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SCHOLARLY COMMENTARY

Critical Consciousness-Based HIV Prevention Interventions for Black Gay and Bisexual Male Youth

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ABSTRACT

Black gay/bisexual male youth are one of the groups most affected by HIV in the United States, but few behavioral interventions have been created specifically to address this health inequity. Oppression related to these youths' multiple social identities—including racism, heterosexism, and HIV stigma—contribute to increased health risks. Primary and secondary HIV prevention interventions created specifically for Black gay/bisexual male youth that address the negative impact of oppression are urgently needed. We present empowerment as a framework for understanding how oppression affects health, and critical consciousness as a tool to be utilized in behavioral interventions. This approach helps to move Black gay/bisexual male youth from a place of oppression and powerlessness that leads to elevated health risks to a position of empowerment that promotes feelings of control and participation in healthy behaviors. Finally, we present a case example of our own critical consciousness-based secondary HIV prevention intervention created specifically for Black gay/bisexual male youth.

KEYWORDS

Critical consciousness; Black; gay; HIV prevention; empowerment

Though Black gay/bisexual male adolescents and emerging adults are one of the groups most affected by HIV in the United States, few behaviorally-focused prevention interventions have been created specifically for this population (Harper & Riplinger, 2013). Much research has shown the detrimental health effects of various types of oppression (e.g., racism, heterosexism, HIV stigma) that pervade the lives of these young men within the United States (Arnold, Rebchook & Kegeles, 2014; Bogart, Wagner, Galvan et al., 2011; Bogart, Landrine, Galvan, et al., 2013; Wade & Harper, 2017). As such, we document the utility of using empowerment as a framework for understanding how oppression impacts the health and well-being of

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Black gay/bisexual male youth, and offer critical consciousness as an effective method of operationalizing empowerment in behavioral interventions for this population. Since our goal is to support the inclusion of critical consciousness strategies into both primary and secondary HIV prevention interventions, we discuss data and literature that addresses both Black gay/bisexual male youth living with HIV and those who are not living with HIV.

HIV prevention interventions for black gay and bisexual male youth

Black gay/bisexual adolescents and emerging adults are disproportionately affected by HIV in the United States and represent one of the largest subgroups of people living with HIV (Centers for Disease Control and Prevention (CDC), 2016). HIV cases among youth ages 12–24 years in the United States have more than doubled in the last 15 years, and now constitute 22% of the epidemic (CDC, 2016, 2017a,b). The youth epidemic is particularly concentrated among gay and bisexual male youth, who comprise more than 81% of all new infections and 55% of newly diagnosed males are Black (CDC, 2016). In the United States, the risk of acquiring HIV is highest among Black gay/bisexual men, with estimates that half of all Black men who have sex with men will acquire HIV in their lifetime (Hess, Hu, Lansky, Mermin & Hall, 2017).

These data demonstrate that HIV is a public health crisis among Black gay/bisexual male youth. Without culturally grounded HIV prevention interventions developed specifically for this population, higher numbers of these young men will become infected. These data also suggest that, in addition to primary prevention interventions, secondary prevention interventions are desperately needed for Black gay/bisexual male youth living with HIV to both improve their health and decrease the likelihood that they will pass the virus on to others.

Gay and bisexual male adolescents typically do not receive sexuality education in schools that addresses same-gender sexuality, with a recent study also showing that they were less likely than their heterosexual male youth counterparts to be taught about HIV (Rasberry, Condron, Lesesne, Adkins, Sheremenko, & Kroupa, 2018). A review of sexual health promotion and HIV prevention interventions specifically for adolescents between 1991 and 2010 revealed that only 5% of peer-reviewed articles on evidence-based behavioral interventions were focused on gay/bisexual male adolescents, with none exclusively for Black male youth (Harper & Riplinger, 2013). In addition, the clear majority of these interventions utilized information and cognitive-behavioral approaches to HIV prevention, with none encouraging critical approaches to sexual health promotion.

A more recent qualitative systematic review focused on behavioral HIV prevention interventions for young gay and bisexual men (ages 13–24), and found 15 interventions published in the peer-reviewed literature that produced statistically significant findings (Hergenrather, Emmanual, Durant, & Rhodes, 2016). Only two of these interventions were specifically focused on Black gay/bisexual male youth—Hightow-Weidman et al.'s (2012) HelathMpowerment.org interactive internet based intervention and Hosek et al.'s (2015) POSSE community-level popular opinion leader intervention for Black youth involved in the House and Ball Community. Although some of the interventions reported incorporating aspects of empowerment into their intervention, this concept was differentially defined and none of the interventions specifically addressed the health impacts of oppression on Black gay/bisexual young men.

Interventions specifically targeting Black gay/bisexual male youth are needed because existing interventions do not focus on the multitude of factors that promote heightened risk in this population, or the unique resilience processes demonstrated by these youth men (Harper et al., 2016; Wade & Harper, 2017; Wilson & Moore, 2009). The popularity of biomedical interventions to prevent HIV such as pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) has decreased the focus on behavioral interventions, but unfortunately, these prevention methods are not well utilized among youth at highest risk for HIV. Black gay/bisexual adults and youth are least aware of and least likely to use PrEP (Eaton, Driffin, Bauermeister, Smith, & Conway-Washington, 2015; Strauss et al., 2017). Even though PrEP has demonstrated acceptability among gay/bisexual male youth (Hosek et al., 2017), PrEP utilization is only 8%–9% (Hosek et al., 2017; Strauss et al., 2017). Thus, culturally grounded sexual health promotion and HIV prevention interventions (both primary and secondary) that address the impact of oppression on the health and well-being of Black gay and bisexual male youth are needed.

Multiple layers of oppression

Black gay/bisexual male adolescents and emerging adults experience multiple layers of powerlessness and oppression due to their age, race, and sexual orientation (Frye et al., 2015; Harper & Wilson, 2016; Wilson & Harper, 2013). Frequently, ethnic minority gay/bisexual youth must not only contend with negative societal reactions to their sexual orientation, but also may experience racial prejudice, limited economic opportunities and resources, and limited acceptance within their own ethnic cultural community (Harper & Wilson, 2016; Hightow-Weidman, Phillips, 2011). Unfortunately, ethnic minority gay/bisexual youth also may experience

racial prejudice, marginalization, and sexual objectification within the larger predominately White mainstream gay community (Harper, 2007; Wilson & Harper, 2013). Black gay/bisexual male youth who are HIV-positive occupy an additional stigmatized identity, experiencing HIV stigma as an added layer of oppression (Arnold et al., 2014; Dowshen, Binns, & Garofalo, 2009). A recent review of peer-reviewed literature ($n = 125$ studies) regarding the health and well-being of sexual minority youth of color found that few articles intentionally examined how intersecting oppressions and privileges related to sexual orientation and race-ethnicity contributed to their outcomes of interest (Toomey, Huynh, Jones, Lee, & Revels-Macalinao, 2017).

It is important to recognize the discrimination and stigmatization experienced by Black gay/bisexual male youth with regard to sexuality, race, and HIV status as social processes that can be understood as oppression by dominant groups in order to maintain power and privilege (Parker & Aggleton, 2003). We adhere to a definition of oppression that is grounded in the concept of asymmetry or the unequal distribution of coveted resources among socially salient groups (Watts, Griffith, & Abdul-Adil, 1999; Watts, Williams, & Jagers, 2003), a core concept of oppression that is shared by other oppression theorists (cf. Serrano-Garcia, 1984; Serrano-Garcia & Lopez-Sanchez, 1992; Prilleltensky, 2003; Prilleltensky & Nelson, 2002). Oppression can be propagated through more direct or overt mechanisms of denial, exclusion, control and/or restriction (e.g., denial of rights, control of resources, restriction of mobility), as well as by more indirect or subtle ideological systems of influence (e.g., institutionalized racism, heterosexism, sexism, classism, and their related practices) (Watts et al., 2003).

These oppressive forces are experienced at multiple socioecological levels, including the personal, interpersonal/relational, and social/community. Many members of privileged groups are not aware of the heterosexist and racist nature of most societies, since heterosexist/racist language, icons, images and messages are so pervasive within the various realms of our existence (Harper, 2010; Herek, 2015). Complex interconnected political, social, and cultural forces create hegemony within a society, legitimizing the structures of social inequities (Bowleg, 2017). Though members of marginalized groups are often aware of the heterosexist/racist nature of most societies, they are often led to accept and even internalize the stigma to which they are subjected (Parker & Aggleton, 2003).

We propose that oppression and resulting feelings of powerlessness drive the HIV epidemic among Black gay/bisexual male youth in several key ways. Multiple layers of powerlessness can negatively impact these youth's self-concept, future life options, sense of social connectedness, and intimacy needs—all potentially increasing participation in risky sex (Harper, 2010;

Miller 2007). Recognition of the role of powerlessness in HIV risk behaviors among Black gay/bisexual men is not new. Early qualitative research studies examining increased HIV risk among Black gay/bisexual men first documented how the men's negative experiences related to race, sexuality, and gender lead to the self-concept issues that many of these men contend with, as well as the way these issues can affect risk and health-seeking behaviors (Beeker, Guenther-Grey, & Raj, 1998; Stokes & Peterson, 1998).

In examining the facilitators and barriers to HIV prevention faced by health departments and community-based organizations working with this population, Wilson and Moore (2009) found that many of the barriers to prevention were related to psychosocial problems including poor or low self-esteem and self-worth. As in other studies, this was related to deep-seated external and internalized stigma around sexuality, race, and gender. Participants suggested that interventions aimed at improving self-concept were needed to respond to HIV among Black gay/bisexual men. One provider highlighted where current interventions may be missing the mark, providing direction for future interventions: "so basically, in terms of HIV for Black gay men, it's not—and this is the punch line—it's not a question of them not knowing how to save their lives. It's a question of them knowing if their lives are worth saving" (Wilson & Moore, 2009, p. 1017).

Black gay/bisexual male youth who are living with HIV must contend with an additional stigmatized identity. HIV-related stigma has been shown to influence the quality of life and adherence to care of adolescents and young adults living with HIV (Harper et al., 2013; Harper et al., 2014; Martinez et al., 2012). The perception and internalization of HIV-related stigma, coupled with the lack of supportive social relationships, can lead to increased substance use, decreased general psychological health, and decreased engagement in the HIV care continuum (Bruce et al., 2011; MacDonell, Naar-King, Murphy, Parsons, & Harper, 2010; Nugent et al., 2010). The stigma associated with HIV also has been shown to be associated with specific psychological challenges for young people living with HIV in the form of increased symptoms of depression and anxiety, as well as decreased self-esteem (Andrinopoulos et al., 2011; Brown, Whiteley, Harper, Nichols, Nieves, & ATN, 2015; Varni, Miller, McCuin, & Solomon, 2012). Such psychological distress, in turn, has been associated with decreased adherence to antiretroviral therapies (Hosek, Harper, & Domanico, 2005; MacDonell, Naar-King, Huszti, & Belzer, 2013) among adolescents living with HIV.

Black gay/bisexual male youth who acquire HIV have, on average, lower rates of engagement in the HIV care continuum as compared to their Latino and White counterparts (Hightow-Weidman, Jones, 2011; Hussen et al., 2015; Johnson et al., 2013). Here again the influence of oppression

can be seen. First, on an intrapersonal level, the same low self-worth issues discussed above that may cause Black gay/bisexual male youth to engage in high-risk sexual behavior may also cause Black gay/bisexual male youth living with HIV to avoid engaging in care. These young men may not seek care because of internalized stigma related to sexuality, race, and HIV. Harper et al. (2013) found that, among a predominantly ethnic/racial minority sample of 200 gay/bisexual young men living with HIV, lower levels of ethnic identity affirmation, higher levels of negative attitudes toward same-sex sexual activity and behavior, and higher levels of HIV-positive identity salience were associated with significantly greater risk for missed appointments in the past 3 months.

Second, on an interpersonal level, Black gay/bisexual male youth may also avoid engagement in the HIV care continuum in order to hide their HIV status out of fear of the external stigma they would encounter from family, friends, employers, and other community members if their HIV status was known (Arnold et al., 2014; Radcliffe, Doty, Hawkins, Gaskins, Beidas, & Rudy, 2010). Furthermore, for some male youth, receiving an HIV diagnosis may lead them to struggle with not only accepting their medical diagnosis but also accepting their gay or bisexual sexual orientation. They may also fear that disclosure of their HIV status to family and friends may be a disclosure of their sexual orientation (Zea, Reisen, Poppen, Bianchi, & Echeverry, 2007). In addition, youth who have a negative attitude toward their sexuality may feel less comfortable seeking medical care in a clinic where they may have contact with other gay/bisexual youth—thus restricting them from receiving the social support benefits of interacting with other youth who are living with HIV (Hosek, Harper, Lemos, & Martinez, 2008; Lam, Naar-King, & Wright, 2007; Macdonell et al. 2010). Lacking the psychological resources to address these dual issues, some youth may avoid the medical care system to cope.

Finally, Black gay/bisexual male adolescents experience institutional- and structural-level oppression. Prevalence of reported racial discrimination by Black individuals in healthcare settings is relatively high, ranging from 6.9%–52% (Shavers et al., 2012). Adult Black gay, bisexual, and other men who have sex with men are less likely than others to report satisfaction with medical providers, to report an absence of nondiscriminatory practices among medical staff, and to trust the quality and competence of outpatient medical services (Malebranche, Peterson, Fullilove, & Stackhouse, 2004). Within HIV epicenters, AIDS-related mortality rates are higher within majority Black neighborhoods than majority White neighborhoods with similar prevalence rates (Nunn et al., 2014). These and other forms of structural-level racism supports findings by Kahana et al. (2016) that youth living in more disadvantaged areas were less likely to report current antiretroviral therapy (ART) use.

Empowerment theory provides a theoretical framework for understanding how oppression and empowerment impact health

Even though research indicates that Black gay/bisexual male youth contend with multiple threats to their self-esteem that are linked to their social and cultural identities (Harper, 2007; Jamil et al., 2009; Malebranche, Fields, Bryant, & Harper, 2009; Millett et al., 2007), poor self-concept, decreased self-esteem and self-efficacy, and psychological distress remain largely unaddressed in interventions targeting Black gay/bisexual men. It has been proposed that before engaging in traditional behavioral interventions aimed at increasing health promotion behaviors, it is essential for Black men to first be exposed to interventions that promote positive self-concept and increase self-esteem and awareness of social, political, and structural factors that may thwart positive development (Watts et al., 1999). For these reasons, empowerment provides a useful theoretical framework for interventions with Black gay/bisexual male youth.

The theory of empowerment consists of several definitions of the construct, as well as complex models of empowerment for individuals, organizations, and communities. Rappaport (1987), who is credited with first introducing the concept of empowerment into psychology and related fields, defined empowerment as "a mechanism by which people, organizations, and communities gain mastery over their affairs" (p. 122). Zimmerman's (1995) model of psychological empowerment has become one of the most widely used models for studying empowerment at the individual level. The model puts forward three dimensions of psychological empowerment: intrapersonal, interactional and behavioral. The intrapersonal dimension refers to a sense of control that one has over important resources for one's well-being, and it is frequently measured as sense of mastery, various forms of self-efficacy, or locus of control. The interactional dimension refers to a critical awareness of the social and political environment and how resources are distributed in the environment. The behavioral dimension refers to behaviors that individuals enact based on their critical awareness and sense of control.

Some aspects of psychological empowerment are closely linked to the Social Cognitive Theory (Bandura, 1986) constructs of self-control of behavior and self-efficacy. Sense of agency and control, have been identified as key constructs in the process of adolescents and young adults moving toward improved critical consciousness in prior interventions (Dunlap et al., 2017; Watts et al., 2002; Wallerstein & Sanchez-Merki, 1994). These key constructs, in combination with critical reflection and empowerment, are understood as mediating mechanisms between intervention exposure and engagement in health promotion behaviors (Super, Wagemakers, Picavet, Verkooijen, & Koelen, 2015). Intervention activities that are

grounded in Social Cognitive Theory typically aim to increase participants' behavioral capability by promoting mastery learning through skills training, thus improving participants' perceived self-control. Such activities typically facilitate improved self-efficacy by increasing participants' confidence that they will be able to perform protective behaviors and remove barriers to performing health promoting activities.

The framework of psychological empowerment has been applied to populations who experience varying degrees of oppression and marginalization (Taghipour, Sadat, Latifnejad, Keramat, & Jabbari Nooghabi, 2016; Zimmerman et al., 2018). Feelings of powerlessness, or lack of control over one's destiny, emerge as a broad-based risk factor for negative health outcomes, whereas empowerment has been demonstrated as an important promoter of health (Eisman et al., 2016; Super et al., 2015). The process of becoming empowered involves gaining greater internal control or capacity and overcoming external structural barriers to accessing health-promoting resources (Speer & Hughey, 1995, Super et al., 2015). The promotion of empowerment has been the basis for both primary and secondary HIV prevention programs for a range of adolescent and adult populations who experience oppression related to their gender, sexual orientation, and/or race/ethnicity (cf. Hahm et al., 2017; Harrison et al., 2016; Hosek, Lemos, Harper, & Telander, 2011; Li et al., 2018).

With the success of empowerment interventions in improving the health and well-being of adolescents and young adults, some authors have recommended an expansion of empowerment-related constructs or methods used in these programs. Mohajer and Earnest (2009) conducted a global literature review of empowerment-based and empowerment-focused programs and interventions for vulnerable or marginalized adolescents, including a total of 910 articles, books, documents and theses. They asserted that despite evidence of such programs' success in bringing about behavior change, the focus on individual empowerment in program implementation has missed "the critical focal point of empowerment" (Mohajer & Earnest, 2009). Authors suggest that the true essence of empowerment includes an emphasis on social change, its multidimensional attributes, and its potential to address the social determinants of health—all of which are essential to improving the health of oppressed and marginalized adolescents (Mohajer & Earnest, 2009).

Spencer (2014) proposes a new dynamic and generative conceptualization of empowerment for youth health promotion that synthesizes individual, structural, and ideological elements of power and is based on two interrelated understandings of health—dominant and alternative. The current conceptualization of how empowerment interventions produce changes in health—through a linear process, whereby individual empowerment leads

to avenues and opportunities for more community-empowerment through collective consciousness and critical action—is cautioned against by Spencer (2014) because it omits a critical discussion of power. She warns that such a conceptualization fails to recognize the ways in which power shapes social structures and contexts in which health behaviors occur and suggests that health promotion frameworks for youth need to engage with youths' lived experiences even though they may challenge dominant perspectives on health (Spencer, 2014). The framework for empowerment interventions put forth by Spencer underscores the importance of interventions involving transformative forms of empowerment that allow youth to interrogate and challenge dominant systems of meaning and create new and affirming conceptualizations of health and well-being. Such interventions would thus involve critical analyses of dominant ideologies regarding youth and their identities, as well as their health-related behaviors.

Critical consciousness as a tool for empowerment interventions

While empowerment theory provides a framework for understanding how oppression and empowerment impact health, critical consciousness provides the tools for moving individuals from oppression and resulting powerlessness and engagement in health risk behaviors to empowerment and resulting feelings of control and participation health promoting behaviors. We present the "Pathway to Health" figure to demonstrate the potential of critical consciousness interventions to disrupt the cycle of oppression-feelings of powerlessness-health risk behaviors, and to move participants to a cycle of empowerment-feelings of control-health promoting behaviors. The following will further support our recommendation to use critical consciousness as an effective method of operationalizing empowerment in behavioral interventions for Black gay/bisexual male youth.

Defining the process of critical consciousness

Critical consciousness emerged out of the seminal work of Brazilian educator and activist, Paulo Freire (1973, 1990, 2000), who created the concept of "conscientization" to represent the multistage process of developing a critical awareness of societal, historical, political, and cultural forces, which serve to oppress particular groups of people, and learning how to disrupt these oppressive forces through resistance and social change efforts. Freire (1973, 1990, 2000) describes a liberatory pedagogy for enhancing critical consciousness and asserts that this transformative process can help individuals and groups resist the negative effects of oppression and move into a

state of liberation and well-being. Watts and Serrano-Garcia (2003) stress that this resistance to oppression does not occur without some type of action or intervention, and that the process is often challenging. The difficulty in this process of conscientization or critical consciousness may be related to the need to deconstruct the cultural and ideological foundations of oppression (Watts & Serrano-Garcia, 2003), which requires a critical analysis of dominant ideologies and societal assumptions that are pervasive and endemic within all realms of one's existence. Critical consciousness then requires an active and intentional process of challenging these assumptions and presuppositions and exploring avenues for resisting oppression. Unfortunately, pervasive and long-standing oppressive and dominant ideologies and hegemonic beliefs can lead to an internalization of a stigmatized and subordinate status (Parker & Aggleton, 2003), thus decreasing the likelihood of spontaneous resistance to oppression.

As critical consciousness is enhanced and developed, individuals and groups become more aware of the power differentials and multiple points of asymmetry that exist in society (Watts et al., 1999) and move toward acts of resistance and liberation, both of which promote health and well-being (Nelson & Prilleltensky, 2010; Prilleltensky & Nelson, 2002). Critical consciousness is a process that takes time and taps into multiple aspects of one's awareness (Watts et al., 2003). Through this process of critical consciousness, individuals and groups are able to redefine themselves and their realities in a more positive, health promoting, and affirming manner that is based on their own perspectives and realities as opposed to those assigned to them by others. This process of gaining critical consciousness and an understanding of one's sociopolitical environment, coupled with active engagement in one's community and heightened sense of competence, are critical aspects of psychological empowerment (Zimmerman, 2000).

Use of critical consciousness with youth

Enhancing critical consciousness among youth has been identified as an avenue for promoting physical and mental health by assisting young people with understanding and challenging negative social influences such as sexism, racism, and other social injustices that can lead to poor self-concept and low self-esteem (Campbell & MacPhail, 2002; Diemer, Kauffman, Koenig, Trahan, & Hsieh, 2006; Watts, Abdul-Adil, & Pratt, 2002; Watts & Guessous, 2006; White, 2007). It has been incorporated into numerous health promotion interventions for populations across the globe who experience multiple social pressures influencing their behavior (c.f., Benoit et al., 2017; Hatcher et al., 2011; Mahr, Wuestefeld, Ten Haaf & Krawinkel, 2005; Strange Daghio, Vezzani, & Ciardullo, 2003; White, 2007).

These programs have been implemented with diverse populations, including adolescents, indigenous Canadian youth, urban youth, people with mental illness, college-aged women, domestic violence survivors, and health educators (Sharma & Romas, 2008), but not Black gay and bisexual male youth living with HIV in the United States.

Sharma (2001) suggests that the Freirian model of critical consciousness is an effective model for health promotion programs, but one that has been underutilized. Despite not being widely implemented, interventionists have detailed successful youth-focused interventions aimed at using critical consciousness or Freirian methods to promote and enhance critical consciousness and increase awareness of social injustices among African-American adolescents in the United States (particularly those living in urban low-income environments) (Balcazar, Tandon, & Kaplan, 2001; Watts & Abdul-Adil, 1998; Watts et al., 2002). Wallerstein and Bernstein (1988) used Freire's critical consciousness-/empowerment-focused educational theory in the Alcohol and Substance Abuse Prevention Program, a community- and school-based prevention program for adolescents in New Mexico. The intervention resulted in significantly higher rates of perceived risk for drug and alcohol abuse and promoted a greater personal awareness of the consequences of alcohol abuse among youth who participated. Although these studies have operationalized critical consciousness differently and used various methods to achieve increased levels of critical consciousness, they have shown the potential for critical consciousness interventions with youth.

Use of critical consciousness in HIV prevention interventions

Critical consciousness is a necessary first step in helping young people to renegotiate stigmatized identities so they can be empowered to change their sexual risk behaviors (Campbell & MacPhail, 2002). Campbell and MacPhail's (2002) work on critical consciousness development as an HIV prevention strategy for South African youth supports the need for marginalized young people to critically examine the relationships between race, sexual and gender constructions and sexual health, as well as the need to provide youth with a space for deconstructing the harmful aspects of these constructions. Specifically, empowerment to engage in healthy behaviors may need to be preceded by increases in young people's intellectual understanding of how structural factors such as racism, heterosexism, misogyny, HIV-related stigma, poverty, and political forces influence their mental and sexual health. According to Freire (1973), individuals must first develop an intellectual understanding of how social conditions such as the inequitable distribution of resources perpetuate social injustices and the continued marginalization of oppressed groups before they can work to resist and

change their situation. Thus for youth who are experiencing high rates of HIV such as Black gay/bisexual young men, they must develop a critical understanding of the role of dominant forces of White privilege (McIntosh, 1990), hegemonic masculinity (Connell & Messerschmidt, 2005), and social constructions of gender, race, and sexuality (Wilson, 2008) in influencing their sexual and health-seeking behaviors in order to create collective action that challenges and resists health damaging societal notions.

Use of critical consciousness with black male youth

Watts and his colleagues have developed an intervention to cultivate and enhance critical consciousness in young Black men in the United States entitled the Young Warriors program (Watts & Abdul-Adil, 1998; Watts et al., 2002, 1999). This research is part of a larger program of work that has led to the articulation of a theory of sociopolitical development (SPD) that holds critical consciousness as central tenet and emphasizes an understanding of the cultural and political forces that shape one's status in society and the capacity to envision and help create a just society as an essential part of the process (Watts & Guessous, 2006; Watts et al., 2003). SPD theory emerged from both liberation and developmental psychology and is viewed as a critical developmental process during adolescence, which reflects "growth in a person's knowledge, analytical skills, emotional faculties, and capacity for action in political and social systems" (Watts et al., 2003, p. 185). The theory may have significant implications for HIV prevention, as behavioral research focusing on sociopolitical involvement among gay/bisexual men of color has found SPD to be linked to condom use and less HIV risk behavior (Ramirez-Valles, 2002; Wilson, Yoshikawa, & Peterson, 2002).

The Young Warriors program has a focus on enhancing critical consciousness as part of facilitating Black young men's SPD and targets Black male youth in the United States living in low-income urban environments. Given the challenges that these young men face across multiple ecological systems and the negative societal messages pervasive in U.S. urban cultures about "Black men," the intervention has a focus on promoting healthy constructions of masculinity. In line with this, the "warrior" image used in the intervention was selected due to its association with masculinity and manhood. The intervention presents aspects of the "true" warrior archetype to participants that promote belief in a higher purpose, goals, discipline and cooperation; thus enacting and reinforcing a culturally conscious reform of traditional masculinity (Watts et al., 2002). In this sense the intervention serves as a facilitator of manhood development and can impact constructions of masculinity among youth.

Similar notions of reinterpreting dominant social constructions can be taken from Watts and colleagues' Young Warriors intervention, and the intervention can likely be applied to dominant notions and societal beliefs surrounding race, sexuality, and HIV status—all of which impact the self-esteem and health behaviors of Black gay/bisexual male youth (Hightow-Weidman, Phillips, Jones, et al., 2011; Voisin, Bird, Shiu, & Krieger, 2013). Watts has operationalized Freire's notion of critical consciousness and applied it to the SPD of young Black men using a social action research methodology (Watts & Abdul-Adil, 1998; Watts & Guessous, 2006; Watts et al., 2002, 1999). The Young Warriors program uses movies and music videos about contemporary urban culture as stimuli for the critical analysis of popular culture messages about gender, culture, race, and social class to increase young men's critical thinking skills. The program's critical consciousness coaching technique involves youth watching a movie or music video clip and then engaging in group dialog and discussion using five prompts that map onto components of critical consciousness: (a) What did you see (hear)? (i.e., related to the youth's perception of stimulus); (b) What does it mean? (i.e., links to the youth's interpretation and meaning of the stimulus); (c) Why do you think that? (i.e., related to the defense of the youth's interpretation); (d) How do you think and feel about what you saw or heard? (i.e., links to the emotional and intuitive response of the youth); and (e) What would you do to make it better? (i.e., related to action strategies) (Watts & Abdul-Adil, 1998; Watts et al., 1999, 2002).

These group discussions are facilitated by trainers who coach participants on critical thinking and critical consciousness exploration. In evaluating the critical thinking skills and critical consciousness development of the young men participating in the Young Warriors program, Watts et al. (1999, 2002) found that young men demonstrate an increase in the frequency of critical thinking/critical consciousness responses as a proportion of all categories of verbal responses over the course of the intervention. They have implemented the Young Warriors program with Black young men in a range of settings under different time schedules and lengths of time and have found similar results (Watts et al., 2002).

Use of critical consciousness with black gay/bisexual male youth: a case example

In the following section, we present a case example to illustrate a practical approach to using critical consciousness as part of a sexual health intervention for urban Black gay/bisexual male youth living with HIV. This case example illustrates how we used critical consciousness as the strategy for moving individuals from oppression and resulting powerlessness and engagement in

health risk behaviors to empowerment and resulting feelings of control and participation health promoting behaviors. Since prior reports of critical consciousness-based interventions typically do not offer specific examples of how they operationalize critical consciousness and the steps they take to increase critical consciousness in their intervention, we present this case example. Although this case example is focused on an intervention for Black gay/bisexual male youth living with HIV, we have used a similar critical consciousness strategy as part of a primary prevention intervention for Black gay/bisexual male youth who are not living with HIV. The basic structures of the critical consciousness-related activities are the same, but the stimulus materials and discussions with participants are tailored to the population.

To address the paucity of interventions developed for Black gay/bisexual male youth who are living with HIV, we drew from the critical-consciousness intervention work of Watts and colleagues to create Mobilizing Our Voices for Empowerment (MOVE). Formative work and implementation was completed through the Adolescent Medicine Trials Network for HIV Intervention. To ensure feasibility and acceptability, youth input was vital to the development of the intervention and youth were involved throughout the entire process.

We began the first phase of intervention development by reviewing the relevant data and interventions and discussing the findings with a New York City-based Youth Advisory Board composed of Black gay/bisexual male youth living with HIV. In phase two, based on the Youth Advisory Board's feedback, we drafted the intervention curriculum. We then tested the curriculum with focus groups consisting of the priority population in Philadelphia and Los Angeles in phase three. In phase four, we modified and further developed the curriculum based on the focus group findings with the help of a Chicago-based Youth Advisory Board, also composed of members of the priority population. Last, in phase five, we finalized MOVE curriculum with input from both the New York City- and Chicago-based Youth Advisory Boards. The intervention was then pilot tested in Chicago for feasibility and acceptability; participants took part in a focus group after completion of the intervention sessions, and the intervention activities were further refined based on that feedback. In the final step, we conducted a small-scale randomized control trial in four cities (Los Angeles, New York, Houston, and Memphis) to assess feasibility, acceptability, and initial evidence of intervention efficacy.

Like the Young Warriors program, MOVE utilizes media clips to initiate critical analysis of oppressive forces, such as those related to race and sexual orientation, and to help participants develop and practice potential responses to oppression to create positive change. Each intervention group includes two facilitators: an interventionist and a peer buddy. The peer buddy is a

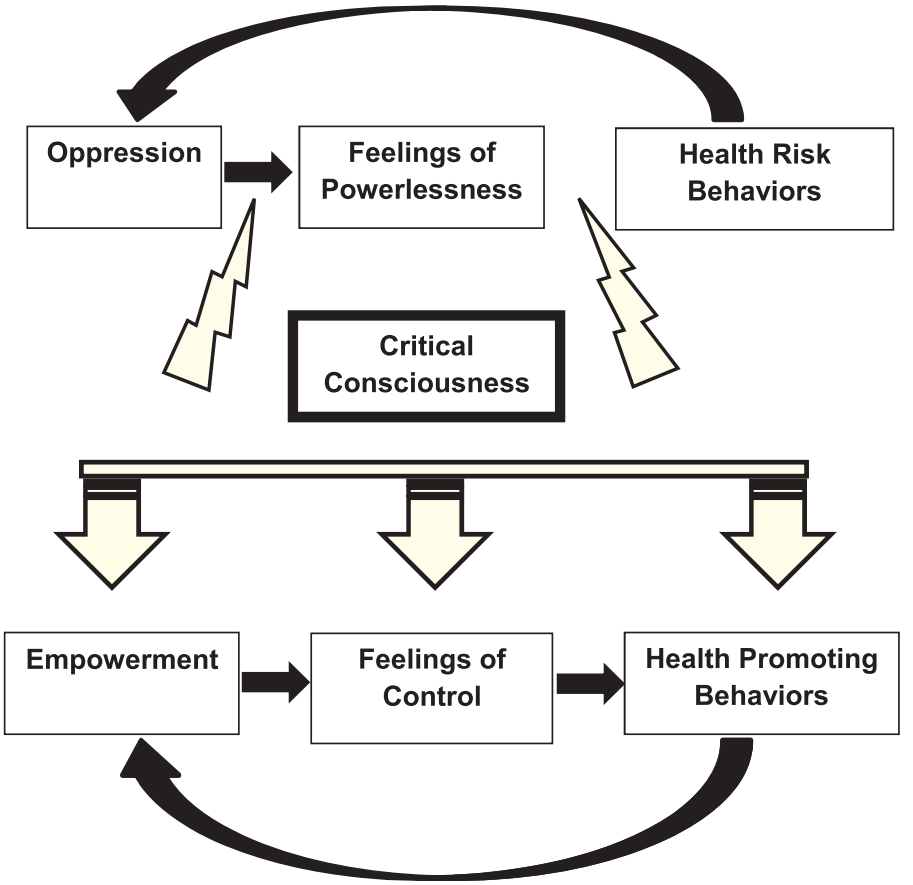

Figure 1. Pathway to health.

Black gay/bisexual young man living with HIV who is close in age to the target population. Those selected to be peer buddies are responsible and successful young men with whom participants can both relate and look to as a role model and undergo extensive training and supervision.

Within the intervention, the Pathway to Health model makes explicit the links from oppression to health risk and from empowerment to healthy behaviors (see Figure 1). We use several concrete examples that clearly illustrate the ways that oppression can impact health (e.g., lack of educational opportunity is a form of oppression that leads to limited job prospects, a consequence of oppression, which may lead to engaging in unprotected sex or selling drugs for money, a health risk) and then encourage participants to come up with their own examples. Not only does this provide the grounding for the focus on oppression and empowerment within an HIV-related intervention, but more importantly it helps participants contemplate how oppressive forces are affecting their own health. Explicitly linking oppression and empowerment to health and presenting

critical consciousness as a tool to move from oppression to empowerment is a distinctive aspect of this intervention uniquely suited to the fact that MOVE is a secondary HIV prevention intervention.

The media clips used in MOVE to stimulate group discussion and critical analysis represent forms of oppression relevant to Black gay/bisexual male youth living with HIV, focusing on racism, heterosexism, and HIV stigma (Wilson, Cherenack, Jadwin-Cakmak, & Harper, 2018). We refined Watts et al.'s critical consciousness coaching technique of stimulating group discussion with five prompts by expanding the fifth prompt and including extensive follow-up to encourage participants to think realistically about taking action against oppression. Participants are provided with a worksheet called Exploring External Negativity and Actions for Critical Transformation (E^2N-ACT) that lists each of the five steps: (a) What did you see or hear? Describe everything that you saw or heard in the stimulus; (b) What is the message or meaning behind what you saw or heard? Describe what you think the underlying message is in the stimulus. What do you think this says about (Black people, gay people, etc.)? (c) Why do you think that is the message? Describe what it is about the stimulus that makes you think it has the particular meaning you just described. What may have influenced that interpretation for you? (d) How do you feel about it? Describe your emotional reaction to the stimulus; and (e) What can you do about it? Describe what actions you can take to improve the situation.

This fifth step is then expanded, prompting participants to explore ways they can act to respond on individual, relational, and community levels. Specific examples of ways in which others have acted against oppressive forces at these multiple levels give youth the opportunity to understand "real world" examples of effective social actions and social change. Participants are asked specific follow-up questions encouraging them to critically examine their action step, including: What is my goal? What do I need to achieve this goal? Who needs to be involved? Who do I need to contact? What should my message be? How do I share my message? What are my barriers (challenges)? How will I overcome these barriers? What are my facilitators (helpers)? How will I use these facilitators? How will I know I achieved my goal? By encouraging participants to think concretely about actions they can take against oppression across ecological levels, we hope they will be better prepared to respond to oppressive forces they face in their everyday lives.

Conclusions

There is a need for primary and secondary HIV prevention interventions created specifically for Black gay/bisexual male youth that address the

structural factors—including racism, heterosexism, and masculinity norms—that propagate Black gay/bisexual male youth's vulnerability to HIV (Johnson et al., 2009; Millett et al., 2007; Yoshikawa & Wilson, 2004). Empowerment provides a context for understanding the influence of such oppressive forces on individuals' health and well-being. While many empowerment-based interventions have effectively produced behavior change (Mohajer & Earnest, 2009; Spencer, 2014), such interventions have been critiqued for frequently concentrating on the individual and neglecting to focus on understanding how existing power structures and dominant narratives negatively impact marginalized youth's health and well-being. Utilizing critical consciousness in empowerment-focused interventions addresses these critiques, as developing critical consciousness is a mechanism by which individuals can move from oppression to empowerment.

In the process of developing critical consciousness, individuals learn to critically analyze society's often invisible and unquestioned dominant narratives about marginalized people and identities. Once these narratives are made visible, individuals learn how to deconstruct and challenge these dominant narratives, gaining feelings of control that lead to behaviors that promote health and well-being. The MOVE intervention provides one case example of a critical consciousness-based intervention developed specifically for Black gay/bisexual male youth. In small groups lead by a facilitator and peer buddy who are similar in age, race, and sexual orientation identity, dialog is facilitated by viewing media clips that includes subtle or obvious racism, heterosexism, HIV-related stigma, or another type of oppression commonly experienced by this population. As a group, the young men critically analyze the message and generate various ways to respond to or challenge these messages using structured questions that encourage participants to think across ecological levels. Over the course of the intervention, the young men create their own definitions for what it means to be a Black gay/bisexual male youth, learn to be aware of and deconstruct damaging societal representations of their various identities, and begin to understand prosocial and health-promoting behaviors as a form of resistance.

The development and evaluation of additional empowerment-focused interventions for Black gay/bisexual male youth that incorporate critical consciousness-based activities should be a public health priority given the increasing rates of HIV among this population. Such interventions should provide youth with skills to decrease HIV-related risk behaviors and assist these young men in combating the potential negative effects of discrimination and stigmatization. Critical consciousness-based interventions can assist youth in not only identifying oppressive forces that may negatively impact their HIV-related health behaviors, but also enacting social action efforts to combat these oppressive forces and build an overall sense of

empowerment and control. The enhancement of a positive sense of self is especially critical during the developmental stages of adolescence and emerging adulthood, given the critical importance of identity development during this phase of life. Thus empowerment-focused HIV prevention interventions may have the potential to positively impact other elements of health and well-being among Black gay/bisexual male youth beyond HIV. Interventionists who wish to develop such programs should partner with youth to develop critical consciousness-based interventions for the prevention of HIV among Black gay/bisexual male youth, and actively engage these young people in all phases of intervention development.

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