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"There's a lot of conflict between your queer identity and also your Muslim or Arab identity;" A qualitative exploration of the intersectional minority stressors of U.S.-born Arab sexual minority cisgender men

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1. Introduction

In the United States (U.S.), sexual minority men (SMM) experience significant health disparities compared to heterosexual men. SMM are twice as likely as heterosexual men to report symptoms of depression and anxiety (Cochran & Mays, 2009; Meyer, 2003). Depression and anxiety co-occur with sexual risk behaviors among SMM, such as sex without condoms or PrEP, poor communication about condoms, and sex under the influence of substances (Mimiaga et al., 2015; Pachankis et al., 2015; Tsai & Burns, 2015). Early and ongoing stigma, such as bullying and parental rejection, has been identified as a persistent driver of health disparities among SMM.

According to minority stress theory, (Meyer, 2003) individual, interpersonal, and structural forms of stigma increase proximal stress experiences that in turn elevate health risks for SMM (Hatzenbuehler & Pachankis, 2016). Minority stress reactions refer to *individuals'* cognitive, affective, and behavioral responses to stigma such as internalized homophobia, rejection sensitivity, and identity concealment, (Hatzenbuehler & Pachankis, 2016) and have

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Declaration of competing interest

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Appendix A. Supplementary data

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been associated with HIV risk behaviors, anxiety, alcohol and drug use, and unhealthy coping mechanisms (Hatzenbuehler & Pachankis, 2016). *Interpersonal* forms of stigma refer to prejudice and discrimination enacted toward SMM, which are also associated with co-occurring HIV risk behaviors and poor mental health among SMM (Choi et al., 2013; Flentje et al., 2020). *Structural* forms of stigma refer to societal level conditions, cultural norms, and institutional policies that restrict the freedoms, resources, and opportunities of SMM, which have been associated with identity concealment, internalized homonegativity, and social isolation, yielding depression, suicidality, and low life satisfaction (Pachankis & Bränström, 2018; Pachankis et al., 2021; van der Star et al., 2021).

1.1. Arab immigrant SMM

As of the year 2019, approximately 26% (18 million) of all children in the U.S. under the age of 18 lived with at least one immigrant person, up from 19% in 2000; 88% of the 18 million individuals are U.S.-born and defined as second-generation immigrants (Ward & Batalova, 2023). From 2000 to 2019, the number of immigrants from the Arab world nearly doubled, with approximately 3.7 million people tracing their ancestry to one of the Middle Eastern/North African countries (Arab American Institute, 2022). Despite the growing Arab population in the U.S., information on their demographic and health outcomes is lacking due to their racial misclassification as white by the U.S. government (Abboud, Chebli, & Rabelais, 2019). The inclusion of Arab in the white racial category has caused them to be historically excluded from mainstream conversations about systemic racism and also made it very difficult to identify, much less measure quantitatively, the diverse experiences and outcomes for this group, rendering their lives and needs invisible. This erasure creates a discrepancy between the perceived and actual size of the health disparities borne by this population (Abboud, Chebli, & Rabelais, 2019; Abuelezam et al., 2018; Awad et al., 2022).

Arab immigrants in the U.S. have experienced stigmatization and discrimination such as hate crimes, Islamophobia, and xenophobia (Berry & Wiggins, 2018) that significantly increased following the 9/11 terrorist attack (Awad & Amayreh, 2016; Berry & Wiggins, 2018; Jamal & Naber, 2008). Often layered with gendered, religious, or racial biases, Arab immigrants are subject to unique forms of discrimination (Abu-Ras et al., 2021), which are significantly associated with adverse psychological and physical health outcomes (Abuelezam & El-Sayed, 2018; Atari & Han, 2018; Awad & Amayreh, 2016). For instance, depression and anxiety symptoms among Arab American college students have been found to be significantly higher than non-Arab American college students (36.0 vs. 31.5%; 31.9 vs. 27.5%; respectively) (Abuelezam et al., 2022).

Sexual minority men (SMM) from an Arab ancestry are affected by additional layers of stigma and invisibility due to the scarcity of health research with this intersectional population (Harfouch & German, 2017).

Arab immigrant SMM are subject to both similar and different life stressors as other SMM of color. Cultural values, social norms, and religious beliefs play distinct roles in the lives of particularly second-generation immigrant Arabs and their families (Abu-Ras et al., 2021; Hayek et al., 2022; Zhou & Gonzales, 2019), creating distinct experiences for SMM in their development and health across multiple life domains (Eichler & Mizzi, 2013; Ikizler

& Szymanski, 2014). Second-generation Arab immigrants have reported being pressured by their parents to uphold Arab cultural values and traditions, that are often described as reinforcing heteronormative understandings of gender, gender roles, relationships, family, and marriage (Abboud et al., 2022; Naber, 2012; Abdulhadi et al., 2011). In addition, the rendering of Arab immigrants as invisible by categorizing them as "white" (Abboud, Chebli, & Rabelais, 2019; Awad et al., 2022), coupled with the stigma associated with being a SMM, leaves the experiences of Arab immigrant SMM uniquely misunderstood.

1.2. Intersectional stigma

Intersectional stigma refers to the confluence of stigma toward multiple minoritized identities generated by interlocking systems of structural oppression (Berger, 2014; Sievwright et al., 2022). Stigma toward multiple identities held by the same person (e.g., sexual identity, race, ethnicity, and immigration status) contribute to intersectional stressors (e.g., homophobia and racism and xenophobia), and exacerbate health inequities experienced by SMM of color (Ayala et al., 2012; Cyrus, 2017; Ramirez & Paz Galupo, 2019).
In addition to experiencing societal homophobia and racism, SMM of color experience homophobia from other people of color, and racism from the white gay community (Ayala et al., 2012; Choi et al., 2013; Parmenter et al., 2021). Furthermore, immigrant status confers a distinct identity with unique social implications. Consequently, immigrant SMM may be particularly vulnerable to co-occurring HIV-risk and adverse mental health outcomes compared to non-immigrant SMM or immigrants who are not SMM (Fournier et al., 2017; Lewis & Wilson, 2017). Therefore, the objectives of the current study were to characterize the experiences of second-generation (U.S.-born) Arab immigrant SMM living in the U.S., and to examine the impact of intersectional minority stressors on their mental and sexual health.

2. Methods

2.1. Design, participants, and recruitment

We employed a qualitative design (Bradshaw et al., 2017) with codebook thematic analysis typology (Braun & Clarke, 2021). We conducted semi-structured, one-on-one interviews with second-generation Arab immigrant SMM in the U.S. We used non-probability purposive sampling and the following inclusion criteria: 18 years or older; cisgender man; second-generation (born in the U.S. to parents born outside of the U.S.) immigrant; Arab ethnic identity; gay, bisexual, or queer sexual identity; and living in the U.S. We recruited participants through personal contacts; online community outreach to individuals, groups, and organizations that are Arab/Middle Eastern/North African and queer affirming, who in turn shared the study flier on their social media pages (Twitter, Facebook and Instagram); and snowball techniques. Participants received a $30 gift card. The study was approved by the University of Illinois Chicago and Yale University institutional review boards.

2.2. Procedures

We ensured participant eligibility and, once confirmed, scheduled a virtual interview and sent a Zoom invitation, link to the informed consent form, and a brief demographic questionnaire. Before the interview, we reviewed the informed consent form and answered

questions. We conducted the interviews in English, which were audio-recorded and lasted on average 52 min (range = 28–91 min). To ensure uniformity of content, we followed a semi-structured interview guide (Appendix A) that was developed by the first and last authors based on study aims, previous literature, and our expertise in immigrant health and sexual minority health. Interviews were conducted between November 2020 and August 2021.

2.3. Analysis

After professionally transcribing the interviews, we de-identified them and assigned them a unique identification number and a pseudonym. We used Dedoose to code transcripts and followed an inductive codebook thematic analysis typology guided by process of Braun and Clark (Braun and Clarke, 2006, 2014, 2021). Codebook thematic analysis captures a cluster of methods that broadly sit within a qualitative paradigm (Braun & Clarke, 2020). Researchers use some kind of structured coding framework for developing and documenting the analysis. Themes are typically initially developed early on, but can be refined or new themes can be developed through inductive data engagement and the analytic process (Braun & Clarke, 2020).

After multiple readings of the transcripts, the first and third authors independently used open coding to generate a set of descriptive codes from the first three interviews. Although this approach was not designed to fit a preset or theory-driven coding schema, we acknowledge that this analysis is not entirely inductive as the interview guide was developed to elicit the ways in which participants experienced specific domains of identity stressors, mental health, sexual health, and coping mechanisms. The first and third authors met regularly following the coding of the first three transcripts to assess the extent of their agreement on their initial open-coding schema. They identified meaningful inconsistencies in initial coding. Initial disagreements in coding and areas where consensus was required were resolved through team discussion and adjustment of coding criteria. Once the codebook was developed based on recurrent codes from the first three interviews, the third author coded the remaining interviews. Then, the first and second authors conducted a more focused analysis, whereby they identified recurring subcategories across the data, organized and synthesized the subcategories into categories, and delineated their relationships to identify specific themes. A total of 19 s-generation immigrants were deemed sufficient to achieve data saturation (Hennink & Kaiser, 2022; Malterud et al., 2016).

2.4. Rigor

To ensure the rigor of the study, we followed the strategies described by Morse (Morse, 2015). We performed prolonged engagement through extensive community outreach that included contacting five community organizations, personal and social media outreach, and recruiting a research assistant who was well connected to the community. Our interview guide and interviewing skills supported rich and thick descriptions of participants' experiences. We also used peer debriefing to discuss initial thoughts and impressions after the interviews. We employed a codebook thematic analysis typology that was regularly discussed among the authors. Data analysis including transcript reading, coding, and regular team meetings totaled 10 months and ensured appropriate immersion in the data. We

developed an audit trail that included our memos, observations, data analytic notes, and clarification of our biases.

Our team includes four co-authors living in the U.S. (first author is a first-generation immigrant; second and third authors are second-generation immigrants). We are two cisgender women and two cisgender men, with diverse sexual orientation (e.g., bisexual, queer, gay) and racial/ethnic backgrounds (Arab, mixed race, and white). We have complementary expertise in sexual minority health, immigrant health, mental and sexual health, and qualitative research. Our multiple identities and expertise provided insider and outsider perspectives and influenced our research interests, including the approach of this study. To address our biases related to our demographic identities and values and beliefs about the topic (Rae & Green, 2016), we engaged in ongoing reflexivity throughout the research process, we met regularly and discussed our worldviews and experiences, the research procedures, findings, and implications to ensure the rigor of the study. Lastly, we were mindful to not draw assumptions or conclusions based on our experiences, however, as most of the co-authors shared identities (i.e., sexual orientation, immigration, or ethnicity) with the participants, we think that our lived experiences strengthened the analytic process.

3. Findings

Participants' mean age was 29.7 (*SD* = 5.1) years. All participants were born in the U.S., except one who was born in an Arab country but moved to the U.S. at age two. The participants identified as gay/queer (52.6%), gay (42.1%), or queer (5.3%). They represented six different states with the majority being from New York (42.4%) or California (31.8%). Table 1 provides additional participant characteristics.

We identified five themes: (1) a heteronormative culture: "It's not just any masculine mask, it's an Arab masculine mask"; (2) the Arab immigrant identity in the U.S.: "am I Arab? Or Am I American?"; (3) intersectional identity stressors: "there's a lot of conflict between your queer identity and also your Muslim or Arab identity"; (4) impact of stressors on health: "internalized homophobia messed me up"; and (5) coping strategies: "assimilation for survival". In the following sections, we provided exemplar quotes from participants with their pseudonyms and age.

3.1. A heteronormative culture: "It's not just any masculine mask, It's an Arab masculine mask"

Participants described the concept of heteronormativity in terms of upholding Arab masculinity and related struggles with family relationships and expectations. Subsequently, their early socialization into a heteronormative culture frequently resulted in internalized homophobia.

3.1.1. Upholding Arab masculinity—Participants reported different experiences with how masculinity was portrayed and enacted in their communities. From a young age, toxic masculinity forced the association of behaviors that did not conform with the Arab masculinity norms as non-Arab and gay, resulting in a loss of personhood. Amir (26) recalled:

> A lot of us resort to this masculine mask, but it's not just any masculine mask, it's an Arab masculine mask. It comes along with arrogance and other stuff. Because there is a certain way of being an Arab male […] and if you're not doing it, it's gay, it's weird, it's this, it's that.

Policing gender expression was another way of ensuring appropriate Arab masculinity. Rashad (25) reported this experience:

> When I had my earrings in, my [first-generation] grandma called me a faggot straight to my face. I'm not even out to them. Even the most subtle things that step outside of this gender binary, things like earrings […], can almost out you in a way.

Parents used the idea of marriage and starting a family to remind participants of the need to conform to Arab heteronormative culture, even when participants had previously disclosed to them their sexual identity. Bilal (32) recalled:

> Every time they call me, somehow marriage comes up, and if a family friend, their kids get married, there's always that indirect, 'I wish you go and have a family and this and that. Oh, you'll make me so happy.' They're quite masterful in guilt tripping, and so that's where some of the shame comes from.

3.1.2. Struggles with family relationships—Almost all participants described their struggles with family relationships and their sexual identity. They described being "disowned" by parents (Naji, 23), lacking parental support, and parents instilling fear: "I remember my mom went through my phone when I was 18, and she said, 'If you're gay, I'm gonna kill myself.' I decided to hold back. […] I remember my dad said, 'You're gonna get AIDS if you're gay'" (Mustafa, 31). Wael (40) described regular fights with his mother affecting his sleep. Bilal (32) described shame and judgement when talking about his relationship with his parents:

> Every time I talk with my parents, it's almost like I'm going through a car wash, but instead of water, it's shame and judgements, and then I'm wet afterwards. It just takes time for me to dry.

Participants experienced discrimination from their families. Abdullah (41) described his parents' embarrassment with his identity: "one time, we went to San Diego where my sister was, and the neighbor came over—Arab neighbor—and my partner and I sat outside like dogs waiting for them to leave 'cause my mom was embarrassed of us." Similarly, Wael (40) recounted his experiences with his extended family in the U.S.:

> My cousins sent me death threats. My aunts told me that I was going to hell, and they blamed me for my parents' unhappiness. One of my aunts told me to stop displaying my ugliness to the world. Another one of my aunts said that my sisters were never going to get married because they have a gay brother.

Despite the challenges, a few participants such as Mustafa (31), described an improvement in the relationships over time:

> They [parents] recognized that, 'this isn't something [I] can control.' My dad made a comment like, 'just like your brother is left-handed, we can't force him

> to be right-handed. It's natural.' That was a revelation when I heard that […] They recognize that I'm happy. It went from a very terrible, rocky, anxiety-ridden journey to free. Being gay is not even a thing to me anymore.

For other participants, their relationship with their families became characterized by avoidance of and disregard for the participants' sexual identity, personal life, and intimate relationships: "They [parents] sat me down for dinner with my sister at my university. They were like, 'we're gonna accept this, and we're not gonna talk about it ever.'" (Naji, 23).

3.2. Internalized homophobia: "this is abnormal"

Participants described society's perception of being gay or queer from within the Arab community. Many experienced rejection, verbal and emotional abuse, and marginalization from their families and communities. Naji (23) recalled a time when his father shared an encounter:

> My dad was like, "This is abnormal." He describes the story of when he first moved to the states as being like, 'I was in an elevator in New York and some man winked at me, and I beat him up in the elevator.'"

A few participants mentioned religion and cultural norms as reasons for the stigma that exists within the community: "the Arab Muslim community I grew up in views gay and bisexual men as sinners and as not a part of Islam. They're doing deeds against God's will or intent" (Faris, 25), "it goes against religious ideology, regardless of what religion they practice" (Hassan, 30).

Several participants explicitly expressed that they internalized all the negative and heteronormative messages that they grew up hearing: "It was always something I was doing wrong, as opposed to just someone that I am" (Kamal, 26). Rashad (25) described the impact of exposure to years of homophobia on his identity:

> You grow up in a household for 19, 20 years of your life being told and shown that all these things are bad. Do not do this. Don't look like this. Don't act like this. Stop acting feminine. All of it. Every single piece of my gay identity was demonized. Then when you're out of that environment and it's now up to you to go back and do the work of untangling and rewinding and relearning all of these things that are so negative, it takes a very, very long time. I even still catch myself with these weird homophobic tendencies.

3.3. The Arab immigrant identity in the U.S.: "Am I Arab? Or Am I American?"

This theme encompassed two categories that reflected the intersectional aspects of their immigrant identity and racial/ethnic identity: the Arab identity crisis and experiences of Islamophobia and racism. Despite not being explicitly associated with their sexual identity, the immigrant identity stressors and racial/ethnic identity stressors were important to highlight, as racism and discrimination were a significant aspect of the participants' experiences.

3.3.1. The Arab identity crisis—Participants described the pressure to maintain the Arab identity, including their family values and beliefs, as second-generation immigrants. Participants were reminded by their parents of the struggles they endured in their home countries, which belittled the struggles that the participants faced here in the U.S., based on their own identities. Faris (25) shared his experiences:

> I didn't know how to bring up the stuff with my family even if it wasn't about gayness. I didn't know how to bring up sadness before it turned to depression. Any type of discomfort that we felt as kids was always met with, 'well, when we lived in Syria, this was difficult and we did this and we did this, and you're complaining.'

Participants had to navigate the Arab American identity while being cognizant that they might not be fully immersed in any one of the individual parts of this identity, neither Arab nor American. Yusuf (25) explained:

> It really sucks because, as an Arab American, you deal with the identity crisis of: Am I Arab, or am I American? You want to find the balance between both, but America makes it so hard. Because you're not Arab, but at the same time, because you're not fully American, you're still gonna face troubles and discrimination, and because you're not fully Arab, your Arab community back home is like, 'well, you're sort of half of us'.

3.3.2. Islamophobia and racism—Participants experienced different forms of discrimination based on their religious and ethnic identity, mostly from the white mainstream American community. These experiences ranged from subtle racist questions like "where are you from?" (Naji, 23) to explicit racism: "In high school too, they wrote on the locker 'where were you on 9/11?'" (Amir, 26); "there were these times constantly growing up where, 'where are you from? are you a terrorist? are you a sand N-word?' Just perpetual discrimination my entire life" (Abdullah, 41). Similarly, Khalil (28) shared:

> Growing up Muslim and Arab, post-9/11 in a mostly white suburb. Yeah, everything from being called terrorist, to Osama bin Laden, to Saddam. I remember, in my dad's convenience store, we had to put up an American flag after 9/11. Like we're safe. We're cool. We're here. We're in this together.

In addition to experiencing Islamophobia, Faris (25) explained how he constantly had to defend his American identity because people immediately assumed he was a refugee based on his Syrian ethnicity:

> After the Syrian revolution started […], when I would share that I was Syrian, there would always be the assumption, that I was a refugee. They'd be like, "Wow, well, your English is great. How did you escape the war?" It's like I mean—I was born here. Being forced into that space where you have to defend your American identity too is really uncomfortable and annoying.

3.4. Intersectional identity stressors: "There's a lot of conflict between your queer identity and also your Muslim or Arab identity"

In this theme, participants described the identity stressors they endured based on their intersectional ethnic, religious, and sexual identities, as well as sexual racism.

3.4.1. Challenges of dual ethnic and sexual identities—The challenges with participants' multiple identities were rooted in personal turmoil and conflict related to their existence as gay Arabs, and in society's perceptions of their multiple identities. Several participants described going through different phases to accept the co-existence of these identities:

> I think my experience as a queer Arab man has come in phases. There was the coming to accept my sexual orientation. That was its own battle, right? But then coming to accept my Arab identity as a queer person, which was a separate battle than just accepting I was queer (Nasir, 26)

Naji (23) added: "Currently, I'm trying to reclaim the Arab identity in the context of queerness, also with the family baggage and with the American baggage and the intergenerational trauma." Kamal (26), who was raised in a conservative Muslim household in the U.S., described his identity conflict in terms of ethnicity, religion, and sexuality:

> Unfortunately, there's a lot of conflict between your queer identity and your Muslim or Arab identity. When you feel like one of them isn't accepting you—I remember, I used to say, 'how could I accept a religion that doesn't accept me?' I used to say that all the time. […] I know I'm queer, so then I can't be Muslim. That very thing that people would say. How can you be gay and Muslim?

In addition to their internalized identity struggles, participants were subjected to society's perceptions of their irreconcilable multiple identities, from their own Arab communities, "I remember growing up, saying the word gay was discouraged; my religious Arab community found it an oxymoron to be both Muslim and gay, and it's this idea that you have to choose one over the other" (Bilal, 32). More commonly, participants were subjected to the stigma based on their intersectional identities from the white American mainstream community, including the queer community: "Non-Arab people would look at a gay guy and be like, isn't that against your religion? Can't you be killed for that and not accepted?" (Kareem, 36). Amir shared the following:

> I think they view us as like, 'they're probably getting killed for this.' Like, 'his parents probably beat his ass for that.' I think there's a perception that we go through such a brutal time based off of the violence that they see on television. They think 'Oh, if this violence is going on back home over a war, I can only imagine what kind of violence is going on if their son's gay'.

3.4.2. Sexual racism—Almost all participants experienced some form of sexual racism and they identified that these behaviors were rooted in racism and white supremacy in the U.S. Sexual racism created challenges in dating and sexual contexts, in both online and in-person settings. Abdullah (41) recalled this experience:

> Just like there's racism in the straight community, there's definitely racism in the gay community, so dating was very challenging for me growing up or being younger, I should say, because if I checked a white box on a dating site, people would say I'm not white the second they saw my photos. Then, if I check a Middle Eastern box, nobody would ever talk to me.

Participants also described the constant fetishization of their gender, ethnic, and sexual identities within the queer community: "Arabs are fetishized so much. I think that too, especially from white, gay men. If you're Arab, you have to be this really masculine man going to completely inhibit their submissive feelings" (Kamal, 26); "Pre-pandemic, they [a Middle Eastern group] had almost three or four social dance parties a year. Then, you would definitely see these white, lurky men coming to those events to find their fetishized version of an Arab man" (Wael, 40). Khalil (28) similarly stated:

> Especially post 9/11, it created this world where we became the fetish because we were seen as this hypermasculine, butch, dom top because of the terrorist trope that we see in the media. My interactions with people on the apps and stuff like that is always centered on my body hair or whether or not it's a secret. Will this hookup be a secret? Is it *haram*? [meaning "forbidden" in Arabic].

Abdullah (41) very clearly connected the roots of sexual racism to white supremacy, especially under the pretense of "sexual preference" within the white gay community:

> The joke about the preference gays. Like, 'Oh, just my preference that I wanna date someone who looks like this, so you can't tell me who to date or who I'm attracted to.' Again, they don't understand that those preferences are rooted in white supremacy and oppression and racism and the concept of what it means to be picked or what it means to be attractive.

3.5. Impact of stressors on health: "internalized homophobia messed Me up."

3.5.1. The psychological impact of identity stressors—Almost all participants experienced negative impact on their psychological well-being because of the different stressors that they experienced. The most significant impact was based on their sexual identity stressors. Participants described high levels of stress, anxiety, depression, and suicidal ideation and attempts.

Hassan (30) shared: "I was most anxious and most stressed because I realized all I was thinking about 24 h a day was being gay and closeted." Many participants shared that they struggled with mental health issues, but were only able to address them until they left their parents' house or were able to afford their own health insurance. Malik (31) stated: "Mental health-wise, internalized homophobia messed me up […] I think that I've been feeling a lot less anxiety. I was paralyzed for a long time by just intense stress and anxiety." Similarly, Ibrahim (34) stated:

I've probably had low level anxiety and depression since high school that just hasn't been diagnosed or addressed until recently, and I'm now seeing a therapist over the last three years and stuff like that and helping manage that. […].

One participant, Amir (26), attempted suicide twice. He shared his experience with his first suicidal attempt when his father was able to stop him: “I’ve always dealt with depression, and I attempted suicide on a roof. The roof, it’s on top of my—it’s right next to my bed back home. […] he [father] stopped me before I had the chance.”

Three participants mentioned suicidal ideation. They described feeling isolated, lonely, and depressed, which led to contemplating suicide: “I would look at how do you cut yourself. I contemplated suicide a lot. I never got to the point where I acted on it, but it was always in my mind” (Mustafa, 31).

In addition to stress, anxiety, and suicidal ideation, Faris (25) struggled with his body image by trying to have the “perfect masculine body” to be accepted and not bullied, and subsequently developed an eating disorder:

> At the beginning of my journey, I didn’t cope well. I was very depressed, and I focused my energy on my appearance, and I felt that if I could control my appearance, I would prevent pain. I would be accepted. I developed bulimia in undergrad. For four years, I had an eating disorder, and it got to a point where I was unable to continue school.

3.5.2. The impact of identity stressors on sexual health—Almost all participants had good awareness of their sexual behaviors and what were considered risky sexual behaviors, even when they engaged in them (inconsistent condom use, “unsafe” encounters). Abdullah (41) shared:

> For me, it was more of anonymous sex, seeking validation from sex and from men, and it wasn’t that unsafe practice of condomless sex, but it was definitely the multiple partners, anonymity, unsafe situations, internet hookups, online, going to people’s houses.

Nine of the 19 participants reported using condoms consistently, in both committed and casual relationships; they described “irrational fear of HIV specifically and STIs” (Naji, 23) as the main reason for their consistent condom use. Some participants worried that having a STI, particularly HIV, would disclose their sexual identity to others. Yusuf (25) said: “Most of my early sexual experiences were without protection […] It was such a taboo that I would be reluctant to even get tested […]. Nothing protects you from Arab gossip.”

Three of the ten participants who reported not using condoms consistently were not on PrEP (pre-exposure prophylaxis). Overall, seven participants reported being on PrEP and two had been in the past; consequently, they got tested for STIs regularly to receive their medications.

Almost all participants discussed the lack of appropriate sexual health education, whether at home or school, and the taboo associated with conversations around sex in their communities: “A lot of Arabs in my community, heterosexuals as well as queers, are still undereducated about sexual health, and I think it comes from taboo and conservative ideas and beliefs” (Yusuf, 25).

3.6. Coping strategies: “assimilation for survival”

Participants used different coping strategies to navigate their identities and ensure their overall wellbeing. The strategies were contextual and reflected participants’ intersectional identities.

3.6.1. Sexual identity concealment and disclosure: “A pretty good code switcher”—Participants described their ability to identify situations where they could authentically be themselves, versus other situations where they have to hide one of their multiple identities to fit in and be safe. Rashad (25) shared: “I can read a room really well. I can understand when it’s safe to be my extravagant, flamboyant self and when it’s not. […] the way I dress, too, protects me in a way. It’s just very plain.” Khalil (28) reflected on the need to “run away from one identity to fit into the next.” He stated:

> You’re not finding a space for you, you start feeling like there never is going to be a space for you, so you start changing yourself to fit into those spaces. That’s what I mean when I say assimilation for survival.

3.6.2. Over achievement: “you have to work twice as hard just to be seen as equal”—Here, participants described how they used work, academic, and financial achievement to cope with their realities. They had to work harder than others in their community to protect themselves, to ensure their current and long-term safety, and to deflect attention from their sexual identity elsewhere. Khalil (28) shared:

> It creates this having something to prove of ‘I’ll show you guys. You’re gonna respect me […] I’m gonna be someone that you would envy, or you would respect.’ You have to go above and beyond, and you have to work twice as hard just to be seen as equal or on the same level.

Rashad (25) reflected on this coping strategy that he had also witnessed with other Arab gay men:

> I’ve noticed that queer people will aspire to be super successful, like more successful than their straight counterparts, and super, super high achieving. I think a part of that, including myself, is trying to make up for the fact that I’m gay and my family, they don’t accept me, but look at all this abundance of success I brought to you.

3.6.3. Avoidance, alcohol, and substance use: “how do we cope? We do drugs”—Participants reported using avoidance, alcohol, and other substances to cope. These strategies helped them escape their current situations: “I used alcohol, smoking, and sex as coping mechanisms prior to coming out and after coming out, for sure” (Abdullah, 41); “again, how do we cope? We do drugs. We drink. We just pretend like it’s not happening. I’m drinking as much as I possibly can. Drugs offer us an opportunity to just shut everything down for at least a little” (Rashad, 25); “in my personal experience, I’m dealing with it with […] avoidance and drugs and alcohol and sex and things like that. I guess those are maladaptive” (Ibrahim, 34).

3.6.4. Mental health care: "It's incredibly challenging"—Almost all participants recounted either being in therapy at the time of the interview or at some point in their lifetime. Although a few participants described the benefits of receiving mental health care, many participants struggled with several barriers to receiving the care they needed that included 1) financial barriers: "I don't really wanna be paying $100 a week to talk myself through things" (Malik, 31), 2) stigma related to mental health within the Arab community: "there was a large in-home stigmatization of what it meant to go to therapy. It meant that you had problems. That you were problematic" (Nasir, 26), and 3) the inability to find a provider capable of understanding their intersectional identities, cultural background, relationships with their families, and historical traumas. Khalil (28) recalled:

> I'm just not down for having a white therapist, ever. It would need to be a person of color, and it would need to be a queer person, and preferably someone that comes from the same backgrounds and identity as me […] Whenever they can't share that with me, I don't feel safe enough to be vulnerable.

3.6.5. Finding community support: "putting power in our hands"—Participants found comfort and safety when they had access to an Arab queer community whether virtually or in-person. They described building relationships, including romantic relationships, meaningful connections, and healthy support systems. They also found strength through their involvement in queer activism and joining queer student-run or community-based organizations. Jamil (26) stated: "Over the years, I've definitely gained a lot more comfort by identifying other folks who identify as Arab and queer. Enjoying different social circles, different organizations, different networks, conducting my own LGBTQ research."

Abdullah (41) added:

> Putting power in our hands and the community […] has been very impactful on my mental health and on my ability to exist in this space. The support group has been incredibly helpful because it really has allowed me to reconnect with my community, which I missed for so long.

4. Discussion

This study explored the experiences of second-generation (U.S.-born) Arab immigrant SMM living in the U.S., with specific focus on the impact of intersectional minority stressors on their mental and sexual health. Our findings demonstrated the relevance of intersectional minority stressors in this population in terms of their sexual, ethnic/racial, and immigrant identities, and the need to incorporate the sociocultural context when addressing the impact of the stressors on their health. Our findings provide new data into the complex experiences and challenges that Arab immigrant SMM face in the U.S. and offer opportunities to develop culturally relevant interventions to improve their health.

Similar to previous research with other sexual minority populations in the U.S. (Flores et al., 2019; McDermott et al., 2019; Pollitt et al., 2019; Flores et al., 2019; McDermott et al., 2019; Pollitt et al., 2019), participants described being raised in a

heteronormative environment, including within their families. Some participants internalized these heteronormative messages while others had to wear an "Arab masculine mask" to conform to the gender and cultural expectations. Our first theme, "*a heteronormative culture: 'it's not just any masculine mask, it's an Arab masculine mask*,'" is consistent with how Allen and Mendez (Allen & Mendez, 2018) described heteronormative hegemonies "exist not merely within the realms of gender, sexuality, and family but also within the contexts in which those realms are embedded" (p.74). Participants' experiences with their gender expression (for example, wearing earrings, having more feminine mannerism), were a cultural signal of their sexual identity, their nonheterosexuality, all within hegemonic masculinity and heteronormativity.

Consistent with previous research on Arab immigrant identity in the U.S. (Jamal & Naber, 2008; Naber, 2012; Awad et al., 2021; Abboud, Jemmott, & Sommers, 2015) including with Arab American sexual minorities (Ikizler & Szymanski, 2014), participants struggled with their hyphenated racial/ethnic Arab American identity. They felt pressured by their parents to withhold Arab cultural values and norms. Similarly, among second-generation immigrants in the U.S., diverse ethnic identity development patterns over the life course are shaped both by ancestral attachments and the existing U.S. racial structures (Feliciano & Rumbaut, 2019). In addition, many participants experienced multiple forms of discrimination including racism, Islamophobia, and xenophobia, which have been reported in previous studies (Abuelezam et al., 2017; Atari & Han, 2018; Awad & Amayreh, 2016; Berry & Wiggins, 2018; Shammas, 2017). Twenty-two years after the tragic event of 9/11 that took place in the U.S., a few participants mentioned its continuing impact on their lives and their families' lives. Their experiences highlight how that event permanently and negatively shaped how Arabs are perceived in the U.S. and it fueled a hostile sociocultural and political context that participants had to navigate constantly.

Identity stress was a common experience related to co-existing as both Arab/Muslim and gay/queer, and was perceived to be an "oxymoron" by participants, their Arab/Muslim communities, and the mainstream white queer communities. Some participants internalized this perception and engaged in different coping mechanisms until they were able to embrace their intersectional identities. Although participants felt that this identity stress was unique to them, it has been previously reported among SMM of color, particularly Black and Latino men (Ghabrial, 2017; Meyer, 2010; Swann et al., 2023). This stress is not inherent to SMM of color's identities, but is a response to society's stereotypes and misconceptions of SMM of color that position them as an outsider group to the mainstream, white queer communities. On the other hand, embracing one's intersectional minority identities has been reported to also have a positive impact in terms of identity affirmation, growth, pride, and resilience (Ghabrial & Andersen, 2021; Meyer, 2010). In fact, despite the stress induced by their intersectional identities, participants indicated that their intersectional identities also served as a source of social support and identity affirmation. Finding a safe space, particularly within Arab queer communities, either in-person or virtual, improved the psychological and social well-being of many participants. Notably, a greater connection with the queer community and a positive sexual identity has been shown to be associated with better mental health outcomes in LGBTQ people (Heath & Keene, 2023).

Sexual racism is defined as racial discrimination between potential sexual or romantic partners and is associated with adverse health outcomes, including depression, anxiety, stress, and sexual risk behaviors (Díaz et al., 2011; Han et al., 2015; Hidalgo et al., 2019). In our study, participants described the reproduction of white supremacy through racism and Islamophobia in virtual and in-person sexual spaces, reporting experiences of objectification and fetishization of Arab male bodies, masculinities, and Arab culture, especially post-9/11. In fact, experiences with identity stress are consistent with previous research on sexual racism and the use of "personal preferences" filters in dating apps to further exclude and marginalize SMM of color, including immigrants (Callander et al., 2015; Hidalgo et al., 2019; Huang & Fang, 2019; Robinson, 2015; Stacey & Forbes, 2021).

The impact of intersectional identity stressors on the health of participants is also consistent with previous research among SMM of color (Ching et al., 2018; Choi et al., 2013; Jackson et al., 2020; Ramirez & Paz Galupo, 2019). Intersectional stressors based on sexual identity (e.g., internalized homophobia) and racial/ethnic identity (e.g., racism, xenophobia) are linked to adverse mental health outcomes including depression, anxiety, suicidality, substance use (Ching et al., 2018; Hidalgo et al., 2019) and sexual risk behaviors (Ayala et al., 2012; Ching et al., 2018; Han et al., 2015). Almost all participants in our study reported high levels of stress, anxiety, depression, and suicidal ideation and attempts. However, most participants described good awareness of healthy sexual behaviors in terms of testing and being on PrEP.

4.1. Limitations

The findings should be interpreted while considering three primary limitations: First, the sample included mostly young, well-educated, gay/queer-identified men; therefore, findings do not necessarily represent the experiences of older men, those with less education, or those who identify as bisexual. Second, selection bias might have also influenced the quality of data, since Arab immigrant SMM who were more comfortable with disclosing and discussing their sexual identities were more likely to participate in the study. Third, the cross-sectional design limited our ability to examine changes in participants' sexual identity development and stressors and their impact on health outcomes over time.

4.2. Clinical and research implications

Our findings highlight two common barriers to mental health service utilization for Arab immigrant SMM: a lack of culturally competent mental health providers and unaffordable mental health services. Previous research with Black and Hispanic sexual minority people has similarly identified challenges with finding culturally competent providers and affordable mental health care (Moore et al., 2020). While long-term and system-wide change to increase funding for mental health services and to train minority providers is crucial, the development of support groups, either in-person or virtual, for Arab SMM may be the most feasible interim solution to address acute mental health needs. Spaces for Arab SMM to discuss their shared experiences would offer them the opportunity to better navigate collective experiences of discrimination, trauma, and mental health challenges. These groups could also offer a space to overcome stigma experienced toward mental health care seeking in the Arab community. Group-level interventions may also foster the

development of healthier coping mechanisms for identity-related life stressors, including through reduced substance use and forming relationships outside of a purely sexual context. Aside from mental health services, participants also pointed to the need for more sexual health education, a need that could also be met in community spaces.

In terms of research implications, this work provides an impetus for ensuring that data from Arab populations are not continued to be rendered invisible through their characterization as "white" in national datasets. The study findings identified numerous unique experiences resulting from intersectional stressors that would otherwise be missed using current and common national data collection strategies that group Arabs under the white racial category. Therefore, we advocate for a crucial need to include a separate racial category for individuals with Arab ancestry in the U.S. census that will advance research that specifically addresses the health issues unique to the Arab community (Abboud, 2023).

5. Conclusion

This study illustrates the lived experiences of U.S.-born Arab immigrant SMM and demonstrates the unique intersectional stressors and their impact on participants' health. Intersectionality and minority stress theories are important in health and policy research, as they highlight the unique realities of individuals whose experiences are usually invisible in most research, and whose needs are often ignored in society. The findings of this study showed the importance of feeling connected to community support who share similar identities, both Arab and sexual minority, and the importance of spaces that are specific for racialized individuals. Our findings also provide evidence that appropriate mental health services can play instrumental roles in improving the mental health of Arab immigrant SMM. These findings highlight the disparities experienced by Arab immigrant SMM and necessitate efforts to provide comprehensive, tailored mental and sexual health care services, and the need to provide a separate racial category on the census for Arabs in the U.S.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Demographic characteristics (N = 19).

	Total N (%)
Age (Mean, SD) (Range: 23–41)	29.7 (5.1)
Ethnicity	
Arab American	12 (63.2%)
Arab	2 (10.5%)
Lebanese American	2 (10.5%)
Arab Latino	1 (5.3%)
Palestinian American	1 (5.3%)
Chaldean	1 (5.3%)
Place of birth:	
Born in the U.S.	18 (94.7%)
Outside of the U.S. (but moved to the U.S. at the age of two)	1 (5.3%)
Arab country participants identify with	
Lebanon	5 (26.3%)
Egypt	4 (21.1%)
Palestine	3 (15.8%)
Syria	2 (10.5%)
Iraq	1 (5.3%)
Jordan	1 (5.3%)
Morocco	1 (5.3%)
Palestine and Jordan	1 (5.3%)
Palestine, Syria, and Lebanon	1 (5.3%)
Education	
College degree/some college	7 (36.8%)
Graduate degree/post-graduate	8 (42.1%)
Currently enrolled in college	4 (21.1%)
Employment	
Full time	9 (47.4%)
Part time	5 (26.3%)
Self-employed/freelancer	2 (10.5%)
Unemployed	3 (15.8%)
Yearly Income	
Less than $25,000	6 (31.6%)
$25,000-$45,000	4 (21.1%)
$45,000-$65,000	1 (5.3%)
More than $65,000	8 (42.1%)
Current residence in the USA:	
New York (New York City, Rochester)	8 (42.4%)
California (Los Angeles, San Francisco, San Jose)	6 (31.8%)
Illinois (Chicago)	2 (10.5%)

	Total N (%)
Michigan (Detroit)	1 (5.3%)
Massachusetts (Worcester)	1 (5.3%)
Arizona (Phoenix)	1 (5.3%)
Religious affiliation:	
Muslim	7 (36.8%)
Atheist/agnostic/non-religious spiritual/other	7 (36.8%)
Christian	4 (21.1%)
Other (Druze)	1 (5.3%)
Religiosity (“On a scale of 0–10, how important is your religion in your daily life?” mean, *SD*)	4.8 (3.2)
Relationship status	
Single	7 (36.8%)
Serious relationship/engaged/partnered	5 (26.4%)
Casual/dating relationship	3 (15.8%)
Married	2 (10.5%)
Other (e.g. long distance)	2 (10.5%)
Sexual orientation	
Gay	8 (42.1%)
Queer	1 (5.3%)
Gay/Queer	10 (52.6%)