argues that "…language needs to reflect the fluidity and complexity of sexuality and gender expressions in everyday life and their intricate interweaving with other conditions such as class, race, ethnicity and place" (p. 109). Beyond interrogating the ubiquitous and uncritical adaptation of Black MSM, the chapter also examines common conceptualizations of 'risk' and 'prevention' to explore how these terms are characteristically operationalized within research, clinical, and service provision contexts, paying particular attention to the ways in which these concepts often remain decontextualized. Collectively, health and allied health professions are preoccupied with identifying, evaluating, and managing risk. It is my contention that the dominant approaches to both defining and framing 'risk' and

[1] According to the World Health Organization (WHO), key populations are defined as groups who, due to specific higher-risk behaviors, are at heightened risk of HIV acquisition regardless of epidemic type or the local context. Presently, World Health Organization (WHO) guidelines designate five key populations: 1) men who have sex with men, 2) people who inject drugs, 3) people in prisons and other closed settings, 4) sex workers and 5) transgender people (World Health Organization, 2016).

'prevention,' respectively, construct Black gay men as high-risk subjects and that this risk category underwrites much of the research, program, and policy level focus on HIV risk. For Black gay men—a diverse community intersectionally marginalized along axes of racial, gender, and sexual identity and socioeconomic (SES) status—this reductionist impulse crowds out from its analytical purview other essential interpersonal, social, and structural domains of risk and vulnerability experienced by many urban Black gay men, including the social, structural, and spatial exclusion surrounding access to medical care and social services. The study concludes that a reframing of 'risk' and 'prevention' has substantive implications for devising and implementing context-driven HIV prevention strategies among populations of Black gay men.

Public Health Discourses of Risk and Prevention

'Risk' and 'prevention' are organizing principles of public health and social service research and practice. These concepts lie at the heart of the professional industry that has developed to respond to HIV (Guta et al., 2011). The language of the expert plays a vital role in constructing 'risk' and 'prevention' discourses about Black MSM (Argüello, 2016). Interrogating the role of expertise in institutional contexts, and its continued role of expertise in shaping the institutional reproduction of Black MSM discourse, is critical to reconceptualizing notions of 'risk' and 'prevention' in health scholarship, clinical practice, and service provision contexts with Black gay men and other marginal groups.

Experts in public health and related health professional contexts are situated at the intersection of knowledge and power (Carr, 2010). Public health, medicine, and social work professionals as experts are not only empowered to author and to disseminate cultural objects which function in the health professions, such as diagnoses and risk assessments, they are

authorized to assign value to those who interact with these objects—i.e., to applying labels to such individuals as, "risky," or "at-risk" (Carr, 2010). Stated differently, as experts, health professionals have control of valued knowledge and are empowered to enact this authority. Recognizing the power of expert actors to formulate and disseminate ideas about health and disproportionately impacted marginal groups and how notions of risk and prevention are defined and understood is of critical importance to a reconceptualization of risk and/or prevention. The presumed superior validity of expert knowledge (i.e., the intellectual expert) has been constructed over and against marginalized communities (i.e., the non-intellectual other) (Minkler, 2000; Duran et al. 2013). While the power of expert actors to define risk categories and preventive strategies has been addressed elsewhere (see Eyal, 2013; Azocar & Ferree 2013; Davis, 2007; Hardy & McGuire, 2016), the role of expertise in constructing and maintaining the dominant discursive frames of risk and prevention, in relationship to Black gay men—a marginal and vulnerable social group—remains underexamined.

Discourse is defined as a collection of interrelated texts and practices (Foucault, 1979). In public health, medicine, and social work, discourse is used to craft objects of knowledge that become the mechanisms and technologies of professional craft (Goodwin, 1994). A property of expertise in the context of health institutions is the professional authority to naturalize and reproduce objects (e.g., diagnostic criteria, formalized assessments, behavioral categories) (Davis, 2007; Carr, 2010). Across terrains of professionalism in health care—health authorities are experts implicated in shaping and reproducing dominant discourses of risk and prevention. As Gerphart and colleagues (2009) observe, '…[i]t is predominantly in and through these institutions that risk is produced, evaluated, and managed' (p. 4). Although there exists no singular or mutually agreed upon definition of 'prevention,' it is largely conceptualized as

individuals' responsibilities to take the necessary precautions to prevent the spread of HIV by taking care of their own sexual health (Bond et al., 2016; Schneider et al., 2012). Normative approaches to 'prevention' largely emphasize individual responsibility, for example, through adherence to modes of treatment (e.g., using condoms, antiretroviral therapies), and access to preventive institutions, such as coordinated systems of care, trained care providers, nongovernmental organizations (NGOs), formal healthcare outreach efforts, or government programs. These professional institutions are collectively organized to respond to the diverse needs of HIV-vulnerable populations. Rarely do modes of preventions emphasize interrogating institutional and/or structural characteristics as units of analysis.

Collectively, prevailing notions of risk and prevention are constructed by expert actors operating in the context of professional institutions that dictate the dominant discourses regarding risk and prevention, including who gets defined as being "at-risk." According to Carr (2010), expertise references the "…social configurations of profession, craft, and discipline" (p. 18) and articulates specialized knowledges. The role of expertise in the construction of risk and prevention discourse is often overlooked. Through institutional validation and authentication, experts are empowered to mobilize linguistic resources of disciplinary and professional jargons, acronyms (e.g., Black MSM), and technical language (e.g., diagnostic criteria) to produce and disseminate knowledge about health (e.g., risk, prevention, etc.) (Carr, 2010). This has weighty implications for research study participants and client populations, i.e., those key populations who utilize the prevention and intervention modalities developed by experts.

Health organizations such as the Centers for Disease Control (CDC), Joint United Nations Programme on HIV/AIDS (UNAIDS), and the International AIDS Society, are expert institutions authorized to craft behavioral categories, classification systems, and diagnostic

criteria, and designate 'key' and 'target populations' for intervention e.g., Black MSM or intravenous drug users) (Parker et al., 2016; Kaplan et al., 2016). Prior studies that shed light on the politics of language in public health discourse and language's power to produce stigmatizing systems of classification (Parker et al., 2016) that marginalize sexual and gender minority populations (Vance, 1998; Carr, 2010; Carr, 2010; Garcia et al., 2016). One need look no further than the historical construction of homosexuality as a 'psychiatric disorder' by experts in the fields of American psychiatry and medicine to be reminded of the stigmatizing power of institutional biomedical discourse and the dire social consequences for sexual and gender minorities (Bayer, 1987; Vance, 1998).

The categorization of particular marginal groups, and assumptions of both risk and 'risk behavior ascribed to them in the context of HIV prevention are rooted in the history of the epidemic. Notions of risk and prevention are underscored by assumptions of intervention at the individual level. To address this, I trace sociologist Tim Rhodes' (1997) examination of the utility of current theories of 'risk' and 'risk behavior.' Rhodes (1997) challenges dominant scientific constructions of 'risk' and 'risk behavior' principally by challenging the emphasis on individual-level risk behaviors and emphasizing the ways in which these conditions are 'socially organized,' i.e., the notion that 'risk' and 'risk behavior' are conditioned by distributions of power in society and its influence in people's lives, and not solely contingent on the behaviors of individuals. In addition, I draw on Rhodes' (2005) notion of the social structural production of HIV risk which develops the concept of the HIV 'risk environment,' i.e., "…the space, whether social or physical, in which a variety of factors exogenous to the individual interact to increase vulnerability to HIV" (p. 1026), e.g., urban or neighborhood deprivation and disadvantage; the

roles of peer groups and networks; and the role of social stigma and discrimination in reproducing inequity and vulnerability (Rhodes et al. 2005).

What's in a Name? The Trouble with Black MSM

The behavioral term of 'men who have sex with men' (MSM) was first codified in both public health and HIV literature in the early 1990s. The term was subsequently applied within HIV and sexual health research, community outreach, and intervention contexts (Young & Meyer, 2005). MSM was initially developed as a 'neutral' category, emphasizing sexual behavior to avoid perpetuating stigmatizing narratives of risk and deviance ascribed to gender and sexual minorities (Young & Meyer, 2009; Khan & Khan, 2011). Early investigations referenced MSM to acknowledge racial and sexual diversity among populations of men who have sex with men (Young & Meyer, 2009). Since its inception, however, the MSM category has undergone a series of successive transformations, accumulating a racialized valence. Through a range of social, cultural, and institutional processes, 'MSM' has transitioned from being a neutral behavioral category to a floating signifier for economically and socially marginal sexual minority Black men (e.g., Black gay men).

The demographics of the HIV epidemic have shifted, and Black gay men are presently the most heavily impacted group (CDC, 2016). Current scholarship focused on Black gay men has increasingly consolidated diverse subgroups of Black men (e.g., gay-identified, straight-identified, behaviorally bisexual, gender variant) under the conceptual category 'Black men who have sex with men' (Garcia et al. 2016; Kaplan et al. 2016). Prevention science and public health research approaches focused on MSM and sexual health have largely uncritically adapted this category, though a number of scholars increasingly express ambivalence towards its use (see Young & Meyer, 2005; Khan & Khan, 2006; Rutledge et al. 2018). Scholarship to date has

largely neglected analyses of the fundamental causes of the health disparities confronting Black gay men. The proliferation of the term 'Black MSM' across interdisciplinary and professional boundaries (e.g., clinical social work, public health, medicine) *has* further stigmatized Black gay men, marking them as the central figures in a racialized HIV prevention paradigm primarily committed to monitoring their sexual practices and health statuses.

Just as the emphasis on 'Black MSM' makes Black gay men hyper-visible as a group 'at-risk,' it simultaneously renders the risk behaviors of their White gay counterparts relatively invisible under the prevailing risk paradigm. 'White MSM' and their sexual practices often remain absent from studies as the central units of analysis in health sciences research and discourse focusing on 'MSM' and sexual health (Ward, 2008; Carrillo & Hoffman, 2016). When and if they are included, they serve as the comparison or reference group. This persists even as health sciences data consistently demonstrate that White MSM report engaging in higher rates of condomless anal sex than other racial groups, including Black gay men (Crosby et al. 2007; Millett et al. 2012; Beer et al. 2014). Moreover, White MSM report higher sexual risk behavior but Black MSM are viewed as riskier in the literature due to the lack of attention paid to structural vulnerabilities (Bailey, 2019; Bailey, 2019). While participation is not limited to White gay men, sexual subcultures of "bug-chasing," i.e., HIV negative men who intentionally seek to acquire HIV through condomless sex), "gift-giving" (i.e., HIV positive men intentionally seeking to transmit the virus to an HIV negative partner, through condomless sex), and "bare-backing" (i.e., intentional anal sex without condoms) are documented among segments of White gay communities (Tewksbury, 2006; Grov & Parsons, 2006; Ashford, 2015; Klein, 2016). The clear shortage of studies investigating the sexual practices and identities of White MSM is rooted in

the ways in which whiteness[2] functions as a universal and invisible category within the contexts of public health research, clinical practice, and primary care settings (Vanidestine & Aparicio, 2019; Gilbert et al., 2016). As a subgroup of 'MSM' privileged by their race, class, and gender, 'White MSM' are often treated as the comparison or reference group in research and practice contexts that address 'MSM' sexual health (Daniels & Schulz, 2006). Due to their relative racial, gender, and class privilege, these men's identities and sexual practices are not scrutinized or punished in the same ways as Black gay men.

Certainly, a counter-argument to the omissions of analyses of 'White MSM' and their sexual risk behaviors is that the disproportionately high rates of HIV among Black gay men justifies the narrow focus on their sexual 'risk' behaviors to the exclusion of additional social, cultural, and contextual factors that frame their lived experiences. Emergent literature attentive to the structural determinants that inform the disproportionate rates of HIV incidence among racial, sexual, and gender minority communities suggests that this line of reasoning ignores the growing consensus among researchers across a range of disciplines that structural characteristics such as urban poverty and neighborhood deprivation are all equally implicated in reproducing HIV-related health disparities (Berger, 2006). Multiple studies suggest these social and contextual factors are more determinative of HIV prevalence among Black gay men than individual-level risk behaviors alone (Rhodes et al., 2005; Millett et al., 2012; Bowleg et al., 2013; Ransome et al., 2016 Rhodes et al., 2005; Bowleg et al., 2013; Gupta et al., 2008; Parker, 2018; Piot et al., 2015).

To demonstrate further how the racialized construction of 'Black MSM' within public health research and practice fixes and stabilizes Black gay men as 'risk' subjects, the current

[2] Whiteness operates as a normative identity, discourse, ideology, and a structure organized to preserve and magnify its dominant status (Griffin, 2015)

paper will also trace a genealogy of 'Black MSM', that deconstructs discourses relating to the so-called 'Down-Low' (or 'DL') through an examination of informal (i.e., popular) and formal (i.e., public health professional) responses to the phenomenon. This will address historical and contemporary forces that have fashioned 'Black MSM' as a 'risk' category.

A Genealogy of Black MSM: The Racial Imagination, and Black (Gay) Male Sexual Pathology

Within the past two decades, an increasingly public discourse about the sexual lives of Black gay men has heightened the visibility of Black men's sexual and intimate lives. Accompanying this heighted visibility, has been greater public health and biomedical scrutiny of their sexual behaviors and practices. In the early 2000s, this transpired against the backdrop of an emergent Down Low (DL) discourse about Black men. The crux of DL discourse was that these were "…ordinary Black men who are said to live on the "down low" or (DL) in that they have primary romantic relationships with women while engaging in secret sex with men" (Robinson, 2009; p. 1464). More generally. the term DL characterized "heterosexual" Black men whose discreet sexual practices with other men may not align with their presentations of self in public (e.g., marriages to women, masculine gender presentation, and heterosexual identity) (Phillips, 2005). However, like the complex sexualities of Black men, DL is a slippery label, representing a range of perspectives, and tensions, concerning the politics of discretion and self-definition (McCune, 2014). While an analysis of the politics of identity affiliation in relation to Black men on the DL lies beyond the scope of this study, a discussion of DL discourse is integral for understanding how the braiding together of risk and Black MSM/Black gay men's identities within the health sciences has transpired and currently functions to shape a broader discourse

about sexual risk among Black gay men that overly focuses on risk by locating it exclusively within the sexual domain.

The specter of the Black man on the DL reinforced existing fears and anxieties within dominantly White US cultural imagination about the recklessness and lack of control among Black men, and about Black male sexuality, more generally. The DL were seen as clandestine communities of Black heterosexual men concealing their true sexual selfhood who were finally giving in to who they really were, pursuing risky and potentially dangerous sex with other men (Phillips, 2005). The assertion that DL Black men were singularly responsible for increasing rates of HIV within Black communities has facilitated the construction of the DL as central to the contagion of HIV/AIDS within health sciences discourse (McCune, 2008; (Phillips, 2005). This construction has fueled the increased public health surveillance of Black gay men and has contributed to the obscuring and occlusion of structural and institutional questions and concerns that underlie health disparities via a singular and problematic focus on individual pathology.

Black Men, Risk, and Institutions

Black gay men share the same history of slavery, oppression, discrimination, and racism in common with heterosexual Black men. The marginal status of Black men in the U.S., is a factor in the social and institutional constructions of 'Black MSM' as a community of individuals always and already at-risk. Across various institutional contexts (e.g., public health, medicine, social work, and education) Black boys and men are often framed as a 'problem' (Curry, 2017; Aduloju-Ajijola & Payne-Foster, 2017; Johnson et al., 2016; Du Bois, 1903). This is true also in the context of LGBTQ communities (Daniel-McCarter, 2012; Andersson; 2015), as Black gay men historically have found themselves marginalized not only in Black community contexts, but also White LGBTQ communities (Bost, 2015).

Institutional responses to Black men are predominantly risk-based, deficit-focused, and punitive (Dumas, 2016). As Patricia Hill Collins (2004) notes, "[w]estern traditions of presenting Black men as embodied, sexualized beings fosters a seeing of Black men's bodies as sites of inherent deviance" (p. 161). Sexuality has always been at the center of depictions of Black men and Blackness in the U.S, frequently framed and understood through a lens of deviance (Collins, 2004). These constructions and narratives of Black gay men's sexual pathology are interwoven with broader Western notions of Black male pathology. These notions of Black men—including Black gay men—and assumptions of pathology have continued to frame contemporary public health discourse and approaches to prevention.

Given the ways in which the dominant US racial imagination has stereotyped the Black men, it is assumed that entrenched sexual health-related disparities are due in part to Black men being engaged in riskier sexual behaviors (Aduloju-Ajijola & Payne-Foster, 2017). Historical and contemporary narratives envision Black men as sexually uninhibited, having multiple sexual partners, and stereotype them as excessively heterosexual (Aduloju-Ajijola, & Payne-Foster, 2017; Collins, 2004). This narrative contributes to the association of risk, danger, deviance, and disease with all Black men, regardless of sexual orientation. Several critical scholars argue that 'Black MSM' has come to operate as an extension of the background stereotypes of Black male sexual pathology (see Robinson, 2008; Robinson 2010). In addition, the media's role in fostering a public moral panic about Black men 'on the 'DL' among the general public and within the public health sector along with limited visions of 'risk' and prevention' has stymied progress in stemming the tide of the HIV epidemic, focusing almost exclusively on individual 'risk' behaviors within the sexual domain (Cohen, 2011; Cohen, 1972) and overlooking the entrenched structural and institutional risks related to persistent social inequality.

A restrictive vision of 'risk' and 'prevention' continues to influence available funding opportunities for researchers, clinicians, and health programming officers. Limited available funding for context-specific HIV research—such as research and prevention approaches attuned to social determinants informed by historical, structural, and sociocultural factors related to health disparities among populations—have remained largely neglected (Wyatt et al., 2009). The limited approaches to conceptualizing risk and prevention minimize and obscure the impact of broader social and structural conditions experienced by many Black gay men—social conditions which have been documented as having direct linkages to heightened HIV risk.

Black Gay Men and Intersectional Stereotyping in Clinical Settings

To demonstrate how the underlying mechanisms and social processes relating to race/ethnicity, gender, sexuality, and SES function collectively within institutional spaces for Black gay men, below, I detail findings from two distinct studies by Calabrese and colleagues, team-based research studies both operating from psychological and epidemiological perspectives—to demonstrate how bias and stereotyping ascribe assumptions of risk and deviance to Black men in healthcare contexts.

In the first investigation (2018), Calabrese and colleagues examined sexual stereotypes ascribed to Black men who have sex with men. The authors used an intersectionality hypothesis, which assumed that one or more sexual stereotypes unique to Black gay men was expected to emerge relative to the two superordinate groups (i.e., Black men, and gay men, respectively)—and their data supported this hypothesis. To determine the general US public's stereotypes about these men, the authors conducted an online survey to identify stereotypes commonly ascribed to Black men and to Black gay men, in an effort to understand whether stereotypes of Black gay men were consistent with those ascribed to Black men more generally. A study sample (N = 285)

was recruited to investigate similarities and differences in stereotypes ascribed to both categories. The racial/ethnic demographic characteristics of the study sample were: White (83%), Asian (7%), Black (4.9%), American Indian/Alaska Native (1.1%), and other (3.5%).

In relationship to stereotypes about Black men and Black MSM, the author's found 11 of the 15 most frequently reported stereotypes ascribed to Black gay men overlapped with the racial stereotypes of Black men (e.g., having a large penis), gay men (e.g., being deviant), or both (e.g., being promiscuous) (Calabrese et al., 2018). Of the 15 most frequently reported stereotypes ascribed to Black men, five were attributed to both Black heterosexual and Black gay men—i.e., promiscuous, compassionate, oversexed/insatiable, reckless/irresponsible, and sexual (Calabrese et al., 2016). Four stereotypes were uniquely ascribed to Black gay men—down low, diseased, loud, and dirty (Calabrese et al., 2016). Shared stereotypes of Black gay men and Black heterosexual men clearly were underscored by racialized assumptions of sexual excess, irresponsibility, and deviance. Conversely, stereotypes ascribed to the category of "gay men" in general (i.e., without racial specification) were more similar to those attributed to White gay men (e.g., deviant, unnatural, sassy, non-monogamous, kinky, clean/groomed).

Overall, Calabrese and colleagues' (2016) findings confirmed the intersectionality hypothesis pertaining to stereotypes of Black gay men by demonstrating that Black gay men, in addition to their perception as 'reckless' and 'deviant' like Black heterosexual men, while concurrently negotiating the multiple and overlapping stereotypes related to their marginalized racial and sexual minority statuses. To be sure, the intersectional stereotypes ascribed to Black gay men may animate provider biases within institutional contexts, such as in social services and in primary care encounters decision-making.

In an earlier vignette-based study examining the impact of patient race on clinical decision-making related to Pre-Exposure Prophylaxis (PrEP)[3], Calabrese and colleagues (2014) evaluated racial bias and stereotyping among a sample of medical students in order to investigate using a hypothetical primary care scenario with sexual minority patients how stereotyping drove providers' perceptions of their clients' likelihood to engage in sexual risk compensation behavior,[4] and how this influenced provider decision-making. For purposes of definition, "sexual risk compensation behavior," generally references changing users' sexual behaviors' in ways that may increase the likelihood of coming into contact with HIV—noting that risk is not endogenous to the person but about the exogenous factors that create heightened contexts of vulnerability. under the assumption that PrEP, as preventive treatment, decreases the likelihood of HIV acquisition (Calabrese et al, 2014).

In the study, the authors include a sample of medical students (N=102) in an experiment that operationalized a clinical vignette of a primary care scenario featuring two PrEP-seeking, HIV negative men—a Black gay man and a White gay man. Both reported having an HIV-positive male partner. The participating medical students reported their individual predictions about potential client sexual risk compensation, and their readiness to prescribe PrEP. Calabrese and colleagues (2014) found that the medical students perceived the Black gay man in the scenario as being more likely to engage in condomless sex than the White gay man. This perception was associated with a reduced willingness on the part of the clinician to prescribe

[3] Pre-exposure Prophylaxis (PrEP) is an effective biomedical intervention that can decrease the risk of HIV infection by up to 99%.

[4] Sexual risk compensation behavior is defined as changes in patterns of individual behavioral risk-taking informed by a perceived change in one's susceptibility to harm (Calabrese et al. 2014). In the context of PrEP, sexual risk compensation behavior involves a PrEP increasing their sexual risk-taking behavior (e.g., reducing one's condom use, or having more and/or multiple sexual partners) under the assumption that PrEP will decrease likelihood of HIV acquisition (Calabrese et al, 2014).

PrEP to the Black gay patient. Calabrese and colleagues concluded clinicians' reluctance to prescribe PrEP to Black gay patients was based upon implicit racial bias, and that results indicate the potential for inequitable access to PrEP across racial groups even when other potential barriers to access (e.g., insurance coverage, cost or access to care) are absent (Calabrese et al., 2014).

Race-based disparities in medical treatment, and health outcomes, are well-documented (Ikemoto, 2003; Hausmann et al., 2010; Abramson et al., 2015). Additional studies have produced similar findings concerning the prevalence of implicit racial bias within a range of contexts. Such disparities are emergent across dimensions of race, gender, socioeconomic status, and sexual orientation (see Geiger, 2003; Dovidio et al., 2008; Dovidio, 2012; Sacks, 2018), providing evidence that providers are "…particularly likely to exhibit racial discrimination in contexts in which behavioral norms or situational demands are ambiguous, particularly when people can justify their actions based on factors ostensibly unrelated to race" (Calabrese et al., 2014; p. 227). A small but growing body of literature clearly demarcates how stereotyping, perceptions of risk, and the regulatory regimes of institutions converge to impact not only clinical decision-making on the part of providers, but also have potential to shape the health outcomes of Black gay men.

These studies, one exploring intersectional stereotypes applied to Black gay men (Calabrese, 2016), and the other providing an 'example from field' using a case from a primary care setting (Calabrese, 2014)—are demonstrative of the ways in which conceptualizations of risk shape how health institutions and organizations, putatively focused on the improvement of the health of Black gay men, primarily view them through a racialized lens of risk, deviance, and deficit. The intersecting social, cultural, and institutional conditions outlined within the current

chapter supports the need for reconceptualizing 'risk' and 'prevention', particularly with regard to how these concepts are commonly defined with regard to vulnerable populations such as Black gay men—individuals who, to be sure, negotiate 'risk' at multiple registers.

Recovering Risk: From the Individual to the Social

Rhodes (1997) describes two paradigmatic approaches in the conceptualization of risk in HIV prevention and behavioral health research: i.e., the individual and social paradigms. Within medical and public health contexts, 'the individual' paradigm has historically treated the individual as a fundamental unit of analysis in risk-related behavioral health research (see Rhodes, 1997; DiClemente and Peterson, 1994). Grounded in theoretical notions of individual rationality relating to decision-making, these paradigms "…assume risk taking to be the outcome of individuals' rational decisions based on the perceived costs and benefits of risk behavior" (Rhodes, 1997; p. 213). To elucidate the determinants of individual risk behavior, these studies are broadly organized to conduct individual assessments of risk, including evaluation of individuals' risk avoidance, perceived self-efficacy, and self-control (Rhodes, 1997).

Conversely, the 'social' paradigm foregrounds investigating various dimensions of 'the social' in relation to 'risk.' In contrast with the 'individual' model, the 'social' paradigm attends to the ways in which 'risk' is socially conditioned. Grounded in theories of 'situated rationality', the social paradigm conceptualizes 'risk' as both situation and context dependent. In Rhodes (1997) terms, this emphasizes the notion that risk-related decision-making does not occur within a context-free vacuum, but rather that individual risk behavior is "…the outcome of socially situated risk perceptions" (p. 213). As mentioned, risk in research and preventive contexts is most often operationalized by treating the individual client or research participant as the unit of analysis. This is a unifying theme across sociological, public health, epidemiological studies and

interventions (see Nolle et al, 2001; Peterson & Jones, 2009; Mena et al., 2009). Certainly, the history of HIV as a biological disease drives the prevailing conceptualizations of risk. HIV's status as a "…real disease, damaging and killing real human beings" (Treichler, 1987; p. 32) informs the conceptualization of 'risk' as largely the product of individual cognition and decision-making, occluding analysis of the social and the structural factors (Rhodes, 1997).

The Individual Paradigm. Within the domains of research, practice, and healthcare, the 'individual as the unit of analysis' is a model consistently applied. Certainly, HIV is a behavioral disease impacting "real human beings" (p. 11) as Paula Treichler (1989) reminds us. Perhaps this clarifies why the majority of HIV studies focusing on elucidating individual characteristics of behavioral risk "…aim to measure individual determinants of risk behavior" (Rhodes, 1997; p. 210). In relation to notions of risk and prevention, the primary aims of these research studies, has been to "…map the extent to which individual perceptions and knowledge of risk contribute to risk avoidance" (Rhodes, 1997; p. 210). With regard to HIV risk and prevention, however, these studies primarily emphasize the evaluation of individuals' propensity for risk and risk avoidance through prevention methods such as condoms, PrEP, and other individual-level prevention modalities.

The Social Paradigm. Conversely, the social paradigm understands risk as "…the product of the interplay between individuals, the actions of other individuals, their communities and social environments" (Rhodes, 1997; p. 210). The social paradigm approach to risk emphasizes the various social factors and cultural meanings ascribed to 'risk' by individuals and communities. A fundamental assumption of studies attending to dimensions of the social paradigm is the notion that risk reduction requires social change. Increasingly, studies in both

health and social sciences that focus on non-normative and marginal communities seek to address the social dimensions of risk within their lives.

Conclusion

A dearth of scholarly attention paid to social and contextual dimensions of 'risk' and its implications for prevention has been informed in part by the manner in which the HIV epidemic emerged and was initially understood as "…a real disease syndrome, damaging and killing real human beings" (Treichler, 1987; p. 32). This perspective continues to define and influence public health approaches to risk and prevention both in research and practice settings. Furthermore, a public health focus confined to the epidemiology of risk has led to a dearth of social and contextual examinations of the social and contextual dimensions of 'risk' for Black gay men and may limit how 'prevention' is conceptualized for this population.

The scope of 'risk' for Black gay men—particularly in urban contexts—is more expansive than is presently defined in most public health, research, and service provision contexts. The limited framing of 'risk' and 'prevention' in relation to Black gay men and Black LGBTQ people more generally is informed by how health and allied health professions have historically failed to account for the ways in which state exclusion and marginalization continues to impact urban Black communities, where Black LGBTQ individuals typically reside. The oppression that gender and sexually marginal youth encounter within these communities mirrors the oppression enacted on marginal groups by the larger society (Cohen, 2004). The discursive limits produced by 'Black MSM' limits the scope of research and intervention approaches in scholarship, programs, and policies pertaining to Black gay men.

The current study concerns itself with social and structural dimensions of 'risk' and their implications for how definitions of 'risk' and 'prevention' are conceptualized and the everyday

dimensions of risk confronted by black gender and sexual minorities that inform, motivate, and often inhibit access to much needed LGBTQ services provided within the urban context of Chicago. Achieving a qualitative understanding of the underlying processes and mechanisms that impact access to the provision of LGBTQ human services is critical to improving outcomes and eliminating entrenched health and social disparities among the LGBTQ population.

Chapter Two

Methods

Introduction

A qualitative and inductive research methodology—i.e., constructivist grounded theory—was used in conducting empirical work for the dissertation. This section details the study methods including the research design, setting, sampling, and data collection strategies. A detailed description of the methods used to analyze the data, as well as to enhance and ensure methodological rigor are also discussed. For the dissertation, qualitative data were derived from conducting in-depth interviews (n = 30), shadowing observations (n = 3), and one year of participant observation at two LGBTQ serving organizations based on Chicago's South Side. Data obtained through participant observation was used to formulate questions and probes for in-depth interviews and shadowing. Formal fieldwork for the dissertation was completed between November 2017 and November 2018—a period of 12 months.

Research Design

Qualitative research encompasses a range of methodological approaches. A unifying characteristic, however, is a focus on describing and understanding social phenomena in context (Padgett, 2016; Creswell & Poth, 2017). This is characteristically achieved through combining multiple approaches to data collection in a single study (e.g., in-depth interviews, focus groups) (Creswell & Poth, 2017). In addition, qualitative methods are widely used in urban social inquiry (Wilson, 1987; Wacquant, 2016) Chicago has also played an important role in the development of urban social inquiry (see Drake & Cayton, 1945; Ventakesh, 2008). A substantial body of urban scholarship addressing the social inequity confronting marginalized groups has been conducted within the city (Duneier & Carter, 1999; Shabazz, 2005; Venkatesh, 1997; Ralph,

2014). Historically, however, this body of scholarship has been biased towards the experiences of populations claiming heterosexuality (Moore, 2006). With notable exceptions (see McCune, 2014), urban inquiry in Chicago has not treated the lived experiences of racialized gender and sexual minority populations as a central unit of analysis.

Black queer studies, a theoretical intervention into the fields of study known as Black studies and queer theory, articulates the lived experiences of diverse Black gender and sexual minority populations (Johnson, 2001). As a body of thought investigating what it means to live at the intersections of marginalized racial, gender, sexual, and class categories, scholars in the Black queer studies canon recognize the expert knowledges of their research interlocutors (Johnson, 2001). Bearing this in mind, this dissertation project aims to be consistent with the epistemology of this body of thought, by emphasizing the knowledge, lived experience, and collective expertise of the Chicago Black gay men who are included in the study. Therefore, in seeking an appropriate research methodology, the researcher was led to constructivist grounded theory (Mills et al. 2006).

Constructivist Grounded Theory

Constructivist grounded theory (CGT) is widely used as a methodological approach in qualitative research (Charmaz, 2014). Similar to traditional grounded theory (GT), CGT's fundamental aim is the generation of a novel *theory* through the methodical collection and analysis of data (Charmaz, 2014; Mills, Bonner, & Francis, 2006). CGT retains foundational elements of Glaserian grounded theory, such as theoretical sensitivity, coding, use of existing theory, and constant comparison (Glaser & Strass, 1967). CGT is distinct from GT in important ways. CGT acknowledges the intersubjective nature of the relationship between the researcher and the researched, acknowledging the role of the researcher in the co-construction of meaning

(Charmaz, 2014; Mills, Bonner, & Francis 2006). Grounded in constructivist thought, CGT views the researcher as a constitutive component of the research rather than as an objective observer. Acknowledging the subjectivity of the researcher, researchers conducting a CGT investigation adopt the position of shared mutuality between themselves and the populations whom they research (Charmaz, 2017), and position themselves as author of a reconstruction of the research experience.

CGT investigations, whose central goal is theory-building, characteristically employ multiple data collection methods (e.g., in-depth interviews, focus groups, participant observation, archival research) (Mills, Bonner, & Francis, 2006). This is completed in order to understand the contexts in which their research participants are embedded (Mills, Bonner, & Francis, 2006). Data collection in CGT investigations proceed through an inductive process, allowing research findings to emerge from dominant and significant themes inherent in the data (Thomas, 2006). Moreover, using multiple data collection approaches can contribute to a more robust and credible grounded theory than would be drawn from a single-approach investigation (Graham & Thomas, 2008). The analytical benefits of combining multiple data collection approaches include data triangulation and verification of research findings using several different research methods or data sources (Charmaz, 2011). Therefore, three qualitative research approaches were employed in the dissertation: (a) in-depth interviews, (b) shadowing, and (c) participant observation. Employing multiple modes of data collection in a dynamic urban setting like the city of Chicago was generative theoretically and empirically for the dissertation, by enabling the researcher to engage in thinking, doing, and asking, in multiple ways.

Study Setting

The city of Chicago is the third largest in the United States (U.S.) (Taber, 2018). A racially diverse yet hyper-segregated setting, the city provides a compelling context in which to examine the lived experiences of urban young Black gay men. In the year the dissertation research was conducted, Chicago's population was 30.5% Black/African-American, 32.7% White, 29% Hispanic or Latinx, 6.2% Asian, and 2.7% other racial/ethnic groups (U.S. Census, 2018).

Presently, more than half of the city's Black residents claim residence in just 20 of its 77 community areas (U.S Census, 2018). Moreover, the majority of Black residents reside on its historic South Side, constituting the most contiguous Black community in the United States (Pattillo, 2003). In addition, Black residents also constitute the majority population on the city's West Side (43%) (U.S. Census, 2018). However, given the city's deeply entrenched social inequality, low-income, predominantly Black and/or Latinx community areas, located on the city's South and West Sides, continue to experience a dearth of community-based assets and resources relative to the city's more affluent community areas, even as the low-income community areas are among the city's most vulnerable communities (Ewing, 2018; Lester, 2014; Lee & Lubienski, 2016). This was the context in which the researcher investigated the ways in which members of an intersectionally marginalized community, Chicago Black gay men, ages 18 to 25, perceive and experience access to the city's LGBTQ health infrastructure.

Recruitment

In the dissertation, several recruitment strategies were employed to identify a sample of Chicago Black gay men ages 18 to 25 to complete in-depth interviews and shadowing observations. In-person recruitment was completed at Collectives—a multi-service LGBTQ

youth-serving health center located on the South Side of Chicago. For the shadowing observations, participant recruitment was also completed through a North Side organization, Spectrum Health Alliance, with the assistance of a professional organizational contact in the organization. Snowball sampling was also used as a recruitment strategy, wherein the researcher provided each participating interviewee with an information sheet providing general details about the study such that participants may circulate them to their interested and eligible peers (Biernacki & Waldorff, 1981) (see Millett et al., 2012; Millett, Malebranche, Mason, & Spikes, 2005). All participating Chicago Black gay men received an incentive for their participation in the dissertation study. For instance, each in-depth interview participant received a $30 incentive. Those who participated in the shadowing observations received a $100 incentive. Employing several recruitment strategies in the dissertation assisted the researcher in identifying a diverse sample of Chicago Black gay men claiming a range of social and geographic perceptions and experiences of the city of Chicago.

Sample

A non-probability convenience sample of 30 Chicago Black gay men between ages 18 and 25 were recruited to participate in structured in-depth interviews. In addition, 3 Chicago Black gay men of similar age were recruited to participate in shadowing observations. In determining study eligibility, all participating Chicago Black gay men were screened by the researcher using a brief five-minute screening interview protocol developed by the researcher. All participating Chicago Black gay men, including those whom the researcher deemed ineligible were screened using a Google Voice account. Participant eligibility criteria included racial identity (Black/African-American), gender (cisgender man), sexual identity (e.g., Gay, Bisexual, or Same-Gender Loving), age (ages 18 and 25), previous and/or ongoing participation

in a range of LGBTQ organizations or gay houses or families, and current residential status in Chicago.

Access

Gaining access to communities of Chicago Black gay men between ages 18 and 25 required building and maintain trusting relationships with community stakeholders. To that end, the researcher established trusting relationships with staff at LGBTQ organizations, community gatekeepers, and house and ball communities (Kim, 2011; Bucerius, 2013).

In the context of the study, my subject positions as a Black gay man, and as a researcher, shaped my interactions with community members in various ways. For example, while conducting formal fieldwork for the dissertation, I negotiated my positionality as an insider in some moments, and as an outsider, in others (Adler & Adler, 1987). Although acknowledged as an insider with respect to claiming shared experiences around marginalized racial, gender, and sexual categories, I was also frequently immersed in social and organizational contexts (e.g., house-ball events, LGBTQ discussion groups, informal social settings) populated primarily with members of Chicago's gay families, and of house and ball communities, contexts in which I was an outsider. Given that I was not a current member of these communities, nor a staff member at the organizations, there were moments in the field when I was asked questions about both my status within and relationship to the community—e.g., "Do you work here?" "So, what do you do for the community?" Questions inquiring about me and my relationship to the community gradually shifted over time, especially as community members increasingly became used to presence. I moved from being an ambiguous figure, to becoming widely known as a graduate student who was in the process of conducting a research study on a segment of the community (e.g., Black gay men). Ultimately, I believe prolonged immersion at two field sites, Collectives

and Chicago South Side Resource Access Initiative, situated on the South Side, not only assisted in facilitating access to the community, but more importantly, was critical in helping to build a sense of rapport and trust.

Indeed, given acknowledged histories of exploitation by researchers who conduct research on marginalized communities, I felt that demonstrating a commitment to the community was critical. The prevailing approach to remedying these troubling histories is through reciprocity (Maiter et al. 2008). Therefore, during fieldwork, I volunteered at the field sites where I engaged in recruitment and data collection. I assisted organizations in drafting and submitting grant proposals for funding and volunteered at community events. In addition, I assisted in both coordinating and planning annual banquets attended by the city's house-ball communities and gay families.

Field Sites

Chicago South Side Resource Access Initiative. The Chicago South Side Resource Access Initiative (CSRAI) was established in 1995 by Black LGBTQ community activists. The organization is committed to disseminating information about community health resources to members of South Side communities impacted by HIV. CSRAI is a collaborative of community partnerships that includes service providers, community activists, and civil servants. Although CSRAI retains HIV prevention as its focus, it increasingly seeks to address broader social and structural determinants of health for South Side residents. The central goal of CSRAI is to "…link people with resources in the community that they may not be aware of" (CSRAI, Mission Statement). The Chair of CSRAI, a prominent Black LGBTQ health activist, assisted the researcher by facilitating access to field sites and in participant recruitment.

Collectives. Collectives, established in 2016, is a multi-service organization located on the South Side of Chicago. Although primarily organized around clinical service provision, the organization provides a range of social services to Black LGBTQ youth and young adults as well. Services offered include HIV/STI testing, mental health services, resource counseling, and youth programming. Collectives is increasingly recognized as an LGBTQ organization accessible to Black LGBTQ youth on the South Side but is also accessed by youth from other areas of the city as well. During fieldwork, I spent substantial time at the organization, volunteering, recruiting participants, and conducting participant observation.

Sampling Procedures

A non-probability purposive sampling strategy was used. Purposive sampling is used when the researcher seeks to understand a specific experience or perspective (Creswell & Poth, 2017). Individuals were eligible if they self-identified as Black, gay, or bisexual, cisgender male, and were between ages 18 and 25. Additional criteria required prior and/or ongoing involvement in Chicago LGBTQ organizations.

Data Collection

Three approaches to data collection were used in the dissertation: in-depth interviews, shadowing, and participant observation. Each approach was employed to investigate a guiding research question: What are the social and contextual factors that motivate or inhibit LGBTQ health infrastructure access or engagement for Chicago Black gay men ages 18 to 25? Chicago Black gay men's perceptions and lived experiences were the unit of analysis. This unit of analysis was triangulated by executing the three data collection approaches: in-depth interviews; shadowing; and participant observation.

In-depth interviews. In-depth interviews with Chicago Black gay men (n = 30) ages 18 to 25 were all conducted by the researcher. On average, interviews lasted between 60 and 90 minutes. To minimize barriers to participation, I traveled to meet the participants using Chicago's public transportation system—the Chicago Transit Authority (CTA) extensive system of buses and trains. I conducted interviews at locations convenient for each participant. This includes community organizations, coffee shops, libraries, and public parks located in neighborhoods throughout the City (i.e., South, West, and North). Each interview was digitally audio recorded by the researcher and transcribed by a third party. Before each interview, the Institutional Review Board (IRB)-approved consent forms were read aloud by the researcher and signed by interviewees in accordance with the institutional guidelines set forth by the IRB. After providing consent, a copy of the form was provided to each participant. Individuals were consenting to participate in one interview, and to potentially be contacted by the researcher at a future date to participate in shadowing.

For the in-depth interviews, a single qualitative interview protocol was developed. The interview explored five major domains: (1) neighborhoods (2) biological families and "coming out" (3) finding supportive queer community (e.g., peers, gay families, house-ball communities) (4) participating in LGBTQ human services organizations (5) and concluding "big picture" questions. Consistent with the iterative nature of qualitative research, the researcher did not rigidly adhere to the interview protocol (Charmaz & Belgrave, 2012). To capture the depth and of individual accounts, novel questions and probes were developed and integrated throughout subsequent interviews. Consistent with emergent design (Creswell, 2007), novel questions were informed by emergent themes that arose in interviews and in participant observation (Charmaz & Belgrave, 2012).

Participant Observation. Participant observation was completed at two organizations—Collectives and at the Chicago South Side Resource Action Group (CSRAG). As defined by Kawulich (2005), participant observation refers to "…learning about the activities of the people under study in the natural setting through observing and participating in those activities" (para. 2). I conducted monthly participant observations at general body meetings of CSRAG for approximately one year. Each observation lasted approximately three hours. Participant observation was theoretically and empirically generative for the study, as these observations informed the researcher about the prevalence of institutional and structural violence in Chicago, and the ways in which these material conditions disproportionately impact the health and well-being of the City's racial, gender, and sexual minority communities. Data obtained through participant informed the formulation of questions and probes for the in-depth interviews.

Shadowing. Shadowing is a qualitative approach that when applied to ethnographic fieldwork, traces the way people move among the various situations and settings in the context of their everyday lives (Gill, 2011; Alaimo & Picone, 2015; Trouille & Tavory, 2016). To execute this mode of data collection, a subsample of Chicago Black gay men (n = 3), as ethnographic informants, were shadowed by the researcher, for a period of between four to six hours per individual observation. This yielded a total of approximately 13 hours of qualitative ethnographic data. The researcher developed a separate interview guide for shadowing but did not strictly adhere to it. I accompanied each of the informants individually from their home neighborhoods on the near and far South Side to North Side LGBTQ human service organizations where participants were routinely using services (e.g., resource counseling, HIV/STI testing) or attending programs (e.g., drop-in programs, job readiness). I recorded each observation on a digital audio recorder and wrote field notes following each observation at a

nearby café or library. These 'ride-alongs' captured informants' perceptions and perspectives of the city of Chicago and its existing LGBTQ health infrastructure (Van Duppen & Spierings, 2013).

Data Analysis

NVivo 12 qualitative data analysis software (QSR, 2018) was used to organize interview and field data (i.e., transcripts, memos, fieldnotes). Data were imported into NVivo 12 and coded for themes that emerged during data collection (QSR, 2018; Padgett, 2008; Charmaz, 2014). The researcher developed open and focused codes on a range of descriptive topics (Padgett, 2008). This included empirical and theoretically relevant domains of life experience for Black gay men such as individuals' childhoods, family relationships, coming out experiences, and their cultivation of community and support systems. Focused coding illuminated challenges such as familial rejection, homelessness, trauma, and mental health. Memo writing was also used as a method of drawing connections between coded data, and to develop themes related to phenomena under investigation. These early themes served as the foundation for interpretation of the data with respect to the articulation of intersectional trauma and spatial marginalization.

Establishing Rigor

Credibility. Credibility in qualitative research, in general terms, relies on the extent to which the researcher's representation of the data fits with participants' views (Lincoln and Guba, 1985). To establish credibility, I used several techniques, including: (a) prolonged engagement, (b) persistent observation, (c) triangulation, and (d) peer debriefing.

Prolonged engagement. Prolonged engagement requires immersion in the field for a length of time enough to capture the essence of the topic of study (Onwuegbuzie & Leech, 2007). The study involved conducting immersive fieldwork for a period of approximately 12

months. This provided the researcher an opportunity to observe and understand the culture (e.g., gay families, house and ball communities), social setting (e.g., LGBTQ organizations), and to understand the phenomenon of interest.

Peer debriefing. Peer debriefing entails sharing one's emergent findings with an audience of disinterested peers (Lincoln & Guba, 1985). These disinterested peers are persons unaffiliated with the research undertaken that may supply the scholar with critical feedback, and input, about the plausibility of data interpretations (Kimball & Loya, 2017; p. 21). I presented preliminary findings at the International Congress on Qualitative Inquiry (ICQI) at an annual qualitative conference attended by qualitative researchers from various institutions. These preliminary findings were also discussed by the researcher at the National Academies of Sciences Engineering and Medicine National Expert Meeting on Intersectionality in Washington, D.C. This meeting was attended by both clinicians and researchers.

Limitations of Study

Although the study is limited due its focus on Black gay men who reside in one urban context—i.e., Chicago—and these men's distinct perceptions and experiences of its LGBTQ health infrastructure, the study does the important work of identifying key processes and mechanisms relating to the social and contextual factors that motivate and inhibit access to and engagement with LGBTQ health infrastructure for marginalized racial, gender, and sexual minority populations. Moreover, grounded in these men's experiences, the study develops two generative theoretical concepts—intersectional trauma and spatial marginalization—both articulate the health seeking and service using motivations and barriers experienced by this population. Future scholarship may employ these theoretical concepts in additional urban settings such as New York City, Detroit, or Washington D.C., to further develop these concepts.

Additional study limitations require acknowledgement. Notably, the study employed a convenience sample, with all participating Chicago Black gay men having ongoing or prior involvement with Chicago's LGBTQ health infrastructure. To be sure, the perceptions and experiences of the participating Chicago Black gay men may not be representative of the entire population, their lived experiences, their identities, nor their perceptions or experiences of the existing LGBTQ health infrastructure.

Chapter Three

Grounded Theory: Intersectional Trauma

Introduction

The present dissertation chapter details findings from the structured in-depth interviews conducted with Chicago Black gay men (n = 30). The in-depth interviews sought to answer a single guiding research question: What are the social and contextual factors that motivate or inhibit LGBTQ health infrastructure access or engagement for Chicago Black gay men ages 18 to 25? The 60 to 90-minute in-depth interviews with Chicago Black gay men (n = 30) were designed to answer the investigation's guiding research question. Through an inductive analysis of in-depth qualitative interview data, I found that the participating Chicago Black gay men's experiences of multiple, prolonged, and overlapping forms of trauma were interrelated, to be sure, with their racial, gender, and sexual identities, but also interwoven with structural trauma confronting Chicago's Black communities, in general. These broader structural traumas had implications for this sample of Chicago Black gay men in their health seeking and service utilization, constructing barriers to both. Intersectional trauma was a common thread I encountered in the narratives of the participating Chicago Black gay men. Moreover, I found that this trauma experience underscored the participating Chicago Black gay men's motivations for accessing the city's local LGBTQ health infrastructure. Notably, analysis of the participating Chicago Black gay men's in-depth interviews revealed that their individual experiences of trauma did not map neatly onto traditional clinical definitions, standard classifications which primarily focus on its psychical effects including psychosocial and emotional symptomatology (e.g., anxiety, depression, shock, nightmares, intrusive thoughts) and related stress disorders (e.g., Post-Traumatic Stress Disorder) (Knight, 2015; Wamser-Nanney & Vandenberg, 2013). In

my treatment of trauma, I draw on the critical perspectives of trauma scholars that address the myriad ways trauma disproportionately impacts intersectionally marginalized racial, gender, and sexual minority populations.

In recent years, scholars of race, gender, and sexuality have begun to reconceptualize trauma by exploring its distinctive character for U.S. Black populations, including among Black gender and sexual minority communities (see Bost, Bruce and Manning, 2019; Bost, 2018; Seay, 2019; Shelton et al. 2018). Black scholars working from a variety of disciplinary perspectives have begun to theorize trauma in historical and contemporary contexts (Mustakeem, 2016; Sharpe, 2009; Isoke, 2014; Pritchard, 2013). These scholars often utilize this medical condition as an analytic to investigate its contours and character within Black communities, specifically to characterize how effects of power manifest in the form of violent harms in the everyday lives of racialized subjects (e.g. structural trauma) (Palacios, 2018). Scholars of the Black LGBTQ experience who study queer people through a lens of trauma are increasingly attentive to "quiet forms of violence" (Bost, Bruce, & Manning, 2019; p. 1). The social consequences of racialized misogyny, transphobia, homophobia, and anti-black violence are characteristics of trauma disproportionately impacting Black sexual and gender minorities. These are modes of harm that render Black LGBTQ individuals vulnerable to various forms of interrelated structural and interpersonal trauma which impact individuals' health outcomes and life opportunities (Fitzgerald et al. 2017; Nadal, 2016). Such forms of intimate, invisible and quiet (Bost, Bruce, & Manning, 2019; p. 1) violence, often found in the routine, and in the quotidian, are relatively unobservable forms of violence yet have a lasting and observable impact on the lives of those affected (e.g., health, life opportunity, developmental trajectories, etc.).

To be sure, public health and social work literature increasingly document the prevalence of a range of experiences of social exclusion endured by Black LGBTQ youth populations. Theoretical and empirical scholarship on Black LGBTQ communities increasingly draws greater attention to underreported domains of their lived experiences, including reported childhood and adolescent trauma, childhood familial abandonment and relocation, housing instability and homelessness, sexual violence, substance abuse, and mental illness (Watkins et al. 2016; Nadal, 2016; Garrett-Walker & Longmire-Avital, 2018; Bost, Bruce, & Manning, 2019). These experiences are shown to collectively shape a range of deleterious and long-term consequences for Black LGBTQ health. However, this body of research currently lacks a cogent theory of how these collective trauma experiences may reflect the interwoven nature of structural and interpersonal oppression for intersectionally marginalized communities (e.g., Black gay men). Below I detail three sensitizing concepts that informed and guided my analysis in accordance with research studies that employ a constructivist grounded theory methodology: intersectionality (Crenshaw, 1989; insidious trauma (Root, 1992); syndemics theory (Singer & Clair, 2003) and complex trauma (Van Der Kolk, 2017). I also address the limitations of these theoretical concepts in my articulation of the need for a theory of intersectional trauma.

Sensitizing Concepts

Intersectionality

Kimberle Crenshaw's (1989) theory of intersectionality is useful given the central tenet that the effects of oppression become amplified when combined. As theorized by Crenshaw (1989) and prior woman of color feminists, intersectionality challenges single-axis conceptualizations of identity and analysis of the effects of oppression. In general terms, intersectionality explains how race, gender, ethnicity, class, age, sexual orientation, and other

categories, are mutually constituting dimensions of everyday life for marginalized individuals (e.g., racial, gender, and sexual minorities) (Crenshaw, 1989; Sangaramoorthy et al. 2017). How intersectionality manifests in the lives of members of marginal communities demonstrates its utility as a lens for understanding the lives and material conditions of Black gay men. Although widely taken up, intersectionality also has recognized analytical limitations. For instance, a central thesis of intersectionality is the assumption that Black men experience relative privilege given their gender, even as they are oppressed by their race (Curry, 2014). Therefore, some scholars suggest that intersectionality is analytically limited when applied to the study of Black men, including Black gay men (Curry, 2014). Still, others find intersectionality useful in studying Black gay men, given that questions of sexual orientation are inextricably linked with questions of both gender and gender oppression (Butler, 2002; Wood, 2004). In sum, beyond its utility in the domain of theoretical research, numerous scholars have incorporated intersectionality as a useful framework in health research, policy, and practice contexts (see Bowleg, 2012; Manuel, 2006; Lockhart & Danis, 2010).

Syndemics and Complex Trauma Theory

Existing theoretical frameworks address how multiple forms of marginalization coalesce to impact the health, both physical and mental of vulnerable populations. Foremost perhaps are syndemics theory and complex trauma theory. In relation to trauma as encountered by the Chicago Black gay men participating in the dissertation, however, both have their limitations. Syndemics theory seeks to investigate and explain both biological and social determinants of disease (e.g., HIV) among specific populations and has been widely applied to study HIV prevalence among Black gay men (Dyer et al. 2012; Halkitis, 2013). In general, syndemics theory refers to "…two or more epidemics interacting synergistically and contributing…to

excess burden of disease in a population" (Singer and Clair, 2003; p. 425). As a framework, syndemics theory explains that HIV prevalence in certain populations is inextricably linked to other health problems that disproportionately impact these populations—e.g., psychological comorbidities, substance use, sexual victimization, stigmatization, and multiple forms of discrimination (Singer and Clair, 2003). This framework is also centrally concerned with how these intersect to heighten HIV vulnerability and prevalence within certain populations. In sum, although syndemics addresses how HIV is directed by biological, behavioral, psychosocial, and structural determinants, it is not a theory that explains the social dimensions of exclusion, stigma, or racial, gender, and sexual marginalization, rather it is primarily a framework for understanding the etymology of a biophysical disease (e.g., HIV). When applied to Black gay men, though acknowledging the need for holistic approaches to prevention, a major limitation is its utility for theorizing lived experiences of among Black gay men as well as the conditions under which they live. At present, syndemics theory primarily functions as an explanatory framework for understanding HIV prevalence.

Complex trauma is a theory addressing multiple, chronic, and prolonged forms of trauma experienced by individuals, often of an invasive and/or interpersonal in nature (Van Der Kolk, 2017). Complex trauma is often developmental since it often begins in early life (Van Der Kolk, 2017). Furthermore, complex trauma "...has been defined as a traumatic event that is chronic, interpersonal, and begins in childhood….it includes child sexual, physical, and emotional abuse; neglect; and witnessing domestic violence" (Wamser-Nanney & Vandenburg, 2013; p. 672). Complex trauma is distinct from single incident trauma in key ways. A distinguishing characteristic is its ongoing, prolonged, and/or repeated nature (Van Der Kolk, 2017). It is also distinct given its severe, persistent, and cumulative impact on those experiencing the complex

trauma phenomena (Van Der Kolk, 2017). Moreover, complex trauma has been demonstrated to heighten the likelihood of experiencing mental, physical, and emotional health disorders among affected populations (e.g., suicidality, addictions) (Courtois, 2008). In addition, some documented coping mechanisms for individuals who endure forms of complex trauma include substance abuse, and self-harm (Courtois, 2008).

Insidious Trauma

Consistent with constructivist grounded theory methodology's use of sensitizing theories, my articulation of intersectional trauma is informed by prior scholars' critical theorizations of trauma, specifically those perspectives rooted in anti-oppressive frameworks. Insidious trauma as conceptualized by Root (1992) describes ongoing, persistent negative experiences related to living as a member of an oppressed group (e.g., racial, gender, and/or sexual minority). As a theory of trauma attentive to power it provides a framework for understanding pervasive social phenomena that can have profound effects on health and potential life opportunities, through the detrimental effects of phenomena such as racism, heterosexism, and homophobia (Root, 1992; Kaplan, 2006; Balsam, 2002). One way of understanding insidious trauma is the notion that it is a form of trauma that isn't directed at you but is all around you (Watson et al. 2016; Lowe et al. 2012). Among U.S. Black communities there are many historical traumas to consider. The traumas of slavery, genocide, mass displacement and migration constitute what scholar Stuart Hall (2014) characterizes as "traumatic ruptures" (p. 227) in the context of Black life. For U.S. Black communities, the violent character of these historical experiences is characterized as trauma, theorized as historical phenomena that continue to shape contemporary social relations particularly around questions of race, gender, sexuality, and socioeconomic status (SES).

Certainly, the HIV epidemic among Black gay men may viewed as a symptom of insidious trauma.

Analysis

In the case of the Chicago Black gay men who participated in structured interviews for the dissertation, an inductive qualitative analysis of the interviews found that these individuals' lived experiences relating to their racial, gender, and sexual identities, informed their experiences of familial rejection, homelessness, involvement in sex work, and experience of sexual abuse, and interrelated mental health issues, and were also linked to broader characteristics of traumatogenic social oppression (e.g., homophobia, transphobia, and racism) (Allen, 1996). My theoretical articulation of intersectional trauma in relation to these Chicago Black gay men's lived experiences is in line with existing models of trauma which integrate an anti-oppressive lens, I conceptualize as traumatogenic—e.g., racism, homophobia, and socioeconomic deprivation (Franklin et al. 2006; Burman, 2016), and not isolated to a singular psychologically or psychosocially traumatic moment or life event.

Rather, my participants described an array of intersecting and overlapping experiences of trauma that precipitated their health seeking and service utilization of the LGBTQ health infrastructure in Chicago. Using intersectionality (Crenshaw, 1989), insidious trauma (Root, 1992) and complex trauma (Van Der Kolk, 2017) as sensitizing concepts, I situate the participating Chicago Black gay men's experiences within a grounded theoretical framework that I label intersectional trauma, to explain their unique experiences of interpersonal and structural trauma (Cook et al. 2017), one acknowledging the saliency of broader forms of oppression and structural violence (Farmer, 1996) that we might therefore understand these Black gay men's likelihood of experiencing phenomena such as homelessness, rejection, sex work, sexual abuse,

and mental health concerns, as collectively traumatogenic. In the context of understanding the factors motivating young Chicago Black gay men health seeking and service use, I found that Black gay men's experiences of intersectional trauma motivated engagement with a range of LGBTQ organizations in the city of Chicago.

The inductive nature of the data collection and analysis played an important role in allowing a grounded theory of intersectional trauma to emerge from these Chicago Black gay men's narratives. Although I entered each in-depth interview with an interview protocol, throughout the duration of data collection, I continued to incorporate additional questions and probes in subsequent interviews to be consistent with the iterative nature of qualitative research (Glaser & Strauss, 1967).

Theoretical Concept: Intersectional Trauma

In the dissertation, intersectional trauma functions as a grounded theoretical framework to organize and explain the multiple and overlapping adverse circumstances reported by the participating Chicago Black gay men. Data analyses revealed these individual Black gay men's experiences were interrelated with their developing identities as Black gay men. This grounded theory is informed and guided by theories of insidious and complex trauma (Root, 1992; Van Der Kolk, 2017). Although these critical theories of trauma attend to marginalization and social oppression, neither addresses the specific challenges confronting urban young Black gay men. Intersectional trauma is attentive to the ways in which larger social forces and mechanisms of social oppression, such as racism, homophobia, and socioeconomic deprivation, sediments, and shapes individuals' interpersonal experiences, interactions, and daily lives by manifesting through distinct experiences of trauma events that place individuals at heightened social risk for a range of potentially deleterious health and developmental outcomes.

Although a number of public health and epidemiological studies document the prevalence of a range of negative health outcomes for Black gay men in various domains (e.g., HIV/STIs, stigma, and discrimination) (Centers for Disease Control and Prevention, 2014), a comprehensive framework of the social and contextual factors placing Black gay men at greater social risk has yet to be articulated in the current literature. Given this omission, I employ the empirical data collected in the dissertation toward the development of a theory of trauma that articulates the lived experiences of the marginal urban Black gay men I interviewed. Notably, men's trauma experiences are often embedded in social contexts with few institutional resources in place to assist men in processing challenging and stressful experiences around family, sexuality, and additional developmental challenges (e.g., housing, employment, educational attainment).

Data analyses revealed the prevalence of themes of familial rejection, non-acceptance, homelessness, sex work, sexual assault and abuse, and mental health disorders in the lives of many participants. These social phenomena are often discussed in the extant literature on urban LGBTQ youth of color, and Black LGBTQ youth (see Nadal, 2016; LaSala & Frierson, 2011; Fields et al. 2008; Bogart et al. 2011). Rarely are these phenomena theorized or understood as interrelated phenomena. In using an intersectional and a trauma approach, I develop an integrated framework of intersectional trauma to address individuals' distinct experiences as interrelated with individuals' non-normative and marginal identities. Intersectional trauma experiences disrupted individuals' developmental timelines in a range of domains (e.g., school completion, employment, etc.). Below, I present empirical examples demonstrating how intersectional trauma placed these marginal Black gay men at greater social risk, demonstrating the ways in which individuals' challenging experiences relating to their intersecting racial,

gender, and sexual identities led to challenging and stressful experiences. I also incorporate a discussion of the roles that LGBTQ human services organizations played in the individuals' lives.

Results

Familial Rejection, and Homelessness

Consistent with the existing research on LGBTQ youth and Black LGBTQ youth populations (Robinson, 2018; Côté & Blais, 2019), many participating Chicago Black gay men reported encountering parental and/or familial non-acceptance or rejection related to their sexual minority identities and experiencing subsequent episodic or protracted periods of housing instability and/or homelessness. Current research demonstrates that family conflict about LGBTQ youth gender and sexual minority identities remains a primary factor shaping rates of LGBTQ youths' experiencing homelessness (Robinson, 2018). Extant data suggests that seventy-three percent of gay and lesbian youth and twenty six percent of bisexual youth that experience homeless report that parental disapproval of their sexual orientation as the primary reason for their homelessness. Additionally, service providers who work with LGBTQ youth experiencing homelessness indicate that sixty eight percent have experienced parental and/or family rejection (Robinson, 2018). While these studies are informative, few studies specifically foreground the lived experiences of Black gay men relating to parental and/or familial rejection and homelessness.

Intersectional trauma recognizes a confluence of structural, interpersonal, and individual factors, including familial poverty and SES, collectively play a role in the homelessness experiences of Black gay men. Troubling a narrative that has historically pathologized Black families, families of color, and low-income families, characterizing them as more homophobic

than White, middle-class and/or affluent families, intersectional trauma escapes this paradigm, operating as a framework that, "…acknowledges how poverty and instability shape the social processes around gender and sexuality that influence why some parents and families may reject their child" (Robinson, 2018; p. 386). In the case of the participating Chicago Black gay men, parental or familial rejection often led participants to experience periods of alternating housing instability and homelessness. The latter also served as pathways to additional vulnerability for participants. Below, I provide empirical case examples as a demonstration.

Zay is a 23-year old Black gay man and was among the first participants that I interviewed for the study. During our interview, Zay disclosed being abandoned by his mother, father, a minister, and, his siblings at only 11 years of age, finding himself effectively homeless. In the wake of this traumatic event, he would recount enduring a five-year period of housing instability, homelessness, and persistent financial security, that led him to later engage in survival sex. Describing the experience for me, he says:

> Zay: I was homeless at 11 years old. That's when I got like abandoned or whatever. I was basically homeless for like five years. My father is a minister, and he wasn't really up for me being gay. And then my mother…. she was, and still is, a heroin addict, so she wasn't able to take care of me. At that point, she abandoned me and my little brother. I ended up trying to get back with my father. But he just wanted to help me from a distance, he didn't want me being outwardly gay at 12-years old. I think that he basically didn't want me to make him look bad as a minister. He really didn't want people to know that I even existed.

With exception of his younger brother, Zay believes that his other siblings were not similarly abandoned because, in his words, his father, "…didn't allow any of the rest of them to be homeless." As his narrative makes clear, Zay describes perceiving both his abandonment and subsequent homelessness as due in large part to his family's disagreement with his perceived sexual identity, at the time. His estranged relationship with his father, and his siblings, because

of his sexual orientation, was a recurring theme in the interview. Zay, like many other participants, I learned that these fragmented relationships with his family would substantially shape his adolescent years.

Throughout the interview, Zay's narrative of his biological family seems to suggest a family that is substantially overburdened in various ways—specifically in the domains of financial insecurity and frequent residential relocation. For instance, early in the interview, he describes his family as often living in public housing and having to move on a frequent basis due to the pressures of neighborhood gentrification. In addition, he endured a period of involvement with DCFS, having an unsupportive father, his mother's substance abuse, and an older brother who was navigating serious mental illness. Collectively, these were the conditions under which Zay would experience abandonment and subsequent homelessness. This is consistent with the LGBTQ youth homelessness literature youth demonstrating that individuals likely to experience parental and/or familial rejection and homelessness are often already situated within vulnerable families—i.e., families negotiating social and economic instability (Robinson, 2018; McCann & Brown, 2019). As the evidence demonstrates, these dimensions of family instability and its compounding effects can considerably upset people's lives, including those of children and youth within these homes (Robinson, 2018; McCann & Brown, 2019). In the context of LGBTQ youth homelessness, these factors complicate prevailing notions that these vulnerable Black families are simply unaccepting of their child's sexual orientation.

Indeed, Zay was not alone among the participating Chicago Black gay men in detailing how his experience of sexual identity held important implications for their relationships with their biological families. Fragmenting familial relationships related to sexual identity and social and contextual had implications for a number of participants in relation to experiencing enduring

periods of housing instability and/or homelessness. Likely influenced by the sample characteristics (e.g., LGBTQ organization involved, and/or involvement in house-and-ball communities) this was an unfortunate yet common experience. There also were additional phenomena interrelated with individuals' experiences of familial rejection—in the case of one participant, whose HIV status and sexual orientation contributed to fragmenting his relationships with his family members for a period of his young adulthood.

During our interview, Walter, a 24-year old Black gay man, disclosed being diagnosed HIV-positive at 18 years of age. His disclosure led to a rupture in relations with family and in his housing status. During his interview, Walter describes being expelled from his grandmother's home due both to his same-sex attraction, and several family members' initial discomfort with his HIV positive status. During this segment of the interview, I noted that Walter became quite emotional, particularly while recounting these as experiences constituting a major turning point in his life. Prior to learning about this experience, I also learned that Walter was an involved and a high-performing student (e.g., president of the high school's Gay Straight Alliance). Furthermore, like most of the men I interviewed for the study, Walter's same-sex attraction was not something that he was ashamed of. In his own words, by high school, Walter had already adopted an "I don't care what people say" attitude towards others' views of his sexual orientation, whether they were supportive or not. Nevertheless, experiencing familial non-acceptance around his sexual orientation and HIV status were challenging and transformative life events that generated a series of challenges for Walter including periods of housing instability and homelessness, in which he reported living in an LGBTQ youth shelter on the North Side for a period of one year. During a section of the interview during which he recounts finding the

courage to disclose his HIV status to his mother, and being disappointed in her response, he stated:

> Walter: I did end up telling them. My mother, her reaction kind of shocked me, because I felt like that is not a reaction I would expect from a mother. She was just like, "I kind of knew already. I mean look at your lifestyle." And I was just like, "Well, that wasn't what I was expecting to hear." And my sister she cried, she was like – at the time she was 15, she is like, "Does that mean you are about to die?" I'm just like, 'no' …I ended up moving out about a couple of months after.
> Interviewer: After you found out [about being HIV positive]?
>
> Walter: Yes. Well, I didn't move out – I had been kicked out, I should say.
>
> Interviewer: By?
>
> Walter: My grandmother. It was her house so.
>
> Interviewer: Because?
>
> Walter: My grandmother is an old school Christian. She doesn't believe in homosexuality. And it was just at that point I had taken on this 'I don't care what people say attitude,' you know? At the time, I was still looking at it like, 'I'm going to die anyways.' And I just – I was doing me. That's when I first started smoking and drinking, and she [Grandma] was just like "You got to go." And I ended up going to the shelters; I was there for about a year or two. And then from there, I ended up moving into my own apartment.
>
> Interviewer: Okay so you moved out of the house.
>
> Walter: Right.
>
> Interviewer: You were living in shelters for a couple of years?
>
> Walter: I mean, I could always come home any time, I just couldn't stay there, because we always clashed.

Walter went on to discuss being supported financially and emotionally by an Aunt throughout the two-year period that he alternated between being unstably housed and homeless. The duration of participants' reported periods of persistent housing instability and homelessness varied. Across the sample, experiences of housing instability or homelessness lasted anywhere

from two months to five years. Whether brief, episodic, or prolonged, housing instability and homelessness substantially disrupted participants' lives by inhibiting individuals' ability to complete their education and to acquire valuable skills and experience in the labor market through consistent employment. Both heightened participants' risk for additional vulnerabilities as well (e.g., greater risk of entry into the juvenile and criminal legal system involvement, engaging in survival and/or transactional sex).

For example, Johari, a 24-years old Black gay man, left home at age 18, when his immediate family would not support him due to his sexuality or relationship with his then boyfriend. Johari's decision to leave coincided with his dropping out of high school during his senior year. These decisions had a number of implications for Johari's opportunities. Johari's experience, like Walter's, demonstrates the interwoven implications of additional vulnerability for Black gay men both familial rejection and homelessness for Black gay men in additional social domains.

In his interview, Johari articulated feeling that his sexuality was "taboo" in his family, although he noted that his family's acceptance of his sexuality notably improved over time. Nevertheless, he describes how the initial non-acceptance of his sexuality informed his decision to leave home voluntarily during his last year of high school:

> Johari: I ran away from home to give them space, and…
> Interviewer: Were you a senior at the time?
> Johari: I was a senior.
> Interviewer: Okay.
> Johari: And I did end up dropping out of school.

He continues:

> Johari: So, I was homeless for a year. Then, I got an apartment. I was with a housing program called Harbourville.[5] And I stayed there for a year. And then I moved with some

[5] Harbourville is an anti-poverty organization working with diverse Chicago communities by providing services in the areas of health, housing, and employment.

friends, and then I moved out over a period of time.

Several of the study participants reported navigating protracted periods of homelessness. For instance, Stephen, a 25-year old Black bisexual man, navigated alternating housing instability and homelessness for approximately five years. After graduating high school, Stephen completed one year of college while still maintaining a part-time job, and while residing with his mother. Stephen became homeless after they had a disagreement about his sexual orientation and employment status. Notably, unlike other participants, Stephen's experience of homelessness was not solely related to his sexuality, although it remained a primary factor. Stephen describes going through a "trans phase" at the time that he became homeless. However, according to him, his mother made him leave home primarily because he was employed and believed that he could therefore "make it" on his own. Stephen would subsequently spend the next five years of his life navigating housing instability, and under- and unemployment, and found himself engaging in survival sex to meet basic needs. Reflecting on this experience, Stephen says:

> Stephen: I was homeless almost five years—I had been going back and forth from South to North, South to North. Mostly, I was up on the Addison and Belmont areas though. Homeless, trying to make something out of myself.

I found that moving "up North" either for temporary shelter or for permanent housing provided by these organizations was a common theme among the service using Black gay men. Although these organizations were largely viewed as helpful for homeless youth, some participants, such as Stephen, were critical of the organizations. Stephen characterizes the infrastructure for homeless youth as almost too well-organized. In his view, this potentially facilitates extended periods of homelessness among some LGBTQ youth by fostering dependency on the organization's programs and services. Moreover, from his perspective, this

may inadvertently contribute to the formation of a 'triangle trap' for many Black LGBTQ youth. He states:

> Stephen: It [North Side LGBTQ health infrastructure] is a Bermuda triangle, because you don't get out of it. It's like the Bermuda Triangle, but it's the LGBTQ triangle! (laughs)
>
> Interviewer: Say more.
>
> Stephen: What I mean by that is, you will get there, and you will be like, "Oh, this is sweet, oh I got a shelter from 9:00am to 9:00pm. Then I got Briarwood in the morning from 9:00am to 3:00pm. Then, a program at The Circle is going from 4:30pm to 7:00pm! "Oh! That's a whole day! I don't got to do nothing. I can just sit, and be pretty, and just soak up everything. Shoot, I'll just stay up here and just do this, and not go anywhere." And then, "Oh, I could just lie and stay in the system." You know what I mean? That's the triangle. You got all your basic needs in one area. You don't need to go anywhere…I can stay at the shelter; then, I can get up in the morning; I can go to Briarwood, I can get something to eat; fill out some job applications, boom. Next day, if I need to talk to a service provider about something, that's there. STI testing. It's all there.

Further elucidating this notion of the 'triangle trap,' Stephen also describes his own decision-making process of recognizing the "trap" and being proactive toward changing his situation. He says:

> Stephen: For me, it took me to having to do the hard groundwork while I was homeless. Because there were a lot of, there were a lot of youth that were just, 'out there.' Just trying to survive. Not really trying to maneuver their life better, to possibly help other youth, to get this ball moving, so people could start making a life for themselves.
>
> I ended up making that decision on my own to stand up and say, "You know what? I can't be sitting here doing same thing everybody else is doing, I have apply myself and actually go out here and get these resources that I need, so that I can try to make something better for me, and the youth below me."

Adding additional context to the prevalence of youth and young adult homelessness among Chicago Black gay men, was Isaac, a 24-year old Black gay man, who stated:

> Isaac: It's a lot of people that I know that's under that LGBT umbrella that are homeless.
>
> Interviewer: Why do you think this is the case?

> Isaac: Due to the lifestyle of being gay and trans—especially trans… being kicked out of, you know, their residences with their families, because they're not accepted. And, they're out here on the streets.

Throughout the in-depth interviews, housing instability and homelessness were a recurring theme. Indeed, one pathway to homelessness for the Chicago Black gay men that I interviewed was non-acceptance or rejection by biological families. Even among the participating men who had not personally experienced homelessness, most reported knowing multiple peers who had. Being unstably housed or homeless has previously been conceptualized as traumatic (Goodman et al. 1991). As Goodman and colleagues (1991) address, homelessness can generate or worsen existing symptoms of trauma through several mechanisms e.g., social disconnection, or sudden or gradual loss of one's home. Notably, I found that homelessness heightened individuals' vulnerability to experiencing a range of additional experiences (e.g. survival sex, mental health disorders). Importantly, interviews revealed that the biological families of the participating Chicago Black gay men who experienced homelessness were often vulnerable and overburdened by a range of interconnected challenges.

Survival Sex

Frequently interrelated with participants' experiences of homelessness was survival sex. Generally defined as transactional sex, this is a strategy whereby individuals, frequently youth, will exchange *sex* for food, housing, clothing, and their other basic needs (Dank et al. 2015). In general terms, survival sex functions as an economic survival strategy for marginal populations of urban LGBTQ youth (Dank et al. 2015). Moreover, related to their broader social vulnerability, a recent paper found that youth arrested for engaging in survival sex also report the highest rates of childhood adversity (Naramore et al. 2017). The participating Chicago Black gay men's in the dissertation discussed engaging in survival sex as a strategy to mitigate the effects

of persistent housing insecurity and financial instability. Although not a strategy used by all the participating Chicago Black gay men in the study sample, survival sex and sex work were referenced across the interviews, as participants who did not engage in survival sex often knew peers who had experience.

Zay, previously mentioned, who had been abandoned and experienced housing instability and homelessness, began engaging in survival sex while he was an adolescent, after being essentially abandoned by his family at the age of 11. He says:

> Zay: After like a couple of years passed [of homelessness], eventually I got into like—I was doing sex work at the age of 15. And, my father found me on the street.

Other participants described engaging in survival sex. Johari, previously described, discusses engaging in survival sex during the course of that the year that he was homelessness. However, like many others included in the study, Johari mentions adopting multiple strategies to survive. He says:

> Johari: Well, my family would give me money. I would do these surveys; I would do studies. I would sit outside a club and hope some White man would come by and take me home, or some Black man would come by and take me home.
>
> Interviewer: This is over here [Boystown]?
>
> Johari: Mhm, this is over here.
>
> Interviewer: Okay.
>
> Johari: And then I found the gay mecca.....[The Boiler Room][6]. I was like okay, well I was like, "If that gets me a little change—you know? I can go in there at night, and I can sleep." So, I stayed at [The Boiler Room], a lot.
>
> Interviewer: How often would you stay?
>
> Johari: Uhhh....Probably out of a month.....uhhh.... about 20 times a month.

[6] The Boiler Room is an establishment located on the North Side of Chicago. It is a gym, sauna, and bathhouse for men 18 years of age and older.

Stephen, who was stably housed on the South Side at the time of his interview, described the role that survival sex played in his life while he was homeless and unemployed and navigating the LGBTQ health infrastructure on the North Side:

> Stephen: …I was on and off with my living arrangements, you know? I was, uh, doing things. I'm not going to lie to you, I was…I had to do what I had to do to survive. And so, I was out there, uh, you know…making moves. Finding places to stay. I was having sex with people to get money. I was having sex with people to get to stay somewhere. Like, I was doing these things just to make it.

Adding additional context to the salience of survival sex among marginalized and service using young Chicago Black gay men, Isaac mentions that given their social and structural vulnerability, particularly as individuals begin to age-out LGBTQ organization's age restrictions, individuals may feel coerced into engaging in a range of "illicit" survival strategies. He says:

> Isaac: But like, once you get older, you know, and you're like, an older LGBT person, you pretty much kind of like, you have to survive with your own stuff….And that takes you to a different arena, because, you know, a lot of trafficking comes with that.
>
> Interviewer: Trafficking?
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> Isaac: Drug-trafficking, sex-trafficking, scams. This LGBT community is doing anything to survive. I've seen it all, and in different arenas! People selling different stuff that they aren't supposed to be selling. And, I'm not talking about their bodies—
> stuff that you are not supposed to be selling.
>
> Interviewer: For example?
>
> Isaac: Weapons, drugs.
>
> Interviewer: To make money? To survive?
>
> Isaac: Yes. Link cards. (laughs). People will sell anything if you ask me. Yeah, I mean, everything comes into play.

Isaac's point demonstrates the various ways in which socioeconomic deprivation, in combination with individuals' racial, gender, and sexual minority identities, places individuals at heightened social risk, often requiring individuals to pursue alternative survival strategies to mitigate their

structurally marginal position. As a result, individuals may engage in any number of practices as short or long-term survival strategies, including survival sex (Parker et al. 2017). Consistent with prior research study participants' rationale for engaging in survival sex was consistent with prior research; to ensure material survival as a response to stigma, discrimination, and rejection (Dank et al. 2015; Nadal, 2016; Parker et al. 2017). Given the salience of social oppression and structural vulnerability in many of their lives, participating Chicago Black gay who engaged in survival sex employed this strategy to obtain some sense of stability in circumstances that were otherwise characterized by considerable risk and uncertainty.

Sexual Assault and Abuse

Consistent with prior studies finding that Black LGBTQ youth and LGBTQ of color, are more likely to report histories of sexual abuse than their White LGBTQ counterparts (Nadal, 2016; Fields et al. 2008), a number of study participants discussed traumatizing experiences of sexual assault. In their in-depth interviews, these participants disclosed accounts of sexual abuse that occurred in the context of discussing what motivated them to seek out programming and services through various Chicago LGBTQ organizations.

One such participant was Benjamin, a 24-year old Black bisexual man. Benjamin who was homeless for an extended period prior to participating in the study, was currently living in a residential home for youth and young adults experiencing persistent and/or serious mental illness at the time of the interview. Benjamin disclosed an experience of sexual abuse that he endured while homeless and engaging in survival sex to meet his financial and housing needs. In the wake of the of this traumatic experience, he learned that he had contracted chlamydia from the individual who had violated him. Benjamin mentions these as the primary motivations for his beginning to seek out LGBTQ organizations for assistance. He says:

> Benjamin: For me, the reason why I went that way [LGBTQ organizational involvement] was because of the rape, the torture I went through, and the prostitution I had to go through…I caught chlamydia because I was raped. They tested me and I found out I had it. I got treated for it. After that, Spectrum Health Alliance helped me get access to PrEP. I wouldn't have been able to get it otherwise.

Another man who referenced his personal experience with sexual trauma was K.D., a 24-year old Black bisexual man. His was the shortest interview conducted for the dissertation study – approximately 36 minutes in length. K.D. mentioned that his experience of childhood sexual trauma continues to have an impact on his daily life. Throughout the interview, there were major segments during which he declined to provide answers, including refraining from providing information about his neighborhood, or immediate family, specifically during his childhood and adolescent years. When I gently probed K.D. as to why this was the case, given that we previously discussed the various topics to be covered during the screening interview, he then shared that he believed that he experienced difficulty remembering periods of his childhood given experiences with sexual trauma experienced during childhood and adolescence. Therefore, he preferred that we not discuss that period of his life at all. He says:

> K.D.: Actually Lance, I will be honest. I've had memory loss. So, it's like I honestly wouldn't remember it that much. At the age of 16, I think it was 16 years, I actually got raped. And, I was raped as a child, as well. I've been through a lot. I try to move forward, and not think so much about the past.

Other Chicago Black gay men that I interviewed, briefly discussed experiences of rape in the context of additional experiences of interpersonal violence while growing up in their neighborhoods. For example, another interviewee, A.J., who was a 23-year old Black gay man that I interviewed, recalled of his adolescent years:

> Interviewer: Okay, so formative years in your neighborhood, what stands out in your mind?
> A.J.: Drugs, prostitution, being raped, being beaten, gang activities.

Taken together, Benjamin, K.D. and A.J.'s collective reflections concerning their experiences of sexual trauma as a mode of interpersonal violence can help to demonstrate the ways in which structural trauma and structural violence impacting Chicago's Black communities, also contributed to these young Black gay men's experiences of violence on several registers (e.g., individual, interpersonal, and structural). My analyses found that collectively the above experiences of rejection and non-acceptance, homelessness, housing instability, survival sex, and individuals experiences with sexual violence were factors undergirding their motivations for accessing Chicago's LGBTQ health infrastructure. Bearing this in mind, at the conclusion of each interview, I asked each participant to share what each believed were the most impactful issues occurring in the lives of Black gay men, and what Chicago' LGBTQ health infrastructure could do to better support Black gay men in particular. The next section discusses these findings and puts them into context.

Institutional Failure

Given the myriad social risks confronting many participating Chicago Black gay men, I was curious to discover how individual Chicago Black gay men perceived the efficacy of the city's existing LGBTQ health infrastructure, and they believed it might be improved. In response, participating Chicago Black gay men suggested Chicago's LGBTQ organizations could improve services to the community in a range of ways, but specifically in ways more appropriately tailored to these Black gay men's complex and multidimensional needs. Participants responses illuminated a broader story of potential institutional failure present at the organizational level. This story emerged from data collected at the conclusion of each interview, wherein in order to put each man's broader lived experiences into context, I asked for each of the participating Black gay man's perspectives about what they each viewed as the single most

important issue facing Chicago Black gay men. I then asked each participant to detail a set of recommendations for how Chicago's LGBTQ health infrastructure might better serve Chicago Black gay men.

These "big-picture" questions were designed to gather Chicago Black Gay men's perceptions of how well the city's LGBTQ human service organizations were currently doing in meeting the needs of Chicago Black gay men. To be sure, these questions elicited a range of responses from the participants. However, a common narrative was that notions of prevention, which individuals viewed as limited to a focus on HIV and sexual health, required expansion. Participants responses, though diverse, placed emphasis on two key areas: 1) expanding current definitions of prevention and 2) narrow organizational focus on HIV.

Expand Current Definitions of Prevention

In responding to the question about the most important issue facing Chicago Black gay men, a number of individuals described health-related issues experienced by their peers that require greater attention. Taken together, I understood these participants responses as suggesting the importance of broadening definitions of prevention. Zay, for instance, stated that currently the most significant issue for Black gay men is trauma. He describes trauma as related both to men's marginal identities and their social vulnerability. In response to my question, "what is the single most important issue facing Black gay men in Chicago today?" Zay comments:

> Zay: The most pressing issue?
>
> I: Yeah, the single most important.
>
> Zay: Trauma. I think the biggest issue is to start from there. But where are the conversations for that stuff?

In additional, Zay mentions that organizations are often singularly focused on the presenting-issues of clients (e.g., HIV, homelessness, housing) and suggests these approaches often

overlook the fact that there are range of underlying issues that shape individuals' present conditions and that this requires a sharper focus in the context of programs and services. Characterizing this, he says:

> Zay: They [LGBTQ organizations] focus on the now—HIV, housing, and these immediate needs. But the now, is a whole make-up of the past. And that's where they need to start. And then help us with long-term stuff. Because we do have issues, with housing and like crime, out of all honesty. Yes, those things are an issue. But I think that those issues come, I think, a lot of it comes from the trauma.

Bearing this in mind, Zay believes that the dominant organizational approaches to prevention with Black gay men and Black LGBTQ communities should integrate more holistic strategies to prevention, encompassing treatment of physical, mental, and behavioral health domains. From his perspective, this requires a shift in prevailing organizational approaches around how they conceptualize prevention. He states:

> Zay: I think that like offering—this would go back to clinical—but not like sexual health, more like mental health work, needs to definitely be done. More trauma-informed ways of dealing with like, the community.

Isaac similarly describes mental health as the most salient issue. Consistent with Meyer's (1995) conceptualization of minority stress theory, he characterizes what he refers to as the gay "lifestyle" itself as "traumatizing," mentioning that the everyday stressors of living as a gay person, routinely embedded within heteronormative social contexts as psychologically taxing. He suggests that this ongoing stress underscores many of the personal and social stressors that Black gay men experience, and importantly suggests that this can affect multiple domains of individuals' lives. He comments:

> Isaac: Mental health. Mental, mental, mental is the most important. If you're not mentally stable, everything else is going to crumble around you. Socially you're going to

> be fucked up, sexually you're going to be fucked up, financially you're going to be fucked up, unless you got some type of mental support. Because really, your mental state is the umbrella for everything. That one single thing can affect a lot of things, and there's not enough mental support out here.

Narrow Organizational Focus on HIV

In the context of discussing Chicago' LGBTQ health infrastructure, evidence of HIV fatigue was also present among the sample. While consistent HIV prevention messaging has been shown to reduce or delay high-risk sexual behaviors within diverse populations of gay men (Kingdon et a. 2013), some participants reported organizations risk stigmatizing Black gay men by focusing solely on HIV in relation to this population in isolation from other vulnerable groups. Stephen, for example, exclaims:

> Stephen: All the HIV and AIDS stuff. Oh, god, why?! Where does that come from?
> Interviewer: Well, I noticed that you didn't say HIV that when I asked the single most important issue facing Black gay men is.
>
> Stephen: Because I feel that, I just feel like we, the LGBTQ community, as a whole, just as a community, is getting better at pushing the issue of condoms. 'Go get an STD and STI testing done, go get that done,' and having incentives for it, and making people go get tested.

Stephen, among others, held the perspective that the Black LGBTQ community itself, has improved its health promotion and risk reduction strategies. Moreover, he believes an HIV-centered discourse pertaining to Black gay men, inappropriately singles Black gay men out, perpetuating the notion that this is an issue specific to Black gay men. He says:

> Stephen: I've heard that for a good seven years now at these organizations. Just, AIDS and STDs, and STIs with Black gay males. That's with everybody! It's not just Black gay males! That's with everybody!

Anthony, like Stephen, also criticized the city's LGBTQ health infrastructure for programming

and service approaches too narrowly focused on HIV. He comments:

> Anthony: …When it comes to HIV, we get it crammed into our heads from The Briarwood Center, from The Circle, and all these other places, just about HIV. We know about it! We understand everything about it! And it blows my mind that at most organizations, the main focus is talking about HIV. Because we get that, over, and over, and over. We get the flyers, pamphlets, then we get information pieces, and it be the same stuff, worded differently.
>
> Interviewer: So, over-saturation?
>
> Anthony: Yeah, over! And, I feel like we focus so much on that issue alone. And I don't feel like it should be the sole focus.

In providing an example of such an additional focus, Anthony viewed housing as the most impactful issue currently facing many Chicago Black gay men. Anthony suggests the organizational focus on HIV, which potentially privileges men who are HIV-positive, in his view, may concurrently exclude similarly vulnerable yet HIV-negative Black gay men, who may be looking to secure housing with the assistance of the city's LGBTQ-serving organizations. He says:

> Anthony: Now, I feel like we have so many options for positive folk, trans folk, which is great, and should happen. But I've seen so many people come to the spaces [organizations] who are negative, and they can't really help them, because they don't fit into that demographic of that trans, that positive. And I feel like they are being excluded from it.

Reflecting other participants' perspectives suggesting that organizational conceptualizations and approaches to prevention should be more comprehensive and expansive, Anthony's stance is that he views housing as being foundational for most life domains. He says:

> Anthony: Yeah, like I feel that [housing] is something that we should just put more focus on besides prevention [HIV].
> Interviewer: Because housing can be a mode of prevention?

> Anthony: It is. I believe that. I feel like everybody should have a place to call home. No matter if you straight, gay, negative, positive, whatever. I feel like if you have that home foundation, I feel like that is a start.

Collectively, these Chicago Black gay men's descriptions of the institutional limitations within Chicago's LGBTQ organizational service matrix with respect to marginal Chicago Black gay men, adds additional dimension to the intersectional trauma framework, by demonstrating how organizational funding mechanisms and funding structures of LGBTQ can dictate not only the array of organizational programs and services, but can also identify and be perceived as more inclusive of particular key populations and issue areas, that may privilege addressing specific concerns and/or populations based o funding priorities, which may privilege HIV funding structures, together articulate how organizational funding structures that predominantly focus on HIV shape how these men experience these services and resources.

Discussion

As these Chicago Black gay men's narratives demonstrate, there are a host of risk factors that we might understand as traumatic. I found that these risk factors motivated most participants to access various Chicago LGBTQ organizations. Notably, as the participating Black gay men articulate, these social risk factors extend beyond questions of HIV. Developing a theoretical framework for understanding their collective social risk that acknowledges their social identities and structural location is needed, to articulate the social risk that is salient and often recurrent at multiple registers. Enduring structural inequality deeply impacts many within Black communities, including Black gay men. Moreover, traumatogenic processes of social oppression such as heterosexism, homophobia, and transphobia, that sediment within social formations such as biological families also impact the lives and experiences of these Chicago Black gay men.

Drawing on the theoretical framework of intersectional trauma, a more expansive theory, helps to organize and explain a range of social risk factors encountered by hyper-marginal Black gay men, interrelated with their social identities and their structural location. Unlike other theoretical approaches to conceptualizing risk, intersectional trauma, as a framework, does not locate the solution in individual approaches to behavior change in relation to risk, but rather reiterates its social nature. Importantly, such an explanatory framework does not stigmatize individuals' decision-making, but rather recognizes that individuals are embedded within social and structural contexts that are deeply informed by various dimensions of social oppression (e.g., racism, homophobia, transphobia, etc.).

Chapter Four

Grounded Theory: Spatial Marginalization

Introduction

Shadowing was the final data collection strategy executed by the researcher in conducting the formal fieldwork for the dissertation. This data collection strategy was similarly used to answer the dissertation's guiding research question: What are the social and contextual factors that motivate or inhibit LGBTQ health infrastructure access or engagement for Chicago Black gay men ages 18 to 25? This ethnographic approach was employed to better understand how individuals belonging to an intersectionally marginalized population (e.g., Black gay men) navigate an urban landscape (e.g., Chicago) characterized by spatial inequity in the geographic distribution of its LGBTQ health infrastructure. Few systematic studies of health in Black LGBTQ populations (e.g., Black gay men) have ethnographically investigated or characterized how this particular dimension of urban inequality may impact the health seeking and service utilization patterns of Black gay men, to consider its potential influences or effects on population health (see Rosentel et al. 2019; Levy et al. 2014). In shadowing Chicago Black gay men (n = 3), by taking a view from below (Farmer, 1996), this ethnographic approach brings into view the economic, social, and temporal investments that the participating health seeking and/or service using Chicago Black gay men may make, and the potential structural barriers that may marginalize LGBTQ health services users with similar demographic profiles in cities similar to Chicago, that are in many ways rooted in the racial, gender, and sexual disadvantages unique to this population.

For this component of the dissertation study, I sought to achieve a better understanding of the perceptions and experiences of Chicago Black Gay Men who routinely travel to the North

Side of Chicago, specifically to its relatively affluent community areas, in which its LGBTQ health infrastructure is disproportionately concentrated (Rosentel et al. 2019; Daniel-McCarter, 2012). The empirical rationale for selecting a sample of participating informants who routinely travel North to patronize these particular LGBTQ organizations was to conduct a series of brief case studies that illuminate the perceptions and experiences of health seeking and service using Chicago Black Gay men who travel extensively to access a geographically distal LGBTQ health infrastructure. The prior data collected through the in-depth interviews and the participant observation preceding this phase of data collection indicated this as a common service user experience for many young Chicago Black gay men. Moreover, many of the Chicago Black gay men who sat with me for structured interviews reported engagement with the LGBTQ health infrastructure located up North prior to utilizing the more geographically proximal LGBTQ health infrastructures located on the city's South and West Sides. Given this context, the researcher elected to shadow current health seeking and service using Chicago Black gay men (n = 3) to serve as the participating field informants while they were traveling to the North Side from the South Side for specific services and programs offered through this LGBTQ health infrastructure.

To carry out this phase of the dissertation study, I first contacted professional staff at a formal LGBTQ serving health clinic in the lakefront community of Edgewater which is situated on the city's North Side. The organization, Spectrum Health Alliance (SHA),[7] engages in behavioral, medical, and social service provision to Chicago's diverse LGBTQ populations,

[7] Spectrum Health Alliance is a pseudonym for the actual organization to protect the confidentiality of the informants. SHA is a nationally recognized organization that empowers both individuals and communities affected by HIV and additional health disparities. SHA offers a range of services including HIV/STI testing, PrEP and prevention, peer discussion groups, behavioral health, primary care, living with HIV, and youth services.

including many Black Gay Men from the South and West Sides, who utilize SHA. To recruit the additional Chicago Black gay men for this specific mode of data collection, I requested participant referrals with the assistance of a professional contact in the organization. This contact, a professional social worker, assisted the researcher in identifying organizational clientele eligible to participate in the study, i.e., Chicago Black gay men who were between ages of 18 and 25. Study eligible men who expressed interest in participating, then reached out to the researcher individually through a Google Voice account that was established by the researcher for purposes of the study. Each participating informant was provided with a cash incentive ($100) in exchange for their time. In the end, I successfully recruited three informants to participate in this phase of the investigation. Although one man reported living on the West Side of Chicago within the previous year, all three participating informants, in the end, were residence of the South Side at the time of the study.

During the shadowing observations, the researcher accompanied each of the participating informants for a single observation, each lasting for a duration of between approximately four to six hours. Accompanied by the researcher, these observations collected these Chicago Black gay men's narrative statements and reflections of the city through a series of 'ride-along' interviews that facilitated a series of in-depth conversational and narrative exchanges between each of the individual informants and the researcher. Consistent with Small's (2009) argument for the methodological merit of conducting such 'small-n' case studies when such approaches are situated within the context of a multi-method qualitative examination, the shadowing phase of the examination treated each research observation as a distinct case study designed to illuminate facets of the phenomenon under investigation. Moreover, as the researcher, I found that these three individualized case studies illuminated the underlying characteristics involved in Black gay

men's ability to engage in health seeking and service in the broader context of the city of Chicago's LGBTQ health infrastructure, which remains disproportionately located on the North Side of Chicago (Rosentel et al. 2019). To be sure, when placed into the broader context of the health literature addressing service access and equity, particularly for the most vulnerable populations within LGBTQ communities, the emerging theoretical concept formulated from this data, has implications for the literature on structural barriers to health seeking and service utilization for Black gay men in urban settings, specifically within the literature on structural barriers.

Sensitizing Concepts

Geographies of Exclusion

Consistent with constructivist grounded theory methodology, the theoretical concept, spatial marginalization was informed by existing theoretical concepts. In particular, I draw from Sibley's (1995) notion of the geographies of exclusion. In addition, I draw upon Bailey's (2014) discussion of this concept in relation to Detroit, Michigan's house and ball communities, which Bailey theorizes (2014) as Black queer cultural formations comprised of diverse members of the Black LGBTQ community.

In Sibley's (1995) formative articulation of geographies of exclusion, the scholar argues that the notion describes the 'monopolization of space by the powerful and privileged in society and a relegation of 'weaker groups' to less desirable environments, while systematically excluding these groups from more desirable spaces' (Bailey, 2014; p. 494; Sibley, 1995). Bailey's (2014) formative ethnographic work within house and ball communities, informed by Sibley's (1995) theoretical ruminations, addresses notions of spatial exclusion and marginalization to characterize "…the ways in which Black LGBT[Q] people are structurally

prohibited from, denied access to, and oppressed within public and private spaces due to the race, gender, and sexual identities they claim and the socially transgressive practices in which they engage" (p. 494). Informed by these discussions of space in relation to marginalized populations, my iteration of the concept, spatial marginalization, specifically accents the ways in which participating Chicago Black gay men perceive and experience exclusion and marginalization, in relation to the accessibility of the LGBTQ health infrastructure in relatively affluent communities on the city's North Side.

While these prior theoretical discussions were informative for conceptualizing and shaping spatial marginalization into a coherent theoretical concept, neither specifically addresses the structural challenges that health seeking and/or service using Black gay men may encounter within highly segregated environments, such as the city of Chicago, wherein its LGBTQ health infrastructure remains disproportionately located within relatively powerful and privileged community contexts, geographically, socially, and spatially, located at a considerable distance from arguably the most impacted (e.g. HIV), and most socially and economically disadvantaged, and vulnerable LGBTQ community members (Rosentel et al. 2019; Daniel-McCarter, 2012).

Analysis

In the case of the participating Chicago Black gay men whom I engaged in conducting the shadowing observations for the dissertation, an inductive qualitative analysis of the individual observations found that the contexts in which these individuals resided informed their experiences and perceptions of marginalization and exclusion with respect to LGBTQ-related health seeking and service utilization in the context of Chicago. This finding is in line with the existing literature that suggests that Black gay men may face structural barriers when engaging in health seeking and service utilization, characteristically, these studies examine the accessibility

and barriers to HIV prevention and treatment options for Black gay men (Schneider et al. 2012; Levy et al. 2014; Elopre et al. 2017). My theoretical articulation of spatial marginalization as shaping the participating Chicago Black gay men's lived experiences of the city's health infrastructure is in dialogue with these existing theories of exclusion and marginalization, but also extends these theoretical ruminations by thinking about what these experiences of marginalization mean in the context of structural barriers to geographically distant LGBTQ health infrastructure within highly segregated urban contexts like the city of Chicago.

Using Sibley (1995) and Bailey's respective discussions of exclusion and marginalization in relation to space, I situate the participating Chicago Black gay men's experiences within the framework I label spatial marginalization to organize and explain their distinct experiences and perceptions. In the context of understanding the factors motivating or inhibiting young Chicago Black gay men health seeking and service utilization, I found that these Chicago Black gay men's descriptions of spatial marginalization potentially may constitute barriers for marginalized populations who are navigating a range of LGBTQ organizations in the city of Chicago. The inductive nature of the data collection and analysis played an important role in allowing a grounded theory of spatial marginalization to emerge from these Chicago Black gay men's narratives.

Theoretical Concept: Spatial Marginalization

Constructivist grounded theory, the methodological approach employed by the researcher in the dissertation, facilitated the emergence of a theoretical concept, through an inductive analysis of shadowing data: spatial marginalization. Spatial marginalization, as perceived and experienced by the participating Chicago Black gay men, is demonstrated through their narrative statements and interpretations of the city, and perceived spatial and structural exclusion from its

LGBTQ health infrastructure, from their standpoints as Black gay men. My own observations as the researcher, subject position as a Black gay man, and status as a long-time Chicago resident, although non-native, informed the development of this theoretical concept as well. Included within the umbrella of spatial marginalization are the characteristics that constitute it: uneven service distribution, social isolation, racialized residential segregation, and geographically disconnected LGBTQ health infrastructure.

Spatial marginalization was inductively derived through completing case studies with three Chicago Black gay men—William, Tyler, and Landon—who served as the researcher's field informants. In the context of the broader dissertation, spatial marginalization organizes and explains a range of spatial characteristics including the persistent geographic gaps between Chicago's LGBTQ heath infrastructure and the many of the city's most vulnerable LGBTQ community members, a perceived lack of geographically proximal services within Black gay men's local neighborhoods, and an extensive travel time to access programs and services for the young Chicago Black gay men in accessing the city's LGBTQ health infrastructure. Indeed, during each observation, beyond traveling an extensive distance to access programs and services, I found that the men's temporal investments proved burdensome. In accompanying these three Black gay men to appointments at several LGBTQ organizations on the city's North Side, which were a part of its larger disproportionate LGBTQ health infrastructure, I found that each of the informants were routinely commuting up to an hour and a half to attend health and social services appointments lasting between 30 and 60 minutes, or drop-in programming lasting several hours, even as there were nearby drop-in programs that these individuals were aware of, organizations which were more geographically accessible. The data examples, and the narrative statements drawn from the conversations between each of the individual informants and the

researcher while riding on CTA bus and trains illuminate various characteristics of the proposed theoretical concept of spatial marginalization.

Results

Case Study #1: William

William,[8] one of three participating field informants I shadowed, whose narrative statements I reproduce below, serves as one empirical case of spatial marginalization. William is a 25-year old Black bisexual man. He lives in South Shore, a historic Black community situated along the city's southern lakefront. During a brief screening interview, William characterized his service utilization pattern as "pretty regular," indicating that his services utilization (e.g., appointments with a social worker, drop-in program attendance) at SHA, Briarwood, and The Circle, occurred approximately two to three times per week. Indeed, he reported attending drop-in programming, regular use of social and health-related services, and endorsed general attendance for socializing with his peers. At the time of participation, like many Chicagoans, William did not own a car, nor did the other participating informants at the time of their observations. In addition, William tells me that he must frequently travel to the North Side because he also maintains part-time employment at a company near Lakeview. In sum, traveling to the North Side is nearly a part of his daily routine.

During the evening prior to the scheduled shadowing observation, William and I communicated over the phone, and agreed to meet at a CTA bus stop near his residence, not far from the intersection of 79th and Exchange in the South Shore neighborhood. William indicated that he would be going in to work later in the afternoon, and therefore he agreed to meet with me on that morning. I suggested to William that he set the agenda for the observation. He decides

[8] All participating field informants have been provided pseudonyms and their personal attributes have been modified in order to maintain confidentiality.

that we will meet in his neighborhood first, and then we will travel North. Once there, we will subsequently navigate the Boystown neighborhood to visit several organizations. Specifically, I will accompany him to scheduled appointments both at The Circle and Briarwood Center, as he does not have an appointment at SHA. Afterwards, we will have lunch together at a pizza establishment located on Belmont Avenue prior to him catching another bus to go to work.

In meeting William, I did not have to venture too far from my own residence. I began by traveling from my residence in the Hyde Park neighborhood, via car, to meet with him in South Shore at approximately 9:50am the morning of the appointment. William is tall, with penetrating hazel eyes, and a calm demeanor. On the day of the scheduled observation, William was wearing a White Sox hat, and adorned his left ear with an earring. In making the first leg of the trip to the North Side, we caught our first mode of transportation of the day, the 79 Western CTA bus. William and I boarded this bus shortly after 10:20am. I noticed that this particular bus route was populated predominantly with Black Americans, cisgender men and women, whom I presumed were locals, i.e., residents of the South Shore neighborhood. In my estimation, most individuals onboard appeared between the ages of approximately 25 and 40.

At the beginning of each shadowing observation, I would ask each of the participating informants, in general terms, to characterize their individual experience of traveling 'up North.' In each observation, I began the exchange by asking William to characterize his commute from Chicago's South Side to the North Side, which in his case, entails commuting from approximately 7900 South Exchange Avenue[9] to 3600 North Halsted at least three times per week. He comments:

[9] 7900 South Exchange Avenue; the actual location of where we met has been changed to protect the confidentiality of the informant.

William: The traveling can be a little extensive. Especially just coming from like the 79th and Exchange area, because it's not like you can take a direct bus or a train. It's like, you have to navigate. You have to take a bus, then another bus, and then a train. Or, a bus, then a train. But it's still—even though it's 24-hour access, it's still…it can be a little frustrating. Because later, when you're coming from the North Side [returning South], you can just walk a block or two, and you know, you are right there at the train stop, you know? And then you can pretty much ride right to wherever it is that you need to go.

I: And you said it takes how long to get up there?

William: Uh, it's usually about an hour, or so. And, if I'm going to work, that's an hour and a half.

I: Does dealing with that distance every day, and the time of the trip just get easier for you over time, or, are you just kind of like, more resigned to being like, 'it just is what it is,' or an it's all good, kind of thing?

William: It is, what it is. I mean—I just got my license. So, I'm saving up for a car. So, it's like—It doesn't get any easier, but it's just like—you have a new story to tell. I mean, just last week I saw a grown man peeing on the bus. He was just peeing on the bus. The bus driver had to stop, everybody had to get off the bus, and onto a new bus, because that's a sanitation issue. So it's just like, things like that come up—but you don't want to have to deal with them all the time.

So far, William's narrative demonstrates several characteristics of the concept, spatial marginalization. First, are two central characteristics, significant travel time and considerable geographic distance. For instance, in shadowing William, I learn that within the course of a day he may travel up to forty miles in a single day on the city's public transit system when commuting between the South Shore and East Lakeview neighborhoods to access these LGBTQ organizations. For William, this may entail riding a total of at least three different CTA buses, and at least two trains. William, and the other participating informants, describe their travel times as ranging anywhere from 45 minutes to an hour and a half in one direction.

Even though William resides on the city's South Side, he mentions using several LGBTQ organizations, all are health and social service institutions disproportionately located on the North Side. In shadowing William, a young Black gay man currently living in South Shore, with

a service utilization pattern suggesting that the city's North Side LGBTQ health infrastructure is an important feature of his life, I desired to obtain a better understanding of what compelled him, and other young Black gay men to routinely travel to the city's North Side organizations for health service utilization. During a break in the conversation in our commute north on the CTA bus, I inquire as to whether William would ever consider moving to the North Side, given the frequency of his travel to these destinations:

> I: Given that so much of your life and service access appears to revolve around that neighborhood, have you ever considered moving North?
>
> William: I definitely have, you know. Just financially, it's not easy right now.
>
> I: Yeah.
>
> William: I mean, for a young person in their twenties, up North, affording a place up North, where it's like $1000, for a studio…
>
> I: Right.
>
> William: That's kind of outrageous. Over here [South Shore], you can get a one bedroom for like, $700. You know, it's priced a little cheaper.

Through shadowing William and the other participating informants, I was able to achieve a better understanding of the draw of these LBGTQ organizations for young Black gay men, and LGBTQ Chicagoans more generally, by circulating within the neighborhood and organizational contexts alongside the participating informants. Not only do these organizational spaces provide clientele with access to robust health and social services, not unlike their South and West Side counterparts, but each of these spaces collectively fostered crucial opportunities for youth development and providing individuals with necessary social and material support. Indeed, given the supportive nature of these spaces, I wanted to capture William's perspective about how accessible he felt these facilities, and their programs and services were to LGBTQ Chicagoans.

To gauge this, in the exchange below, using The Circle[10] as an example, I ask William for his perspective.

> I: In your view, does The Circle, for example, do a good job of doing outreach 'out South'? In terms of people knowing about it?
>
> William: Let me tell you, 'The Circle' is just kind of like a known thing [on the South Side]. Like, if you want some services, you know it's like, you just 'go to The Circle,' it's like…
>
> I: It's word of mouth…
>
> William: Yeah! That place is like the Gay Hall of Justice, you know what I mean (laughs)? The Gay Hall of Justice. Like, the Justice League. You don't have to put no outreach out there for that, you know? People are just coming in there; you know what I mean?

Notably, William continues by stating that although The Circle, the largest LGBTQ community center in the Midwest, is recognized by many LGBTQ people who reside on the South Side as a hub for LGBTQ health and social services, however, the geographic organization of its programs and services remains largely geared towards and most available to providing services to those who also reside on the city's North Side. Moreover, given his personal experiences with The Circle's housing program, William walked me through some of the personal challenges he confronted in both utilizing and participating in The Circle's housing program, as an LGBTQ community member who resides on the city's South Side. He continues:

> William: …I do feel like they could do a lot more with just expanding South. And I think they are starting to…I was in The Circle's housing program. But see, that's the only thing that they expanded in their services, moving their housing program out South. And something to me was kind of iffy about that. Because it's like, why would you move your housing programs out South, if all of your resources, your buildings, and everything else, are still up there on the North Side? You know? Create a building, create a place, where you can bridge services [on the South Side], and *then* create a program for housing out there. You know, because it's still the hassle of, even if you have a case manager within your immediate area, it's still the process of, I still have to come up to the North Side to

[10] The Circle is a LGBTQ multi-service center located in Chicago's Boystown neighborhood, and largest LGBTQ community center in the Midwest.

> do different things that I need to do, you know? It just made my trips to the North Side a lot more frustrating.
>
> I: Yeah.
>
> William: And, so it's like, that's another thing I guess, like, if you are going to start offering services in certain locations [South Side], make sure that you are set-up to have your services there, and not try to relocate people, but you don't have the full set of services, you know? There are certain situations where you may not be able to, of course. You may have to go to another location just for a specific service, but, it shouldn't have to be like all your resources are in this location, and then you are still trying to do outreach all the way over here.
>
> I: Right.

Above, William articulates several interrelated dimensions of the spatial and structural barriers that many young Chicago Black gay men often perceive in navigating the city's geographically disparate LGBTQ health services infrastructure when engaging in health seeking and/or service use. William also describes how the potential structural barriers to health seeking and service use potentially impact marginal Black LGBTQ youth specifically those who reside on the city's South Side. He puts this into additional context below:

> William: You know, a lot of people don't want to make that trip going from the South Side, all the way up North, you know? I've known and I've met people that have never even been downtown, let alone to the North Side. Because that's new, and it's confusing to them. They may know down the street from them. And they may know a few stops of the Red Line, but that's it. That's the perception of their reality, you know what I mean? Their reality is not as big. If you are asking people to go across town…that's about an hour and a half to go across town. I'll do it. For some other people, that's actually going to be a challenge for them.

In this narrative statement, William reiterates a prevalent theme within many social science investigations of Chicago that examines its deeply entrenched social inequality and racial residential segregation (see Wilson, 1987). The notion that there are many Chicagoans whose experiences of the city are often localized, i.e., limited to their local and/or immediate

neighborhood surroundings, to their region of the city (e.g. the South Side), and their social interactions limited to interactions with residents of the same race (Keels, 2008; de Souza Briggs, 2008; Moore, 2016). Ethnographic accounts of the city often report that there are residents who mention having never been to downtown Chicago, who have rarely left their own neighborhoods (Love Jr., 2019; de Souza Briggs, 2003). The extreme physical and social isolation experienced by those residing within low-income community areas, such as some community areas on the South Side of Chicago, may have implications for health seeking and service utilization of intersectionally marginalized residents who reside within these community areas.

Moreover, if we take William's commentary to be true, his statement reflects a wider perspective held by many Black residents of Chicago concerning uneven municipal and infrastructure investment across Chicago's diverse community areas. Local community discourses frequently reference uneven municipal investments that contribute to the relative dearth of small and large-scale health infrastructure and development on the city's South and West Sides (Seligman, 2005; Wilson, 1987; Rosentel et al. 2019). Such disparities, to be sure, as William suggests, may present structural barriers to health seeking and service utilization behaviors for Black gay men, as suggested by prior investigations (Levy et al. 2014; Tieu et al. 2018; Meyerson et al. 2014).

Although not directly observable in the data, William's narrative presents a range of questions regarding the health-related consequences of entrenched structural disparities in LGBTQ health service infrastructure in Chicago, and the potential effects for the most vulnerable members of LGBTQ communities who may experience limited access to culturally responsive LGBTQ organizations. William's observations speak to the potential health consequences for Black gay men who express discomfort about commuting to, and navigating the North Side, or

who may be hesitant to patronize South Side LGBTQ organizations. In addition, as William mentions, there may be individuals living on the South Side, for example, with minimal or limited knowledge about its LGBTQ health infrastructure.

Case Study #2: Tyler

The second field informant that I shadowed was Tyler. Tyler is a slender, and a youthful-looking 24-year old Black gay man. He currently lives in the Chatham neighborhood, located on the city's South Side. To meet him, I travel from my own residence in the Hyde Park neighborhood, via car. I first encounter Tyler in person at the 79th Street Red Line station on the train platform. Once I begin the observation, I learn that Tyler is currently in-between jobs. In his terms, he states that he is, "unemployed…for now." He also tells me that he has recently applied for a sales position at a major retail store and is still awaiting a response from the company. "Best of luck," I say, voicing my support of his efforts. During the screening interview, like the other participating field informants, I learn that Tyler does not own a car, and often travels to the North Side for programs and services offered through its LGBTQ health infrastructure. At his screening interview, Tyler stated that he uses programs and services on the North Side approximately once per week. Unlike William or Landon, however, Tyler mentions use of the city's South LGBTQ health organizations also. In Tyler's case, commuting to the North Side, requires catching the CTA bus near an apartment he currently shares with his partner, a one-bedroom residence he describes as "…about six blocks away from the 79th Street station." Once he arrives at the 79th Street Red Line Station, he will then board a northbound CTA Red Line train. On the day of the observation, we follow the same route. Notably, while William characterized traveling from South Shore up to the North Side as "extensive," Tyler, by contrast, who notably did not report utilizing programming or services as extensively as William,

describes neither the travel time or navigation of the North Side as an inconvenience for him. I ask Tyler to characterize the length of his trip to SHA, in particular. He states:

> Tyler: Hmmm, I want to say like probably like almost like an hour…almost an hour. I want to say 40 or 50 minutes—at the most.

Given his residential location, in Chatham, I specifically ask him whether he experiences commuting to the North Side for its LGBTQ programs and services as an inconvenience. He continues:

> Tyler: No, it don't. It don't mess up my schedule. I just have to leave earlier for when the program will start, which is 12pm. Usually, 12:00pm to 4:00pm. And I'll leave my apartment at something like 10:30am, or 11am, to try to get there at 12:00pm. Last week, when I went and I left at around 11:00 and I got there like before 12:00. I was there at probably like four to five minutes to 12:00.

When commuting to utilize SHA services, Tyler will either meet with a case worker, attend a drop-in program, or make use of the organization's behavioral or physical health resources (e.g., primary care, and behavioral health). Tyler also mentions that given his current employment status, frequenting the organization is also useful for him, because it connects him to additional resources and opportunities. He states:

> Tyler: Yeah. Sometimes, I just go to the drop-in programs. I also go there to like, wash clothes, and just to chill, you know? Sometimes they're playing music, and I'll watch movies and stuff… And, if or when we need any kind of resources, they will help us out with that stuff ...They also help out like with the little handouts, and brochures, and give us information about research surveys and stuff like that too…And they also have, like, group sessions for us to get together, to talk about our problems, our relationships. And I like that. They really support us, you know? The gay people, and, The bi people.

Even as Tyler refrains from characterizing either the travel time or distance to SHA as a barrier, given his concurrent residence and health utilization of local South Side LGBTQ health infrastructure, I am curious about what motivates Tyler to continue to travel North. He says:

> Tyler: It's just a different environment…it's classier up here than it is on the South Side. It [the South Side] is ghetto. And, the North Side, I feel like it's just better. Mostly because I just feel like there are more programs up here.

These themes–the South Side as "ghetto," the North Side as "classy" or "better"—would recur in the course of the ride-along with Tyler. At various moments, he would invariably deliver broad generalizations characterizing the North Side, and its LGBTQ health infrastructure as "classier," and "better," in comparison to the profile of those also available on the South Side. This was not an isolated narrative in the context of the broader study, as it emerged in some of the in-depth interviews. At first glance, we might read the assessment as problematic, given their alignment with existing racialized and racist narratives of the city's South and West Sides. However, it is possible to situate these broad generalizations about the North and South Side, respectively, in relationship to the broader context of the history of Chicago, and the historical and contemporary structural violence that has disproportionately impacted low-income community areas and neighborhoods, primarily although not exclusively on the South and West Sides. Historical and contemporary scholarship focused on Chicago has examined the critical role of structural violence in disproportionately excluding residents of Chicago's low-income, and predominantly racial and ethnic minority neighborhoods, specifically those on the city's South and West Sides, relative to the investment in affluent and gentrifying neighborhoods (Wacquant, 2016; Wilson, 1987; Ralph, 2014). These processes have contributed to the, "…placed-based class, racial and ethnic group inequality and uneven geographic development in the city of Chicago" (Farmer and Poulos, 2013, p. 2; Knight, 2015; Reingold, 2001). This history of social inequality in Chicago

has myriad implications for uneven small and large-scale community health resource infrastructure, including within the context of the LGBTQ health services sector (Rosentel et al. 2019). Indeed, if we situate Tyler's characterizations of the North and South Sides into this broader historical perspective—historical processes of social inequality in Chicago's uneven geographic development—we might better understand the participant's characterizations of the North (e.g., classy) and South Sides (e.g., ghetto) and their respective LGBTQ health infrastructure, while continuing to acknowledge the statements as being problematic.

Accompanying Tyler in his commute north to SHA via public transit entailed riding with him on the CTA Red Line train (otherwise known as the "L"-train). This was a distinct opportunity to observe the intersections of race, space, and social interactions in Chicago, and the demographic shifts that occurred while riding on public transit from the South Side to the North Side of Chicago. The segregated nature of the social interactions in the city become especially visible in public settings such as the CTA Red Line (Swyngednouw, 2013; Farmer, 2011). Prior studies have explored how the city's Red Line train, in particular, serves as a site from which to observe how residential racial segregation and racial boundary crossing converge in public settings (e.g., public transportation) (see Swyngednouw, 2013; Farmer, 2011; Raudenbush, 2012). As the researcher, and a Black gay man, who has resided both on the North and South Sides of the city, I have personally witnessed how riding on public transit in Chicago, particularly on the Red Line, can provide a window into Chicago's stark racial and socioeconomic stratification (Swyngednouw, 2013; Farmer, 2011). In this instance of shadowing, commuting North provided the researcher the opportunity to observe this experience shaped the perspective of a health-seeking and service using young Chicago Black gay man.

Given this context, once we arrived downtown during the commute, I asked Tyler to describe any observations that he routinely makes while traveling North on the CTA red line L-train.

> I: What differences do you notice, if any, as you travel from the South Side, to the North Side?
>
> Tyler: Um, well, I do notice a different race. Yeah, I notice differences, between how it is right now on the train [near CTA Monroe Red Line station], than how it was when we were on the South Side. It's different. Way different than it was.

He continues:

> Tyler: Yeah, when you come up, as you travel more, on the train going up-town, it's like it switches. Then, eventually it gets to where our people are at [gay people]. And so it's like you go from the hood, to classy, to gay.
>
> I: Wait, say that again.
>
> Tyler: We went from the hood, to classy, to gay (laughs).

Although each of the participating field informants contributed observations about race and neighborhoods in Chicago, Tyler's narrative about these particular topics, in which he articulated his own assumptions about how and where race, class, and sexuality operated in Chicago, were perhaps some of the most compelling I encountered. In the context of the shadowing observations conducted, this was a unique feature of my exchange with Tyler, as neither of the other two participating field informants elected to use the Red Line to travel North during the observation.

In addition, although Tyler mentions regular participation both in North and South Side organizations (e.g. "I actually went to a new one last week….it was on 76th Street") he details a preference for the North Side LGBTQ health infrastructure, again, due to a perception that there is a more robust programming and service infrastructure for LGBTQ people in that location. Drawing comparisons between the LGBTQ health infrastructure on the city's North and South Sides, he states:

> Tyler: Well, in my opinion, I feel like the North side, I feel like they've been doing it more than the South Side [LGBTQ health infrastructure]. I feel like the South has just started kind of doing programs that I can go to. You know? They really just recently started doing that. I don't remember the South Side having any gay programs before. They probably had programs, I just probably didn't know about them. But the North Side, I don't know, I feel like, it's just better.

Whereas William acknowledges the breadth of LGBTQ health infrastructure on the North Side, while simultaneously critiquing, suggesting that this disparity creates structural barriers to service utilization for LGBTQ populations beyond the North Side, Tyler, in contrast, characterizes the North Side and the profile of its LGBTQ organizational infrastructure as qualitatively "better," in his view. Nonetheless, each of these individual cases articulate and demonstrate the role of spatial marginalization in the health seeking and service utilization of these Chicago Black gay men.

Case Study #3: Landon

In the third and final case study, I shadowed Landon, a 25-year-old bisexual man, who resided in South Shore neighborhood at the time of the shadowing observation. When I first meet Landon, I discover that he is short, possesses a stocky build, and has a stoic demeanor. During his screening interview, Landon reports regular case work appointments at SHA ("…about once a week"). He also mentions routine appointments with a medical doctor at an organization called Health, Inc. Similar to the other informants, Landon also relies on Chicago's public transportation system in commuting to the city's North Side for LGBTQ service utilization. Landon's commute to SHA ranges anywhere from 60 to 90 minutes. Landon tells me that whether he is having an appointment at SHA or Health, Inc., each lasts approximately between 30 and 60 minutes.

In conducting his observation, I meet Landon at a Walgreens in the South Shore neighborhood, and we walk to the nearest CTA bus station. Upon boarding, I ask Landon to speak in specific terms about his commute North to SHA and Health, Inc. Below, Landon details what making this trip looks like for him:

> I: What buses and train routes do you take to get up North?
> Interviewee: I walk from my place to like 71st and Jeffrey and wait for the bus. That's about a five-minutes. From 71st and Jeffrey I'll take the J14 down to the loop, get off at Adams. Wait, no—State and Wabash. Get off. Walk to the Red Line. Wait for the train. I believe that the stop is Monroe. I don't think it's – I think it's Monroe. Yeah. I'll catch the train there and then I will get off at Bryn Mawr.

Related to his service needs at the time of the observation, Landon reports traveling North two reasons, to see his case manager and to see a doctor. I ask Landon to characterize service his utilization pattern:

> I: How often do you go up? Once a week? Twice a week?
> Interviewee: Usually about once a week. But it's about, no, I want to say about once a week, but that's like, if I'm going to see my case manager. If go to see my doctor [at that's like, that's about every two weeks.

Landon mentions these visits are his sole reasons for traveling North Side. According to him, after concluding each visit either to SHA or to Health Inc., he returns home.

> Landon: Pretty much, yeah. I come back South right afterwards. I don't really do anything else [up North].
>
> I: Okay.
>
> Landon: Yeah, pretty much, when I go up North, I mean, that's really the only thing I'm going for.
>
> I: Okay.
>
> Landon: Is the case management or doctor's appointment.

I: Okay.

Landon: Occasionally, I might want to go out to like Belmont or somewhere, at the bar, you know? But it's very rare. With my financial situation it's very rare that I would go out. I only got one job. I work part-time. It's not sufficient to support that. I go to work and I come home.

Not wanting to assume that he knows about the South Side's current LGBTQ health infrastructure, I ask him whether he is aware of any organizations located nearby on the South Side. He says:

Landon: Like on the South Side?

I: Yeah, like SHA, is there anything out there you're aware of?
Landon: No. I don't know anything.
I: Okay.
Landon: I noticed that like – it's – what's the name of it, the something, like, The Tree of Life, or something like that.
I: Mm-hmm.
Landon: Anyway, it's a community building over here.
I: Okay.
Landon: It offers services, like job-related services, they teach you some job skills that you need at a job fair or whatever, stuff like that. That's all I know down in that area. I really don't get out much, except to go to work, and to go to SHA. And, I just moved in that area. So I don't really know what's around there yet fully.

Like the other participating informants, given that the organizations remain at a considerable distance from Landon, I ask him to detail in what, if anything, motivates him to use the LGBTQ health infrastructure that is located on the North Side

Landon: Just the environment and the people in there.
I: Yeah.
Landon: It's away from the South Side**,** too, you know?
I: Okay.
Landon: And just the travel. I like to see the scenery. Just what's going on

throughout Chicago.

Landon mentions that he sometimes experiences challenges in making it to his scheduled

appointments at SHA on time, due to his schedule. He works part-time between the hours of 2am and gets off work at 8am. Moreover, the company that he currently works for is an hour and half away from his home while riding on public transit. Because I am also curious about what navigating the city's public transit system is like for him, not exclusively for health seeking, but in all facets of his life, I ask him to provide me an estimate of how long it generally takes him to get to work. He says:

> Landon: To get there, that's about 15 to 20 minutes—well, 15 minutes driving. But, for me that's about an hour and 30 minutes, I think, if you're taking the bus.
>
> I: Okay, okay.
>
> Landon: Yeah.
>
> I: Wait. You said an hour and 30 minutes?
>
> Landon: Yeah, an hour and 30 minutes. It takes about an hour and 30 minutes ride from South Shore, and back. Because it's a night-time shift, and the buses are running kind of slow then.

Discussion

In recent years, there has been an increasing scholarly interest in investigating the role of place in enduring racial health disparities. While overall population health has improved, health inequalities across racial groups have increased by as much as fifty percent by some accounts (Pearce, 2012; Pearce & Dorling, 2006; Shaw, Davey Smith, & Dorling, 2005). The important of place in racial health disparities has been systematically investigated (Lipsitz, 2011). In recent years, scholarly attention has increasingly been paid to the role of place in shaping the health outcomes of Black gay men, primarily focusing on HIV service utilization (see Pierce et al 2007; Levy et al. 2014). Although existing urban scholarship has addressed how social processes underlie linkages between place, race, and health, these investigations rarely investigate how

distinctive characteristics of urban social contexts potentially factor into health seeking motivation and service utilization patterns of Black gay men.

The findings from shadowing three Black gay men, all of whom resided on the South Side of Chicago, highlight some of the individual-level and structural barriers to health seeking and service utilization for young Black gay men who reside in Chicago. Each case assists in demonstrating and articulating spatial dynamics endemic to Chicago's human service infrastructure and institutional landscape. In particular, the empirical and theoretical findings reveal some of the challenges facing Chicago Black gay men around their negotiations of the city's uneven LGBTQ health infrastructure. The concept of spatial marginalization is potentially a useful analytic for describing and understanding these experiences. While research on race and place has characteristically thought about this phenomenon almost exclusively in terms of its impact on presumed heterosexual racial minority populations, the narrative statements delivered by the Chicago Black gay men in the study, provide some additional texture concerning how negotiations of space within urban contexts can also be experienced and interpreted intersectionally as well.

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